STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555853	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Home of California - Barstow	100 East Veterans Parkway Barstow, CA 92311

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49266 Based on observation and interview , the facility failed to ensure a safe, clean, and comfortable environment, when the wheelchair of one of 15 sampled residents (Resident 29) was not found in good working condition with a torn, cracked, and frayed armrest. This failure had the potential to violate Resident 29's rights to a safe, clean, and comfortable environment. Findings: During a concurrent observation and interview on 6/5/2024 at 8:42 a.m. with Resident 29, Resident 29 was observed sitting in their wheelchair. The wheelchair had a large tear on the right armrest with the cushion exposed. In addition, the armrest had a large worn area consisting of multiple rough raised cracks and the edges were frayed with white lining showing through the black armrest cover. Resident 29 stated that the armrest was torn when they received the wheelchair from the facility. Resident 29 further stated that the worn armrest bothered them, was not comfortable, and did not look nice. During an interview on 6/5/2024 at 3:20 p.m. with Lead Registered Nurse (LRN), the LRN stated the armrest was torn, and Resident 29 needed a new wheelchair. The facility was unable to provide a policy and procedure related to maintaining residents' wheelchair in good working condition during the survey.

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 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** 35792 Based on observation, interview and record review, the facility failed to date an opened bottle of Polyethylene Glycol (medication to treat constipation) for unsampled Resident 30. This failure had the potential for Resident 30 to receive expired and less than optimal medications. Findings: During a review of Resident 30's Face Sheet (resident demographics), the Face Sheet indicated Resident 30 was admitted to the facility on [DATE] with diagnoses of dementia (loss of memory, language and problem-solving abilities that are severe enough to interfere with daily life) and chronic pain. During a review of Resident 30's Quarterly Minimum Data Sheet (MDS, standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 30 had a severe cognitive impairment. During a concurrent medication storage observation and interview on [DATE] at 10:11 a.m. with Licensed Vocational Nurse (LVN) 3, the medication cart for the 600 POD had an opened bottle of Polyethylene Glycol for Resident 30 which was not labeled with the open date. LVN 3 confirmed the bottle was not labeled with the open date. LVN 3 stated she gave the Polyethylene Glycol to Resident 30 on [DATE]. During a review of Resident 30's Medication Administration Record (MAR, a record of all medications administered to a resident), dated [DATE], the MAR indicated the medication was administered. During an interview on [DATE] at 10:53 a.m. with the Director of Nursing (DON), the DON stated the nurse should date the medication (Polyethylene Glycol) when it was opened. The DON stated any licensed staff who administered medication was responsible for checking the medication cart to make sure all opened medications were labeled with an open date. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated [DATE], the P&P indicated, When opening a multi-dose container, the date opened will be recorded on the container.

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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. 50148 Based on observation, interview, and record review, the facility failed to ensure that food was stored in a safe and sanitary conditions in the food service department when: 1. Equipment was not replaced when considered unsafe. 2. The kitchen freezer contained foods that were not dated and labeled. These failures had the potential to expose residents to food contamination and food-borne illnesses (sickness by consuming contaminated food or drinks). Findings: 1. During a concurrent observation and interview on 6/4/2024 at 9:02 a.m. with Food Manager (FM) in the kitchen, there was a spatula (kitchen utensil used to mix ingredients) with cracks on the right lower side and a yellow dried substance on the top edges. FM confirmed the spatula was not safe to be used due to the risk of food contamination and food-borne illnesses. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services-Sanitation (All Homes), dated 11/5/2023, the P&P indicated, All utensils, counters, shelves, and equipment will be kept clean and maintained in good repair (i.e. free from breaks, corrosion, open seams, cracks, and chipped areas). 2. During a concurrent observation and interview on 6/5/2024 at 9:05 a.m. with Food Service Technician (FST) 1 in the Skilled Nursing kitchenette's freezer, six out of six popsicles were not dated and labeled. FST 1 stated, I don't know why it was not labeled. It was usually inside the box with date on it and needs to be labeled to prevent food-born illnesses. During a concurrent observation and interview on 6/5/2024 at 11:10 a.m. with Licensed Vocational Nurse (LVN) 1 in the Skilled Nursing kitchenette's freezer, a meatball package was opened, not dated, and not labeled. LVN 1 stated, This one does not have a label and date. It is not supposed to be like this, or the resident can get sick. During an interview on 6/5/2024 at 11:30 a.m. with the Director of Dietetics (DOD), DOD stated the expectation was for staff to label and date all foods to prevent food-borne illnesses. DOD further stated the date was important to ensure the residents consumed a safe food product. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services-Leftover and Extra Food, dated 11/5/2023, the P&P indicated, Labeling, dating, and monitoring refrigerated food, including but not limited to, leftovers, so it is used by its used-by date or frozen were applicable or discarded.

