STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555848	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Little Comp of Mary Subacute Care Ctr	1322 West Sixth Street San Pedro, CA 90732

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to report an injury of unknown origin (the cause of injury was not observed by any person or could not be explained by the resident) to the California Department of Public Health (CDPH) for one of two sampled residents (Resident 41) when Resident 41 developed a blood (a fluid-filled sac in the outer layer of skin) blister on the right big toe of the right foot. This failure had the potential to result into a delayed investigation to rule out abuse. Findings: During a review of Resident 41's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included respiratory failure (condition when the lungs are not able to effectively take in oxygen and remove carbon dioxide from the blood), cerebral vascular accident (CVA-stroke, loss of blood flow to a part of the brain), tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs) in place, gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 41's Minimum Data Set (MDS- a resident assessment tool) dated 10/23/2024, the MDS indicated the resident had severely impaired cognitive skills (significant decline in a person's ability to think, learn, remember, reason, and make decisions affecting their daily life) and was dependent on staff with bed mobility, oral hygiene, bathing, dressing, personal hygiene and transfer to and from a bed to chair or wheelchair. The MDS indicated Resident 41's skin was intact with no infection on the foot and no presence of pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 41's Flow sheets for skin assessment dated [DATE], at 2:51 p.m., 11/30/2024 at 10:22 p.m., 12/1/2024 at 1:33 p.m., and 12/1/2024 at 11:54 p.m., the flowsheets indicated skin color was consistent with ethnicity, blanchable (skin appeared white or not as reddened after being pressed on and skin returns to its normal color) warm, dry skin, and skin was elastic (ability of skin to stretch and return to its original shape). (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 41's Progress Notes dated 12/2/2024 timed at 7:22 a.m., the Progress Notes indicated resident's right great toe blood blister was observed by an unnamed Certified Nursing Assistant (CNA) while resident was being cleaned on 12/1/2024 at 6:27 a.m. During a review of Resident 41's Progress Notes dated 12/2/2024 at 12:09 p.m., the Progress Notes indicated Registered Nurse (RN3) received report from the morning that the resident had a bruise to the right great toe . The Progress Notes indicated Resident 41's right great toe had a large blood blister, of purple, dark red brown color measuring 1.5-centimeter (cm- unit of measurement) x 2 cm, with slight swelling and tenderness on the right big toe on assessment. The Progress Notes indicated the family, and the physician were notified, and right toe x-ray (imaging that shows organs and bones of the body) was ordered. During a review of Resident 41's x ray of the right big toe performed on 12/2/2024 at 12:49 p.m. and resulted on 12/2/2024 at 1:48 p.m., the x-ray indicated a possible nondisplaced tuft of the big toe fracture (tip of the toe bone has cracked or fractured but the broken pieces of bone are still aligned and have not moved out of position) and soft tissue swelling overlying the big toe. During a review of Resident 41's Custodial Progress Note dated 12/3/2024 timed at 10:56 a.m., the Custodial Progress Notes indicated the possible nondisplaced area is less than 2 millimeter (mm- unit of measurement) and minor enough to buddy tape (a method of treating an injured toe by taping it to an uninjured digit or toe next to it to provide support and protection for an injured digit) as if there is a minor fracture. The Progress Notes indicated the resident would be receiving an antibiotic (medicine used to treat an infection) for five days for the redness and swelling like cellulitis (skin infection that causes swelling and redness). During an observation on 12/3/2024, at 10:37 a.m., Resident 41 was sitting in a wheelchair watching a program on an electronic device. Observed an unnamed physician came and examined resident's right foot. Observed Resident 41's right foot resting on a pillow while in a wheelchair was slightly swollen and red. During an interview on 12/3/2024, at 12:18 p.m., Resident 41's family member (FM1), FM1 stated she could not understand why Resident 41's great big toe was broken or how the injury occurred. During an interview on 12/5/2024, at 3:32 p.m. with Certified Nursing Assistant (CNA1), CNA1 stated on Resident 41 last 12/1/2024 she gave Resident 41 a shower and confirmed she did not observe any skin breakdown or injury on his feet. CNA1 stated she asked CNA2 to assist her with the shower of the resident and used a mechanical lift (device used to assist with transfers from one surface to another for residents that cannot move without assistance) get him out of bed. During an interview on 12/5/2024, at 4:14 p.m., with CNA2, CNA 2 stated she helped CNA1 remove resident's clothes including socks and got him ready for his shower. CNA2 stated Resident 41 required 2 person assist and she did not see any redness, open skin or discoloration during the shower or when they were dressing him up. During an interview on 12/5/2024, at 4:24 p.m., with Licensed Vocational Nurse (LVN5), LVN 5 on the morning of 12/2/2024 when she was making rounds, she observed darkish discoloration on the right big toe of Resident 41 and the resident stayed in the bed that day. