STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555856	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peninsula Post-Acute	1609 Trousdale Drive Burlingame, CA 94010

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41545 Based on interview and record review, the facility failed to ensure a Physician Orders for Life-Sustaining Treatment (POLST, a written medical order that specifies the types of medical treatment a patient wants to receive in the event of a serious illness) was obtained on admission for one of 18 sampled residents (Resident 219). This failure had the potential to result in resident's wishes in an emergency situation and end-of-life choices not being honored. Findings: Review of Resident 219's admission record indicated, was admitted to the facility on [DATE] with diagnoses including fracture of head and neck of left femur (a break in the bone that connects the femoral head to the femoral shaft in the hip), abnormalities of gait and mobility (changes to a person's normal walking pattern), type 2 diabetes mellitus (high blood sugar), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and hypertension (high blood pressure). Review of Resident 219's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated [DATE] indicated, resident has no cognitive impairment. Review of Resident 219's History and Physical (H&P) dated [DATE] indicated, .LCP (Life Care Planning) Status Checked [No Goals of Care Discussion: Review of Life Care Planning Documentation: No existing LCP Documentation: Code status established with Patient . Review of Resident 219's Order Summary Report dated [DATE] indicated, DNR (Do Not Resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating) was ordered on [DATE]. During concurrent interview and record review on [DATE] at 2:02 PM, Licensed Vocational Nurse(LVN) 2 did not find an advance directive and/or POLST form in Resident 219's clinical record. LVN stated, I don't see it here. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the California Emergency Medical Services Authority, .POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts. o POLST must be completed by a health care provider based on patient preferences and medical indications .

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 49264 Based on interview and record review, the facility failed to accurately encode one of 18 sampled residents' (Resident 20) Minimum Data Set (MDS - a federally mandated resident assessment tool) when Resident 20 was encoded has being diagnosed with Depression, but the Resident had no current or past medical history of that diagnosis. This failure has the potential to result in MDS assessments that inaccurately captures quality metrics and a resident's condition over time. Findings: A review of Resident 20's face sheet (front page of the chart that contains a summary of basic information about the resident), dated 10/18/24, indicated that Resident 20 was admitted 2024 with multiple diagnoses including SPINAL STENOSIS (when the space inside the backbone is too small causing pressure and pain) and LOW BACK PAIN. During a concurrent interview and record review on 10/17/24 at 2:31 PM with the MDS Director (MDSD), Resident 20's list of active diagnoses, dated 10/17/24, was reviewed. The list of active diagnoses indicated all the conditions that Resident 20 was being treated or cared for. The MDSD stated that she did not see Depression as an active diagnosis. During a concurrent interview and record review on 10/18/24 at 12:07 PM with the MDSD, Resident 20's discharge summary, date 09/09/24, was reviewed. The discharge summary indicated a summary of the Resident's hospital course including Resident 20's past medical history. The MDSD stated that she did not see Depression as a diagnosis at the hospital or on Resident 20's documented past medical history. During a concurrent interview and record review on 10/18/24 at 12:07 PM with the MDSD, Resident 20's MDS assessment, dated 09/11/24, was reviewed. The MDS assessment indicated that Resident 20 had an active diagnosis of depression. The MDSD stated that this was an inaccurate assessment as Resident 20 had no history of Depression. A review of a facility policy titled Certifying Accuracy of the Resident Assessment, last revised November 2019, indicated that Any person who completes any portion of the MDS assessment .is required to sign the assessment certifying the accuracy .The information captured on the assessment reflects the status of the resident during the observation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49264 Based on interview and record review, the facility failed to develop an accurate comprehensive care for two of 18 sampled residents (Resident 20 and Resident 31) when: 1. Resident 20's care plan for Duloxetine (an anti-depressant medication that can also be used to treat nerve pain) had the incorrect indication (reason to give a medication) 2. Resident 31's care plan for indefinite use of Cephalexin (an antibiotic) was not developed. These failures have the potential for residents' care plans to not be person-centered and specific enough for residents to meet their medical and physical needs. Findings: 2. A review of