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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** 35792 Based on interview and record review, the facility failed to ensure the Medication Administration Record (MAR, a record of all medications administered to a resident) was accurately documented on 6/2/2024 for two of 15 sampled residents (Residents 19 and 48) when: 1. For Resident 19, a licensed nurse did not document that medications were administered for the 8 a.m. dose on 6/2/2024. 2. For Resident 48, a licensed nurse did not document that medications were administered for 10 a.m. dose on 6/2/2024. These failures had the potential to result in inaccurate medication administration including underdosing or overdosing Residents 19 and Resident 48. Findings: 1. During a review of Resident 19's Face Sheet (resident demographics), the Face Sheet indicated Resident 19 was admitted to the facility on [DATE] with diagnoses of high blood pressure and urinary incontinence. During a review of Resident 19's MAR, dated June 2024, the MAR indicated, on 6/2/24, for the 8 a.m. administration time, there were no staff initials in the box to reflect medications were administered for the following medications: a. Amlodipine (treatment for high blood pressure) b. Aspirin (treatment to prevent blood clots) c. Coenzyme Q10 (treatment for high cholesterol) d. Docusate Sodium (treatment for constipation) e. Eliquis (treatment to prevent blood clots) f. Finasteride (treatment to decrease size of the prostate) g. Gabapentin (treatment for nerve pain) h. Glucosamine/Chondroitin (treatment to slow the breakdown of cartilage in the joints) i. Mag Oxide (treatment for magnesium deficiency) j. Metamucil Powder (treatment for constipation) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. Metoprolol succinate tablet (treatment for high blood pressure) l. Oyster Shell (treatment for bone health) m. Sertraline (treatment for depression) n. Vitamin D-3 (treatment for Vitamin D deficiency) During an interview on 6/5/2024 at 2:05 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, I forgot to sign the medications for [Resident 19] that were given on 6/2/2024. During an interview on 6/6/2024 at 10:57 a.m. with the Director of Nursing (DON), the DON stated, The expectation is for the nurse to prepare the medication, pass to the resident, and sign the MAR. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/18/2024, the P&P indicated, Documentation of Medication Administration .As required or indicated for a medication, the individual administering the medication will record in the Resident's medical record .The signature and title of the person administering the drug. 2. During a review of Resident 48's Face Sheet (resident demographics), the Face Sheet indicated Resident 48 was admitted to the facility on [DATE] with diagnoses of hypertensive heart disease (long term high blood pressure that causes changes to the heart) and type 2 diabetes mellitus (disease in which blood glucose levels are higher than normal). During a review of Resident 48's MAR, dated June 2024, the MAR indicated, on 6/2/24, for the 10 a.m. administration time, there were no staff initials in the box to reflect medications were administered for the following medications: a. Amlodipine (treatment for high blood pressure) b. Docusate Sodium (treatment for constipation) c. Furosemide (treatment for fluid retention) d. Glipizide (treatment for type 2 diabetes mellitus) e. Propranolol (treatment for high blood pressure) During an interview on 6/5/2024 at 2:05 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, I forgot to sign for medications for [Resident 48] that were given on 6/2/2024. During an interview on 6/6/2024 at 10:57 a.m. with the Director of Nursing (DON), the DON stated, The expectation is for the nurse to prepare the medication, pass to the resident, and sign the MAR. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/18/2024, the P&P indicated, Documentation of Medication Administration .As required or indicated for a medication, the individual administering the medication will record in the Resident's medical record .The signature and title of the person administering the drug.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 50148 Based on observation, interview, and record review, the facility failed to maintain the kitchen dishwasher in a safe operating condition. This failure had the potential to result in safety concerns. Findings: During a concurrent observation and interview on 6/4/2024 at 9:00 a.m. with Food Service Technician (FST) 2 in the kitchen, the dishwasher was spraying water resulting in a pool of water on the floor. FST 2 stated the spraying started when the machine was turned on. During an interview on 6/5/2024 at 8:40 a.m. with Chief Plant Operations (CPO), CPO stated the dishwasher machine was spraying water because it was missing the multi-flap curtains. During an interview on 6/5/2024 at 8:50 a.m. with the Food Manager (FM), FM stated the expectation was to prevent the water spraying out of the dishwasher machine, due to infection control and safety issues. During a review of the dishwasher's manual, [undated], the manual indicated, Multi-flap curtains are used throughout the dishwasher to keep moisture inside and reduce the potential of hot water injury. During a review of the facility's policy and procedure (P&P) titled, Food & Nutrition Services-Equipment (All Homes), dated 11/5/2023, the P&P indicated, Equipment will be provided and maintained in good working order. All equipment will be operated and maintained according to the manufacturer's specifications for cleaning and sanitizing and safe operating condition.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50148 Based on observation, interview, and record review, the facility failed to ensure a safe and comfortable working environment for staff when the water temperature of the kitchen's hand washing station was 156.1 degrees Fahrenheit (unit used to measure temperature). This failure had the potential for staff burning their hands and poor handwashing practices, leading to a potential spread of infection. Findings: During a concurrent observation and interview on 6/4/2024 at 11:06 a.m. with the Director of Dietetics (DOD) and the Food Manager (FM) in the kitchen, the Surveyor checked the water temperature at the hand washing station using a thermometer (a device that measures temperature), and the water temperature registered at 156.1 degrees Fahrenheit. DOD and FM confirmed the water temperature was too hot and had the potential for staff to burn their hands. DOD stated the hot water has always been out of range, and there was no work order to fix it. FM stated the hand washing water temperature should be 120 degrees Fahrenheit, but there was no work order. During a review of the facility's policy and procedure (P&P) titled, Plumbing and Water Supply Maintenance, dated 2/9/2024, the P&P indicated, If water temperature exceeds 120 degrees Fahrenheit during normal business hours, a work order is submitted. During a review of the 2022 Federal Food and Drug Administration (FDA) Food Code, dated 1/18/2023, Section 5-202.12, titled, Handwashing Sink, Installation, indicated, An inadequate flow or temperature of water may lead to poor handwashing practices by food employees. A mixing valve or combination faucet is needed to provide properly tempered water for handwashing. The International Plumbing Code (IPC) states that tempered water is having a temperature range between 29.4 C (85 F) and 43 C (110 F).