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 41's electronic chart on 12/6/2024, at 10:11 a.m. with LVN 6, LVN 6 confirmed she documented on the chart dated 12/1/2024 that Resident 41's skin was normal. LVN 6 stated the LVNs do a head-to-toe skin assessment and if there was any change in resident's skin, the RN would be notified. LVN 6 stated on 12/1/2024 at 11:54 p.m., confirmed Resident 41 was within normal limits and there were no skin changes. LVN 6 stated on 12/1/2024 she did not observe any skin breakdown, redness or blood blister especially on the feet. During a concurrent interview and record review of Resident 41's electronic chart on 12/5/2024, at 4:53 p.m. with RN 3, RN 3 stated the night RN discovered the blood blister on Resident 41's right big toe and the physician was notified. RN 3 stated the x-ray of the right big toe indicated a possible nondisplaced fracture on the tuft of the right big toe. RN 3 stated the treatment was splinting by buddy taping the first and second toes together. RN 3 stated blood bisters can be caused by pressure or trauma, and nobody knew how the resident got the blood blister or what caused it. RN 3 stated the facility made an incident report because was an injury of unknown origin and should be investigated as to why it happened. RN3 stated she did not know why it was not reported to CDPH and she did not report the incident because she did not think it was abuse. RN 3 stated she notified the House Supervisor (HS) but was not told to report to CDPH. During a concurrent interview and record review of Resident 41's electronic chart on 12/6/2024, at 9:32 a.m., with House Supervisor (HS1) , HS 1 stated the facility did not know how Resident 41 got a blood blister on his right great big toe and it was an injury of unknown origin. HS 1 confirmed LVNs skin assessment for the day shift and the night shift on 12/1/2024 indicated Resident 41's skin assessment was within normal limits. During a concurrent interview and record review of facility's policy and procedure titled Abuse Prevention on 12/6/2024, at 6:35 p.m., and subsequent interview on 12/6/2024, at 7:05 p.m., with the Director of Nursing (DON), the DON stated an injury of unknown origin is reported to CDPH within 24 hours. The DON stated it was important to report any suspicion of abuse or injury of unknown origin to CDPH within 24 hours to rule out abuse or neglect. During a review of facility's policy and procedure(P&P) titled Abuse Prevention dated 6/2021, the P&P indicated investigation of injuries of unknown origin, or suspicious injuries must be immediately investigated to rule out abuse. The P&P indicated if the injury is unexplainable, a report must be made to the facility designated State agency within 24 hours of the initial findings and employee must always report any abuse or suspicion of abuse immediately.

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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** 45269 49889 Based on interview and record review, the facility failed to ensure two of four sampled residents (Resident 84 and Resident 96) were free of unnecessary psychotropic (any drug that affects the brain activities associated with mental processes and behavior) medications by failing to: 1.Ensure Resident 84 and Resident 96 were provided with non-pharmacological interventions (intervention that does not primarily use medicine before administering a prn (as needed) psychotropic medication. 2. Ensure prn psychotropic medication use had not exceeded 14 days. These failures placed Resident 84 and Resident 96 at risk for adverse consequences (unintended, harmful events attributed to the use of medication) due to unnecessary prolonged use of psychotropic medication. Findings: During a review of Resident 96's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses including respiratory failure (serious condition when the lungs cannot get enough oxygen into the blood or remove carbon dioxide from the body). During a review of Resident 96's History and Physical (H&P) dated 10/19/2024, the H&P indicated the resident had a medical history of hypertension (HTN-high blood pressure), intracranial hemorrhage (life-threatening condition that occurs when blood pools inside the skull or between the brain and skull), tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs) and gastrostomy(a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 96's Minimum Data Set (MDS- resident assessment tool) dated 10/25/2024, the MDS indicated the resident had severe cognitive (a person has trouble with memory, learning, concentration, decision making and understanding) impairment and was dependent on staff with bed mobility, bathing, toileting hygiene, dressing, oral hygiene, and personal hygiene. During a review of Resident 96's Physician Order dated 10/18/2024 with an end date of 12/27/2024, the Physician Order indicated an order of Ativan (Ativan- medicine to treat anxiety disorder) 0.5 milligram (mg.- unit of measurement) per gastrostomy tube every 8 hours prn for anxiety manifested by agitation/ restlessness. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 96's Care Plan titled Reduce Risk of Medication Side Effects started on 10/18/2024 (resident is on Ativan) related to diagnoses of anxiety manifested by anxiousness, unable to relax, pulling at essential tubings, and disconnecting from the ventilator (breathing machine) started 10/18/2024 The Care Plan goal indicated the resident will be free from adverse effects focusing on assessment and monitoring for appropriate effectiveness of the medicine and the proper dosage adjustments and reductions. The Care Plan interventions include to monitor mood every shift. Implement diversional activities, observe, and minimize noise level and monitor signs and symptoms of medication's side effects. During a concurrent interview and record review of Resident 96's electronic chart on 12/5/2024, at 11:21 a.m. , and subsequent interview on 12/5/2024, at 2:37 p.m. with Licensed Vocational Nurse (LVN 4), LVN 4 confirmed she administered Ativan .5 mg. on 12/4/2024 at 3:04 p.m., because the resident was fighting the ventilator and was moving a lot. LVN 4 stated she documented the non- pharmacological interventions implemented at the end of the