Resident 20's face sheet (front page of the chart that contains a summary of basic information about the resident), dated 10/18/24, indicated that Resident 20 was admitted 2024 with multiple diagnoses including SPINAL STENOSIS (when the space inside the backbone is too small causing pressure and pain) and LOW BACK PAIN. A review of Resident 20's Order Summary Report (a list of a medical provider's orders for care), dated 10/18/24, indicated that Resident 20 was being given DULoxetine .by mouth one time a day for Chronic low back pain During a concurrent interview and record review on 10/17/24 at 2:31 PM Interim Director of Nursing (IDON), Resident 20's care plan for Duloxetine, initiated on 09/11/24, was reviewed. The care plan for Duloxetine indicated that Resident requires antidepressant medication related to diagnosis of depression as evidence by verbalization of feeling sad/depressed. The IDON stated that this is not an accurate care plan as it has the wrong indication. During a concurrent interview and record review on 10/17/24 at 2:31 PM Interim Director of Nursing (IDON), Resident 20's list of active diagnoses, dated 10/17/24, was reviewed. The list of active diagnoses indicated all the conditions that Resident 20 was being treated or cared for. The IDON stated that she did not see Depression as an active diagnosis. During a concurrent interview and record review on 10/18/24 at 12:07 PM Interim Director of Nursing (IDON), Resident 20's discharge summary, date 09/09/24, was reviewed. The discharge summary indicated a summary of the Resident's hospital course including Resident 20's past medical history. The IDON stated that she did not see Depression as a diagnosis at the hospital or on Resident 20's documented past medical history. 41545 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 31's admission record indicated, was admitted to the facility on [DATE] with diagnoses including fracture of sacrum (a break in the sacrum, the large triangular bone at the base of the spine between the hipbones), osteoporosis (a progressive disorder of the joints, caused by a gradual loss of cartilage), dementia (a progressive state of decline in mental abilities), cancer of right breast, gastro-esophageal reflux disease (GERD - a chronic disease that occurs when stomach acid or bile flows into the food pipe and irritates the lining), and personal history of urinary tract infections (UTI - an infection in any part of the urinary system). Review of Resident 31's Medical Practitioner Narrative Note dated 9/10/24 indicated, .Cephalexin (an antibiotic used to treat infections caused by bacteria, including urinary tract infections) Oral Capsule 250 MG (milligrams) , Give 1 capsule by mouth in the evening every Mon, Wed, Fri for recurrent UTIs Take 1 cap (capsule) PO (per orem - orally or via the mouth) three times weekly . 9. UTI: This can cause discomfort, urinary frequency/urgency, and overall malaise (a general feeling of discomfort, uneasiness, or lack of well-being), potentially impacting patient participation in therapy . Be mindful of potential side effects of antibiotics, which may include fatigue, dizziness, or gastrointestinal issues . Review of Resident 31's Active Orders in the electronic health record (EHR) indicated, 9/7/24: Cephalexin Oral Capsule 250 MG (Cephalexin). Give 1 capsule by mouth in the evening every Mon, Wed, Fri for recurrent UTIs Take 1 cap PO three times weekly. Review of Resident 31's care plan indicated, has dx (diagnosis): Urinary Tract Infection Date Initiated: 09/07/2024 Revision on: 10/15/2024 . Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 09/07/2024 . During an interview on 10/18/24 at 1:47 PM, Licensed Vocational Nurse (LVN) 2 stated, Resident 31 was admitted with an order of cephalexin 200 mg three times a week for recurrent UTI with no stop date. During concurrent review, LVN 2 did not find a care plan for the use of cephalexin. Additionally, there was no monitoring for the side effects of the medications and signs and symptoms of UTI for Resident 31. During further interview, LVN 2 stated the care plan for the use of cephalexin was only added today and that it should have been completed when it was initiated. During an interview on 10/18/24 at 3:07 PM, Interim Director of Nursing (IDON) stated, indefinite use of antibiotic should be care planned as soon as the antibiotic is started. Review of Resident 31's Medication Regimen Review dated 9/9/24 indicated, CURRENT ORDER: Cephalexin Oral Capsule 250 MG - Give 1 capsule by mouth in the evening every Mon, Wed, Fri for recurrent UTIs Take 1 cap PO three times weekly. The above order does not include a stop date. RECOMMENDATION: Please update the above order with a stop date. If the order is to be continued indefinitely, please document to that effect below. Under section Physician/Prescriber Response indicated, Disagree - Family requested for PPX (prophylaxis - action taken to prevent disease). Review of facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, .2. The Comprehensive person-centered care plan should be developed within the seven (7) days of the completion of the required MDS assessment .and should be completed within 21 days of admission .

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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. 41545 Based on observation, interview, and record review, the facility failed to provide care and treatment according to facility policies and procedures and professional standards of practice for two of 18 sampled residents (Resident 291 and Resident 24) when: 1. Insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection was not prepared and administered according to current professional standard of practice and facility's insulin administration policy and procedure for Resident 219 and Resident 24. 2. Glucose (blood sugar) reading for Resident 24 was obtained during meals. Additionally, insulin was administered without a prescribed glucose check for Resident 24. These failures resulted in a medication error and had the potential to affect the absorption rate and efficacy of the insulin which could result in serious complications for Resident 219 and Resident 24. Findings: During medication pass observation on 10/15/24 at 12:13 PM, Licensed Vocational Nurse (LVN) 3 prepared to administer 4 units of Humulin R (also known as regular insulin, is a short-acting insulin used to treat diabetes) insulin based on Resident 219's glucose level of 206. During preparation, LVN 3 wiped the top of the vial, pushed the needle on top of the vial and immediately draw 4 units of Humulin R insulin from the vial. During insulin administration, LVN 3 held the back of Resident 219's right upper arm and injected the insulin in a 90 degree (0) and immediately removed the syringe from the injection site. During a follow up interview on 10/15/24 at 12:22 PM, LVN 3 stated, you don't need to pinch the site when injecting. During medication pass observation on 10/15/24 at 12:25 PM, LVN 3 went to Resident 24's room and saw the speech therapist sitting with a lunch tray in front of the resident. During concurrent interview, LVN 3 stated the speech therapist started to feed Resident 24 and that she will proceed with the blood sugar check since resident just started eating which will not affect the result. During further observation on 10/15/24 at 12:29 PM, LVN 3 obtained Resident 24's blood sugar level which was 202 and prepared to administer 4 units of Insulin Lispro (a fast-acting insulin used to control high blood sugar in adults and children with diabetes) per sliding scale (refers to the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges). During preparation, LVN 3 wiped the top of the vial, pushed the needle on top of the vial and immediately draw 4 units of Insulin Lispro from the vial. During insulin administration, LVN 3 directly injected the insulin on the right upper quadrant of the abdomen in a 900 angle and immediately removed the syringe from the injection site. (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 follow up interview on 10/15/24 at 12:36 PM, LVN 3 stated she knows that Resident 24 had already eaten but did not think it will have an effect on the blood sugar result and insulin administration. Review of Resident 24's active orders in the EHR, indicated, the following (ff) orders: Order date 10/6/24: Check blood glucose at bedtime. Order date 10/6/24: Insulin Lispro Injection 100 unit/ml (Insulin Lispro) Inject as per sliding scale: if 70-150 = 0 Do Not Hold if NPO. Give the ff insulin in addition to nutritional insulin; 151-200 = 2; 201-249 = 4; 250-300 = 6; 301-350 = 8; 351-400 = 10; BG (blood glucose) >400, give 12 units, subcutaneously with meals for DM2. During concurrent interview on 10/15/24 at 12:41 PM. LVN 3 stated, there is no order in the EHR for Resident 24's blood glucose to be checked before meals. I only see the bedtime order. LVN 3 added, there should be a separate order for the blood glucose check every meal. During an interview on 10/16/24 at 10:18 AM, ADON stated there should be an order in place for blood sugar checks and it should be done before meals, not during meals. During further interview, ADON was asked about their policy and procedure on insulin administration. ADON stated, the amount of air to be injected in the vial should be the same as to the dose of insulin to be drawn from the vial. Injecting of air and drawing insulin from the vial should be done within eye level. In addition, ADON stated to gently pinch the injection site, inject the insulin in a 450 or 900 angle depending on the injection site, leave the syringe for at least 5 to 10 seconds, then release and remove the syringe. ADON further stated that a 450 angle technique is followed when injecting on the upper and/or back of the arm while the 900 angle is followed when injecting on the abdomen. Review of facility's policy and procedure titled, Insulin Administration, updated 8/15/24, indicated, .Steps in the Procedure (Insulin Injections via Syringe) . 2. Check blood glucose per physician order or facility protocol . 6. Gently roll the insulin vial between the palms of both hands to resuspend the insulin . 10. Create a vacuum in the vial by injecting air into the vial in the amount equal to the dose of insulin . 