shift at 7:18 p.m., LVN 4 stated they always document the behavioral monitoring and provision of non-pharmacological interventions after administration of a prn psychotropic medicine like Ativan. During a concurrent interview and record review on 12/5/2024, at 2:56 p.m., with Registered Nurse (RN2), RN 2 confirmed Ativan .5 mg. every 8 hours prn for agitation and restlessness was ordered on 10/18/2024 with an end date of 12/27/2024 and the physician's order had exceeded the 14 days for prn. RN 2 stated the initial order for prn psychotropic medicine should only be for 14 days and after the 14 days, the need for Ativan use should be assessed and evaluated by the facility. RN 2 confirmed Resident 96 received Ativan on 12/4/2024 at 3:04 p.m. but non-pharmacological interventions were documented at 7:18 p.m. RN 2 stated LVN 4 should have provided the non-pharmacological interventions first before administering Ativan at 3:04 p. m. RN2 stated administering Ativan first before provision of non-pharmacological interventions could put Resident 96 at risk for side effects and could be considered unnecessary medicine for the resident. During a concurrent interview and record review of Resident 96's electronic chart on 12/6/2024, at 1:06 p.m., with RN 1, RN stated prn psychotropic medicine like Ativan is used for 14 days only and the resident should be reevaluated by the physician for renewal of the order, RN 1 stated the facility should provide non-pharmacological interventions first before administering prn psychotropic medicine to ensure the resident did not receive unnecessary medicine that could cause sedation and side effects. During a concurrent interview and record review on 12/6/2024, at 4:15 p.m. with Registered Pharmacist (RPH 1), RPH1 stated all prn psychotropic medicine should only have a duration of 14 days and after 14 days, the order will be renewed based on the documented evaluation of the physician for continued use. RPH1 stated non- pharmacological interventions should be performed first before administering the prn Ativan. During a review of Resident 84's Admission Record, the Admission Record indicated Resident 84 was admitted to the facility 9/23/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 84's H&P, dated 9/24/2024 the H&P indicated Resident 84 had the capacity to understand and make decisions and also indicated that Resident 84 was admitted with diagnoses of Amyotrophic Lateral sclerosis (progressive degeneration of nerve cells in the spinal cord(ALS), chronic respiratory failure, hyperparathyroidism (high levels of calcium in the blood), panic disorder, functional quadriplegia (completely unable to move due to medical condition). During a review of Resident 84's MDS dated [DATE] the MDS indicated Resident 84's cognition was intact. The MDS indicated Resident 84 was dependent (someone who relies on another person for support) with activities of daily living (ADL's- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 84's All Active Orders list dated 12/06/2024, the All Active Orders list indicated resident 84 had orders for Ativan1mg every 3 hours PRN for anxiety manifested by tachycardia (fast heart beat), hyperventilation (rapid, shallow breathing), verbalization of anxiety and restlessness, Ativan order stated on 10/2/2024 and ends on 12/12/24. During a concurrent interview and record review on 12/6/2024 at 2:50 p.m., with RN1, Resident 84's, Active Medication Orders list for dates 11/5/24 at 2:50 am, 11/23/24 at 3:18 am, and 12/3/24 at 4:34 am was reviewed, the Active medication Orders list indicated Resident 84 was not provided with nonpharmacological interventions prior to being given Ativan 1mg and that the Ativan order started on 10/2/2024 and ended on 12/12/2024, RN1 stated that prior to giving any PRN psychotropic medications you must provide the resident with nonpharmacological interventions to ensure the residents are not given any unnecessary psychotropic medications because they are considered a chemical restraints (is the use of a drug to restrict a patient's movement or freedom, or to sedate them). RN 1 stated that all PRN Ativan orders can only be prescribed for 14 days at a time and that the resident needs to be reassessed by the physician prior to a new order being written. During a concurrent interview and record review on 12/6/2024 at 5:05 p.m. with Pharmacist1, Resident 84's Psychotropic Medication Monitoring dated October 2024, the Psychotropic Medication Monitoring indicated that the pharmacist recommended psychiatry (branch of medicine concerned with the study, diagnosis, and treatment of mental illness) consult due to multiple anxiolytics used for the same indication, concern for polypharmacy (use of multiple drugs to treat a single condition) and also indicated that Ativan PRN needed a stop date in October and that on 11/27/2024 the physician added a stop date of 12/12/2024 for the Ativan and psychiatry consult was done on the same day. Pharmacist1 stated she reviews the medications monthly and makes the recommendations and either her or the nursing staff reach out to the doctors to follow up with the recommendations. Pharmacist1stated that all Ativan orders given PRN can only be given for 14 days at a time and then the resident must be reevaluated by the physician, before the medication can be reordered. Pharamcist1 stated residents on multiple psychotropic medication for the same indications should have a psychiatric consult to prevent possible polypharmacy. During an interview on 12/6/2024 at 8:03 a.m., with the DON, the DON stated that the pharmacy and nursing work together to ensure residents are not prescribed any unnecessary medication. Ativan PRN orders can only be written for 14 days to ensure the resident really needs the medications. The DON stated that prior to resident receiving the Ativan, the Resident should have been provided with nonpharmacological interventions. [NAME] stated if the resident gets more medications, then they need it can affect their quality of life. (continued on next page)