18. Light grasp a fold of skin and insert the needle into the skin at a 900 angle. For very thin residents, insert at a 450 angle to avoid intramuscular injection. 19. Depress the plunge rand remove the needle after approximately five (5) seconds . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the American Diabetes Association article titled, Insulin Administration, dated 1/1/23, indicated, . INJECTION TECHNIQUE . Dose preparation .For all insulin preparations, except rapid- and short-acting insulin and insulin glargine, the vial or pen should be gently rolled in the palms of the hands (or shaken gently) to resuspend the insulin. An amount of air equal to the dose of insulin required should first be drawn up and injected into the vial to avoid creating a vacuum . After the insulin is drawn into the syringe, the fluid should be inspected for air bubbles. One or two quick flicks of the forefinger against the upright syringe should allow the bubbles to escape. Air bubbles themselves are not dangerous but can cause the injected dose to be decreased. Injection procedures - Injections are made into the subcutaneous tissue. Most individuals are able to lightly grasp a fold of skin, release the pinch, then inject at a 90 angle. Thin individuals or children can use short needles or may need to pinch the skin and inject at a 45 angle to avoid intramuscular injection, especially in the thigh area. Routine aspiration (drawing back on the injected syringe to check for blood) is not necessary. Particularly with the use of insulin pens, the needle should be embedded within the skin for 5 s after complete depression of the plunger to ensure complete delivery of the insulin dose . Injection site - Insulin may be injected into the subcutaneous tissue of the upper arm and the anterior and lateral aspects of the thigh, buttocks, and abdomen (with the exception of a circle with a 2-inch radius around the navel) . Site selection should take into consideration the variable absorption between sites. The abdomen has the fastest rate of absorption, followed by the arms, thighs, and buttocks .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 49264 Based on interview and record review, the facility failed to ensure that one of 18 sampled residents (Resident 26) had the necessary language systems for translation accessible when Resident 26 requested a translator but multiple staff were not aware of resources except for family or the use of a communication board (a tool that helps people with limited language skills express themselves by pointing to images or symbols). This failure has the potential for staff to not properly assess residents who speak a different language or make it difficult for a resident to make their unique needs known. Findings: A review of Resident 26's face sheet (front page of the chart that contains a summary of basic information about the resident), dated 10/18/24, indicated that Resident 26 was admitted in 2024 with a primary language of Japanese. During an interview on 10/15/24 at 12:10 PM with Resident 26, Resident 26 stated that their English was not good, and they requested an translator to continue the interview. A review of Resident 26's Medical Practitioner Narrative Note titled, PHYSICAL MEDICINE & REHABILITATION FOLLOW UP EVALUATION, dated 10/24/24, indicated that on assessment by Medical Doctor (MD) 1, MD 1 documented that Resident 26 had precautions (a measure taken in advance to prevent something dangerous, unpleasant, or inconvenient from happening) including speaks Japanese > [greater than] English. During an interview on 10/15/24 at 12:20 PM with Registered Nurse (RN) 1, RN 1 stated that Resident 26 spoke Mandarin. RN 1 further stated that usually a staff member that speaks Mandarin can help translate for the resident. RN 1 also stated that if more complex communication is needed, he would need a translation line [an audio or audio-visual translation service]. During an interview on 10/15/24 at 2:10 PM with RN 1, a translator was requested. RN 1 stated that he does not know how to access a translation line and would need to follow up with social services. During an interview on 10/16/24 at 8:53 AM with RN 1, RN 1 stated that he that usually speaks to Resident 26 in English and Resident 26 can understand a little but if it's more complex questions . you'll have a more difficult time. During an interview 10/17/24 at 11:47 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that if she needs help with translation with Resident 26, she would talk to the family or use non-verbal actions to understand the Resident. LVN 1 further stated, I've never used a translator service. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 2:42 PM with the Director of Social Services (DSS), the DSS stated that staff will often use family for translation services. If the family is not available, the DSS stated that staff can use communication boards with set phrases. If family in unavailable and the Resident has more complex needs that go beyond the communication board, the DSS stated that staff could use translation applications like Google Translate. The DSS further stated that the facility is not subscribed to any medical translation services.

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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** 41545 Based on interview and record review, the facility failed to monitor for behavioral symptoms, side effects and/or adverse consequences for one of 3 sampled residents (Resident 220) on psychotropic (drugs that affects brain activities associated with mental processes and behavior) medications. Additionally, the informed consent for the use of psychotropic medication was signed seven days after Resident was admitted to the facility. This failure had the potential to place residents on psychotropic medications at risk for adverse health consequences which could negatively impact the resident's mental, physical, and psychosocial well-being. Findings: Review of Resident 220's admission record indicated, was admitted to facility on 10/10/24 with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of right ankle and foot, schizophrenia, (a mental illness that is characterized by disturbances in thought), and type 2 diabetes mellitus (DM - high blood sugar). Review of Resident 220's SNF (skilled nursing facility) admission history and physical (H&P) dated 10/12/24, indicated, .Hx (history) schizophrenia: con (continue) amisulpride (an antiemetic and antipsychotic medication used at lower doses intravenously to prevent and treat postoperative nausea and vomiting; and at higher doses by mouth to treat schizophrenia and acute psychotic episodes) tab 400 mg (milligrams) po (per orem, meaning orally or via the mouth) qhs (every hours of sleep) with pt's (patient) own supply. Cont benztropine (treats symptoms that affect your movement caused by Parkinson's disease and other conditions) 0.5 mg po daily for TD (tardive dyskinesia - a chronic condition that causes involuntary, repetitive movements in the body) symptom control . PATIENT TAKES 400 QHS OF AMISULPRIDE TABLETS THESE ARE NOT AVAIALBLE IN USA, PLEASE ALLOW PATIENT TO TAKE HOME MEDICATIONS. DAUGHTER [Name] APPROVES . Review of Resident 220's active orders indicated, start date 10/10/24 AMISULPRIDE 400 MG TABLET. Take 1 tablet at bedtime for Schizophrenia. Daughter will supply the medication. Review of Resident 220's informed consent indicated, LN (licensed nurse) verified verbal or phone consent was received from daughter [Name] on 10/10/24. The informed consent also indicated was signed by the physician on 10/17/24, seven days after Resident 220 was admitted and started taking amisulpride at the facility. Review of Resident 220's Medication Regimen Review dated 10/12/24, indicated, AMISULPRIDE 400 MG TABLET. Take 1 tablet at bedtime for Schizophrenia. Daughter will supply the medication. Recommendation: Please enter orders in PCC to monitor target behavior and SE for the medication(s) listed above. (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 concurrent record review and interview with Assistant Director of Nursing (ADON) on 10/18/24 at 11:59 AM, ADON stated, monitoring of behavior and side effects for residents on psychotropic medications should start as soon as soon as the medication was administered. Resident 220's active orders and medication administration record indicated, amisulpride was first administered on 10/10/24 and the side effects monitoring was started on 10/17/24. Review of facility's policy and procedure titled, Psychoactive/Psychotropic Medication Use, updated August 2022, indicated, .1. General Guidelines: .g. Prior to administration of Psychotropic medication, the prescribing clinician will obtain informed consent from resident (or, as appropriate, the resident representative), and document the consent in the medical record. 2. Psychotropic Medication Management - a. Psychotropic medication management for the resident will involve the facility interdisciplinary team consideration of the following: indication and clinical need for medication, dose, duration, and adequate monitoring for efficacy and adverse consequences. Management will also include preventing (where possible), identifying, and responding to adverse consequences .e. Monitoring of resident receiving Psychotropic medication will include evaluation of the effectiveness of the medication, as well as an assessment for possible adverse consequences. Behavioral symptoms are reevaluated periodically to determine the potential for reducing or discontinuing the drug based on therapeutic goals, and any adverse effects or functional impairment. f. Staff will monitor for potential adverse consequences, such as: .tardive dyskinesia . 3. Informed Consent . iii. Prior to administration of Psychotropic medication, the prescribing clinician will obtain informed consent from resident (or, as appropriate, the resident representative), and document the consent in the medical record . vii. The personal examination and signatures can be completed and signed using remote technology .