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F 0758 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, Psychotropic Drug Management for Long Term Care Facilities dated 4/2021, indicated, psychoactive medications (anti-psychotics, anti-depressants, anti-anxiety, hypnotics) must only be prescribed: By a person authorized to prescribe medications. Non-pharmacological interventions, unless clinically contraindicated, and gradual dose reductions are implemented for patients receiving psychotropic medications. PRN orders for psychotropic drugs are limited to 14 days. PRN Psychotropics other than Anti-psychotics: may be extended beyond 14 days if the physician/provider believes it is appropriate to extend the order and documents the rationale for the extended time period in the medical record. Specific duration must be indicated. Non-pharmacological interventions, unless clinically contraindicated, have been implemented prior to initiating or instead of continuing psychotropic medication. Safe use of psychoactive drugs shall be monitored for adverse consequences or complications, continuation of drug usage, dose/frequency, changed or discontinued, in the monthly drug reduction assessment tool (see attached Monthly Psychoactive Drug Reduction Assessment Tool).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on observation interview and record review the facility failed to ensure one of 22 sampled residents (Resident 46's food and cultural preferences were honored. This failure resulted in weight loss due to inadequate consumed calories for residents who did not receive the food items of their choices and preference. Findings: During a review of Resident 46's Admission Record, the Admission Record indicated Resident 46 was admitted to the facility on [DATE] with a diagnoses including respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide). During a review of Resident 46's History and Physical (H&P), dated 6/11/2029, the H&P indicated Resident 46 had diagnoses of but not limited to craniotomy (a surgical procedure that involves removing a piece of the skull to access the brain), cerebrovascular accident (stroke, loss of blood flow to a part of the brain) with hemiplegia (paralysis of one half of the body) and Moyamoya disease (a rare progressive disease that occurs when the carotid arteries in the brain narrow and become blocked). The H&P indicated Resident 46 only speaks Korean. The H&P indicated Resident 46 does not always eat and requires gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) supplementation. During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 9/19/2024, the MDS indicated Resident 46 sometimes understood others and sometimes made self understood. The MDS indicated Resident 46 was dependent on staff for toileting, showering, dressing, and putting on and taking off shoes. The MDS indicated Resident 46 needed maximal assistance with sitting, lying, standing and personal hygiene. The MDS indicated Resident 46 lost 5 percent or more of weight in the last month or lost 10 percent or more in the last six months. During a review of Resident 46's Care Plan, titled Aspiration (Enteral Nutrition), dated 11/07/2024, the Care Plan indicated Resident 46 had inadequate oral intake related to frequently refusing meal trays. During a review of Resident 46's Physician Orders, dated 11/29/2024, the Physician Orders indicated Resident 46 had an order for tube feeding (nutrition solution provided through a plastic tube surgically inserted into the stomach) carbohydrate (units digested as sugar) controlled at 55 milliliters for 16 hours a day. The Physician Orders indicated Resident 46 had an order for a general dysphagia (difficulty swallowing) diet with thin liquids (a liquid that flows easily) and soft bite sized textured food. During a concurrent interview and record review on 12/5/2024 at 3:18 pm, with, Restorative Nurse Assistant (RNA) 1, Resident 46's Adult Nutrition Summary was reviewed. The Adult Nutrition Summary indicated the following monthly weights: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	June 11, 2024 - 147 pounds July 11, 2024 - Resident 46 refused to be weighed. August 21, 2024 - 135 pounds September 17, 2024 - 136 pounds October 13, 2024 - 139 pounds November 11, 2024 - 139 pounds During an interview on 12/06/2024 at 10:43 am, with, Licensed Vocational Nurse (LVN) 7, LVN 7 stated Resident 46 likes Korean food but she is not given her cultural food preferences. LVN 7 stated it is important to know Resident 46's preferences, likes and dislikes so she can eat and maintain her weight. LVN 7 stated if Resident 46 does not like the food weight loss can occur and the resident will be unhappy. LVN 7 stated any staff member can document residents' food preferences, food likes and food dislikes. During an interview on 12/6/2024 at 4:30 pm, with Registered Nurse (RN) 4, RN 4 stated Resident 46 refuses meals and is getting continuous tube feedings. RN 4 stated Resident 46 had an eight-pound weight loss. RN 4 stated when Resident 46 refuses her meals she gets offered sandwiches, yogurt, and Jello. RN 4 stated Resident 46's cultural preferences were not honored. RN 4 stated when the residents food preferences are not honored the resident can have weight loss. RN 4 stated Resident 46 refused breakfast and ate 20 percent of the lunch tray. During an interview on 12/6/2024 at 7:17 pm with the Registered Dietician (RD), the RD stated there was no documentation of Resident 46's food preferences. The RD stated Resident 46's is given rice, tea and stir fry. RD stated she has not met Resident 46 or Resident 46's family to find out what her food preferences are. During a review of the facility's policy and procedure (P&P), titled Clinical Dietetics: Religious and Culture Food Preferences, dated 10/2023, the P&P indicated, The RD will ensure that religious and cultural food preferences and request are granted in accordance with their diet. The patient will be visited as soon as possible to obtain menu and food preferences.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when: 1.Several food items were not dated for thaw date in the walk-in refrigerator. One box of pepperoni was stored uncovered in the walk-in freezer. One medium container of black beans with expire date of [DATE], one large container of blueberry sauce for toppings and one large container of cooked apple with an expire date of [DATE] exceeding storage period for the food were stored in the reach in refrigerator. Two boxes of (baked pastry) and one package of sliced ready to eat turkey deli meat were stored on the shelf next to raw shelled eggs. One box of raw chicken thighs thawing on the shelf next to raw ground beef. This had the potential to cross contaminate food and result in food borne illness in 14 residents who received food from the kitchen. 2. Ice machine was not maintained in a sanitary manner and the inside compartment of the ice machine was stained and dirty. This deficient practice had the potential to cross contaminate food and put 14 residents, staff, and visitors at risk for food borne illness. 3.One large bucket filled with used grease, fat and oil from cooking was stored on the shelf under the kitchen counter. The bucket was not maintained in a clean manner to prevent the potential harborage of pests and growth of microorganisms. The bucket was not clean and covered with grease and residue and it was sticky to touch. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 14 out of 99 residents who received food from the kitchen. Findings: 1.During an observation in the kitchen on [DATE] at 10:36AM There was on medium container of cooked black beans with dates [DATE]-[DATE] stored in the walk-in refrigerator. There were 4 large pieces of turkey and one pan with smaller pieces of turkey thawing with no thaw or pull out of the freezer date. During a concurrent observation and interview, Food Service Director (FSD) stated the beans are expired and should have been discarded. FSD removed the beans to discard. FSD stated turkey is thawed for 3 days and hold up to 5 days then cooked. FSD stated there is no date and he doesn't know when it was pulled out of the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same observation raw Ground beef with no date was thawing next to raw chicken thighs with no date. FSD stated the ground beef and chicken thighs were delivered [DATE] but does not know when it was removed from freezer to refrigerator to thaw because there is no date for thawing. FSD stated its important to mark the thaw date so staff will ensure the product is prepared on time or discarded. FSD stated ground beef should not be stored next to chicken for potential cross contamination. FSD stated the chicken should be on the shelf below the ground beef. There were also two boxes of croissant and sliced turkey deli meat stored on the same shelf next to raw shelled eggs. FSD stated he will inform staff and review safe storage guidelines. During an interview with [NAME] (Cook1) on [DATE] at 10:45AM Cook1 stated he removed the turkey from the freezer this morning and forgot to put a thaw date. He also said the croissant and the sliced turkey deli meat should not be next to raw shelled eggs for potential for contamination. During a concurrent observation and interview in the facility walk in freezer on [DATE] at 10:50AM there was on large box of pepperoni stored in the freezer. The box was open, and the peperoni were exposed to freezer environment. During an interview with FSD, FSD said food should be covered tight to prevent cross contamination. During an observation in the reach in refrigerator on [DATE] at 11:00AM there was on large pan with cooked blueberry sauce topping and another large pan of cooked apples with dates [DATE]-[DATE]. During a concurrent observation and interview with FSD, FSD stated the cooked fruit has exceeded use by date and should be discarded. A review of facility policy titled, FNS: Food handling Guidelines (HACCP) (revised ,d+[DATE]) indicated, Thaw frozen meat/poultry/seafood count the day the raw meat is removed from the freezer as Day1; it must by cooked by the end of +4 days. Label with the date it was removed from the freezer and the date by which it must be used. A review of facility policy titled FNS: Food Preparation and Distribution (,d+[DATE]) indicated, All stored foods are to be covered. All leftovers are covered, labeled and dated. Leftovers which have not been utilized within 48 hours are discarded. All prepared perishable foods and custard shall be covered, labeled and dated with a three-day expiration date to be discarded on the day of expiration. A review of facility policy and Procedures titled, FNS-Food Handling Guidelines (HACCP) (Revised , d+[DATE]) indicated, Contamination Precautions: Food shall be protected against cross-contamination by: appropriately separating types of raw animal products such as beef, fish, lamb, pork and poultry during storage and processing with the use of separate equipment or areas .and appropriately separating raw (potentially hazardous) foods from ready to eat food products during storage, preparation, and or service. 2.During an observation of the facility ice machine on [DATE] at 10:10AM located in the kitchen, there was brown color residue located inside the ice machine bin (where ice is stored inside the machine). The residue was towards the back wall of the ice bin. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with FSD, FSD stated facility staff Food Service Attendant (FSA1) is responsible for cleaning the ice machine. FSD verified there are brown color residue on the back wall of the ice bin. FSD stated the ice machine is not clean, FSD stated it is important for ice machine to be clean, and any residue can contaminate the ice. FSD stated will discard the ice and clean the ice machine. During an interview with FSA1 on [DATE] at 10:20AM, FSA1 stated she cleaned the ice machine last week. FSA1 stated the bin is not clean and the ice can touch the dirty areas. FSA1 stated she did not clean the back wall of the bin because it was hard to reach. she will remove and discard the ice and clean and sanitize the ice machine. A review of the 2022 U.S. Food and Drug Administration Food Code titled Equipment Food-Contact Surfaces and Utensils Code# ,d+[DATE].11, indicated, Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms. 3. During an observation in the kitchen food preparation area on [DATE] at 11:20AM one large bucket filled with used cooking grease, fat and oil was stored on the shelf under the food prep counter. The bucket and cover were dirty and covered with grease and brown color residue and was sticky to touch. During a concurrent interview with FSD, he stated the oil and fat is collected from the grills and pots then filled into the bucket and transferred to the grease storage tank outside of the kitchen. FSD stated the bucket is reused and it has not been cleaned. FSD stated the outside of the bucket is covered with the oil and fat and can attract pests in the facility kitchen. A review of facility policy titled FNS: Food Preparation and Distribution (,d+[DATE]) indicated, the purpose is to ensure the safe, sanitary and timely provision of food service to patients .All equipment, utensils and work surfaces are sanitized before and after each use away from the food preparation areas. A review of the kitchen task schedule indicated take dirty oil out to the Hazmat Gate, Slowly and carefully pour the dirty oil into receptacle. If any spills, clean it up. A review of the 2022 U.S. Food and Drug Administration Food Code titled Equipment Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils Code# ,d+[DATE].11, indicated, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the 2022 U.S. Food and Drug Administration Food Code titled Equipment Food-Contact Surfaces and Utensils Code# ,d+[DATE].11, indicated, E) surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cleaned: (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 38740 Based on observation, interview, and record review, the facility failed to ensure the trash stored in the dumpster areas located in the loading and food delivery area behind the kitchen were maintained in a sanitary manner. One of six garbage dumpsters had the lid open, the dumpster was uncovered and overfilled with cardboard, and trash. There were disposable gloves, plastic, paper, and food on the ground surrounding the trash dumpsters. The trash was in the loading and food delivery area next to the kitchen back door. This deficient practice had the potential for harborage and feeding of pests, which may be attracted into the facility kitchen. Findings: During a concurrent observation and interview with the Food Service Director (FSD) on 12/3/2024 at 11:15AM, there were a total of six large trash bins. One trash bin was full of cardboard boxes and bags of trash, the dumpster was overfilled and not covered. There was trash on the floor including disposable gloves, paper, plastic wraps, and food. During a concurrent interview with the FSD, the FSD stated housekeeping is responsible for cleaning the trash area. The FSD agreed that the areas was dirty and it was close to the kitchen food delivery area. The FSD stated the area should be clean and the trash bin should always stay covered to prevent attracting flies and other pests to the kitchen. A review of Food and Drug Administration (FDA) Food Code 2022 dated 1/18/2023, code number 5-501.113 titled Covering receptacles, indicated: receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids or doors if kept outside the establishment. The Food Code also indicated under code number 5-501.110 titled Storing Refuse, Recyclables, and Returnable indicated refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.

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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** 49145 Based on observation, interview, and record review, the facility failed to observe infection control measures for three of 10 residents (Resident 29, 62, and 86) by failing to: 1. Ensure Resident 29's water bag was labeled and dated. 2. Ensure Resident 62's tube feeding bottle was labeled and dated. 3. Ensure Resident 86's tube feeding bottle was dated. These failures had the potential to result in the transmission of infectious microorganisms and increase the risk of infection for Residents 29, 62, and 86. Findings: 1.During a review of Resident 29's Admission Record, the Admission Record indicated Resident 29 was readmitted to the facility 11/1/2024. During a review of Resident 29's History and Physical (H&P), the H&P indicated Resident 29 was admitted with diagnoses of ruptured cerebral aneurysm (a weak spot in a blood vessel in the brain, like a tiny balloon, has burst open, causing bleeding in the surrounding brain tissue) and gastroparesis (stomach muscles are weakened or impaired, causing food to remain in the stomach longer than normal). During a review of Resident 29's Minimum Data Set ({MDS}- a resident assessment tool) 8/12/2024 the MDS indicated Resident 29 was comatose (someone is completely unconscious and unresponsive to their surroundings). The MDS indicated Resident 29 was dependent (someone who relies on another person for support) with activities of daily living ({ADL's}- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 29's care plan initiated 12/5/2023 with a focus on Resident 29 having altered nutrition related to dysphagia (swallowing difficulties) as evidenced by chronic tube feed, dependence on gastrostomy tube ({GT}- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 29's care plan initiated 1/6/2018 with a focus on Resident 29 having a risk to develop infection (invasion and growth of germs in the body) related to the presence of a GT Interventions included monitoring Resident 29 for signs and symptoms (s/s) of infection. 2.During a review of Resident 62's Admission Record, the Admission record indicated Resident 62 was readmitted to the facility 11/3/2024. (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 Resident 62's H&P, the H&P indicated Resident 62 was admitted with diagnoses of subdural hematoma (a buildup of blood on the surface of the brain) and chronic respiratory failure (when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). During a review of Resident 62's MDS dated [DATE], the MDS indicated Resident 62 was comatose. The MDS indicated Resident 62 was dependent with ADL's. During a review of Resident 62's care plan initiated 4/27/2022 had a focus on Resident 62 was at risk for infections related to tube feeding dependent due to dysphagia. Interventions included monitoring Resident 62 for s/s of infection. During a concurrent observation and interview on 12/3/2024 at 11:11 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 62's tube feeding bottle was not labeled or dated. LVN 1 stated she is responsible to ensure the tube feeding bottles are labeled and dated when she does her rounding, but stated she missed this one. LVN 1 stated it's important the tube feeding bottles are changed every 24 hours to prevent infection for the resident. During a concurrent observation and interview on 12/3/2024 at 11:27 a.m., with LVN 2, LVN 2 verbally confirmed Resident 29's water bag was not labeled or dated. 3.During a review of Resident 86's Admission Record, the Admission Record indicated Resident 86 was admitted to the facility 11/27/2024. During a review of Resident 86's H&P, the H&P indicated Resident 86 was admitted with diagnoses of encephalopathy (swelling of the brain), hx of hemicraniectomy (Section of skull removed to relieve extreme pressure on the brain), respiratory failure (lungs failing) dysphagia (unable to swallow correctly), g-tube. During a review of Resident 86's MDS dated [DATE], the MDS indicated Resident 86 was comatose The MDS indicated Resident 86 was dependent (someone who relies on another person for support) with ADL's During a review of Resident 86's All Active Orders dated 12/06/24 indicated resident 86 has orders for continuous tube feeding (liquid food being delivered through tube in the stomach) carbohydrate controlled, diabeticsource ac 1.2 (1320kcal/1100ml 50cc hr x 22hours a day. During a concurrent observation and interview on 12/3/2024 at 10:34 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 86's tube feeding bottle was not dated. LVN 3 stated she is responsible to ensure the tube feeding bottles are dated LVN 3 stated it's important to have a date on the tube feeding bottles to ensure the tube feeding is changed every 24 hours to prevent spoilage. LVN 3 stated residents are at risk for stomach issues if tube feeding is not changed every 24 hours. During an interview on12/5/2024 at 10:44 a.m., with the Infection Prevention Nurse (IPN) 1, IPN 1 stated it's important to change and label the tube feeding bottles and water bags at least daily because they are breeding ground for organisms which could result in an infection for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/6/2024 at 8:03 a.m., with the Director of Nursing (DON), the DON stated for their GT's, they use a closed system for infection control and follow the manufacturers guidelines which indicated to change the tubing every 24 hours and label with the resident's name, date, rate, and type of feeding. The DON stated it's important the tube feeding bottles and water bags are labeled and dated so the staff is aware when it was changed because the feeding can spoil which could potentially cause diarrhea and gastrointestinal (stomach and intestines) issues for the resident. During a review of the facility's policy and procedure (P&P) titled, SACC: Tube Feeding Through Nasogastric Tube, Gastrostomy, or Jejunostomy Intermittent and continuous, revised 11/18/2024, indicated, Make sure that the enteral formula container is labeled with the patient's identifiers; formula name; date and time of formula preparation; date and time that the formula was hung. Label the enteral administration set with the date and time that it was first hung. Change the enteral administration set according to the manufacturer's instructions to prevent bacterial growth. 49889

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review, the facility failed to address and monitor the use of antibiotic on two of five sampled residents (Resident 41 and Resident 98) when residents' conditions or symptoms did not meet McGeer criteria(a set of criteria used in long term care facilities to determine if signs and symptoms constitute a true infection). This failure had the potential to result in Resident 41 and Resident 98 developing resistance (antibiotic will not be effective to treat infection) from unnecessary or inappropriate use of antibiotic. Findings: a. During a review of Resident 98's Admission Record, the Admission Record indicated the resident was admitted on [DATE] facility with diagnoses that included respiratory failure (condition when the lungs are not able to effectively take in oxygen and remove carbon dioxide from the blood). During a review of Resident 98's History and Physical (H&P), dated 10/26/2024, the H&P indicated Resident 98 had diagnoses of but not limited to traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), and encephalopathy (damage or diseases affecting the brain). During a review of Resident 41's Minimum Data Set (MDS- a resident assessment tool) dated 11/4/2024, the MDS indicated Resident 98 was dependent on nursing staff for oral hygiene, toileting, showering, dressing, putting on and taking off footwear, personal hygiene, and transferring. The MDS indicated Resident 98 used an external catheter (a noninvasive device that collects urine from outside the body). The MDS indicated Resident 98 did not have a urinary tract infection in the last 30 days. During an interview on 12/06/2024 at 12:05 pm with Registered Nurse (RN) 5, RN 5 stated Resident 98 was prescribed ampicillin (medication used to treat bacterial infections) per oral (PO)o on 10/30/2024 and ended on 11/5/2024. RN 5 stated Resident 98 was prescribed ampicillin for a urinary tract infection (UTI- an infection in the bladder/urinary tract). During an interview on 12/06/2024 at 2:59 pm with Infection Preventionist (IP), the IP stated on 10/27/2024 urine was collected from Resident 98. IP stated on 10/29/2024 the results of the urine collection indicated Resident 98 did not meet the MC Greer's criteria and did not meet NHSN (National Healthcare safety Network) criteria because the Resident 98 did not have any symptoms of a urinary tract infection. IP stated Antibiotic Stewardship is used to determine surveillance and to determine if the resident meets the criteria for antibiotic use. IP stated the Mc Geer criteria is used so resident are not getting overuse and resistance to antibiotics. During an interview on 12/6/2024 at 4:13 pm with Registered Pharmacist (RPH) 3, RPH 3 stated the Mc Geer criteria is used to diagnose a true infection versus colonization. RPH 3 stated unnecessary administration of antibiotics can adversely affect the resident by causing resistance to pathogens. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of resident 98's Physician Orders, the Physician Orders indicated on 10/29/2024 Resident 98 had an order for ampicillin 500 milligrams four times a day. During a review of Resident 98's IP Notes, the IP Notes indicated on 10/27/2024 a urine specimen was collected. The IP Notes indicated the urine specimen resulted on 10/29/2024 and Resident 98 did not meet Long term care NHSN (National Healthcare safety Network) criteria (the infection criteria is used by the National Healthcare safety Network (NHSN) to monitor healthcare-associated infections). b. During a review of Resident 41's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included respiratory failure(condition when the lungs are not able to effectively take in oxygen and remove carbon dioxide from the blood), cerebral vascular accident (CVA-stroke, loss of blood flow to a part of the brain), tracheostomy(an opening surgically created through the neck into the windpipe to allow air to fill the lungs) in place, gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 41's MDS dated [DATE], the MDS indicated the resident had severely impaired cognitive skills(significant decline in a person's ability to think, learn, remember, reason, and make decisions affecting their daily life) and was dependent on staff with bed mobility, oral hygiene, bathing, dressing, personal hygiene and transfer to and from a bed to chair or wheelchair. During a review of Resident 41's Order Report dated 12/3/2024, the Order Report indicated an order of cephalexin (Keflex- medicine used to treat infection) capsule 500 milligrams(mgs- unit of measurement) 4 times daily. During a review of Resident 41's Subacute Custodial Progress Note dated 12/3/2024, the Subacute Custodial Progress Note indicated the resident will be given Keflex for 5 days for the right big toe because the area is red, swollen and like cellulitis(a skin infection that causes swelling and redness). During a concurrent interview and record review of Resident 41's chart on 12/6/2024, at 5:45 p.m. and subsequent interview on 12/6/2024, at 5:22 p.m. with Infection Preventionist (IP), IP confirmed the resident was on Keflex 500 mgs. per gastrostomy tube (GT- a flexible tube surgically inserted through the abdominal wall and into the stomach for delivery of nutrition, fluids, and medications) started on 12/3/2024 to 12/8/2024 for the rt. big toe of the right foot. IP stated the Mcgeer Criteria for cellulitis is diagnosed when there are a pus present in the wound, or a new or increasing presence of at least four signs including: heat at the affected site, swelling, tenderness, and at least one of the symptom of fever, leukocytosis(increased white blood count),acute decline in mental status(sudden and significant change in person's cognitive abilities which can manifest as confusion, disorientation and lack of energy) and functional decline(inability to perform activities of daily living). IP confirmed Resident 41 only met the criteria for tenderness , swelling and redness on the site of the right big toe and there was no drainage or pus was present. IP stated the Mcgeer criteria did not need to be followed because it depends on the physician's order and antimicrobial stewardship collaboration with the pharmacists. IP stated the pharmacists took the lead in the Antibiotic Stewardship Program and performed the surveillance. IP stated residents receiving antibiotic that is not appropriate could build resistance from the antibiotics and could be at risk for the development of multi-drug resistance organism (MDRO- a germ that is resistant to many antibiotics and can be difficult to treat). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 41's Podiatry Consult Note dated 12/4/2024, the Podiatry Consult Note indicated the resident had a complaint of long and painful toenails of both feet of long duration. The Podiatry Consult Note indicated the resident's skin is warm to touch on bilateral (both) feet, no pedal edema (no swelling in the feet and ankles) and toenail plates(visible ,hard, and flat part of a toenail that protects the toe) on the bilateral feet were adequate length and appeared recently trimmed. During a review of facility's policy and procedure (P&P) dated 4/2023, the P &P indicated the facility promotes appropriate use of antimicrobials by helping select the appropriate agent, dose, duration, and route of administration to improve patient outcomes, optimize the treatment of infections and reduce adverse events associated with antibiotic use. 45269