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Peninsula Post-Acute	1609 Trousdale Drive Burlingame, CA 94010

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41545 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent (5%) when 10 medication errors occurred out of 40 opportunities during the medication administration for four residents (Resident 53, Resident 43, Resident 219, and Resident 24, resulting in an error rate of 25%. 1. Licensed Vocational Nurse (LVN) 3 did not observe Resident 53 take her medications after leaving seven (7) of the prescribed medications on the bedside table. 2. Registered Nurse (RN) 1 administered Resident 43's Repaglinide (used to treat type 2 diabetes mellitus [high blood sugar]) during meals. 3. Insulin was not administered according to professional standard of practice for Resident 219 and Resident 24. In addition, insulin was administered without a prescribed blood sugar check for Resident 24. These failures resulted in medications not given according to the prescriber's orders and/or manufacturer's specifications and had the potential for residents not receiving the full therapeutic effects of the medications. Findings: 1. During medication pass observation on 10/15/24 at 9:50 AM, LVN 3 prepared ten (10) medications for Resident 53: a. 1 packet - MiraLAX powder (used to treat occasional constipation) 17 grams (g). b. 2 tablets (tabs) - Oxycodone (a controlled substance used to treat moderate to severe pain) Tablet 5 milligrams (mg). c. 1 tab - Simethicone (used to relieve painful pressure caused by excess gas in the stomach and intestines) 80 mg chewable tablet. d. 4 tabs - Metoprolol Succinate (used to treat chest pain, heart failure and high blood pressure) tablet 25 mg Extended Release (ER). e. 1 tab - Losartan Potassium (used to treat high blood pressure) tab 50 mg. f. Fluticasone Furoate Nasal Spray (used to prevent difficulty breathing, chest tightness, wheezing, and coughing caused by asthma in adults and children) 27.5 micrograms (mcg) per spray. g. 1/2 tab - Spironolactone (used to treat high blood pressure and fluid retention) 25 mg 1 tab, take 1/2 (12.5 mg) by mouth once daily. h. 1 tab - Trospium chloride (used to treat an overactive bladder) tab 20 mg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Docusate sodium (a stool softener medication used to treat occasional constipation) tab 100 mg which was refused by Resident 53. j. 3 patches - Aspercreme with 4% Lidocaine (used for pain relief) pain relief patch. On the same medication pass observation, LVN 3 administered 2 tabs of Oxycodone, MiraLAX powder that was mixed with Gatorade in a small cup full of ice cubes and applied 1 patch of Aspercreme on Resident 53's back. Resident 53 consumed three quarters of the mixture and left the remaining portion on the bedside table. Resident 53 told LVN 3 to leave the rest of the medications on the bedside table and that she will take them later since she was in a rush to use the bed pan and get her peri-care (also known as perineal care - means cleaning the private area of patients) done. During further observation, LVN 3 left the Fluticasone Furoate nasal spray and medicine cup that had the rest of the medications she prepared for Resident 53 on the bedside table and took the 2 Aspercreme patch and stored it in the medication (med) cart to be applied at a later time. During an interview on 10/15/24 at 10:05 AM, LVN 3 stated she was not supposed to leave the medications at the bedside and that she should observe the resident taking it. LVN 3 stated she take the medications with her and store it in the med cart while the resident is not yet ready. LVN 3 further stated, she would come back to check if Resident 53 took the medications she left on the bedside table. Furthermore, LVN 3 stated a total of seven medications were left at the bedside. Review of the manufacturer's instructions for MiraLAX indicated, the medication should be administered with 4 to 6 ounces (oz) of fluid and taken immediately after mixing. Waiting too long before consuming the mixture can cause it to thicken, potentially leading to choking. Review of Resident 53's electronic health record (EHR) indicated, there was no order obtained and assessment completed for Resident 53 to self-administer her medications. During concurrent interview on 10/15/24 at 12:47 PM, LVN 3 stated Resident 53 has no order for self-administration of medication. During an interview on 10/15/24 at 4:31 PM, Assistant Director of Nursing (ADON) stated, the nurse should observe the resident take the medications before leaving the room and that nurses are not supposed to leave any medications at the bedside. Review of facility's policy and procedure titled, Administering Oral Medications, revised October 2010, indicated, .Steps in the Procedure .9. Prepare the correct dose of medication: .c. For powdered medications. Mix with liquids at the bedside . 21. Remain with the resident until all medications have been taken . Review of facility's policy and procedure titled, Administering Medications, copyright 2001, indicated, .20. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR (Medication Administration Record) may be 'flagged'. After completing the medication pass, the nurse will return to the missed resident to administer the medication . 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary planning team, has determined that they have the decision-making capacity to do so safely . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During medication pass observation on 10/15/24 at 12:08 PM, Registered Nurse (RN) 1 prepared two medications for Resident 43 including Repaglinide (used to treat type 2 diabetes mellitus [high blood sugar]) tablet 0.5 mg. RN 1 administered the Repaglinide while Resident 43 was eating his lunch. During concurrent interview, RN 1 stated Repaglinide can be taken before or after meals. Review of Resident 43's active orders in the EHR indicated, Repaglinide Tablet 0.5 MG. Give 1 tablet by mouth two times a day for DM 2 Give 30 minutes before breakfast and lunch. According to the Food and Drug Administration (FDA, is a federal agency responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, vaccines and other biological products for human use, and medical devices) prescribing information for Repaglinide, .2. Repaglinide Tablets Dosage and Administration . The recommended starting dose for patients whose HbA1c is less than 8% is 0.5 mg orally before each meal. For patients whose HbA1c is 8% or greater the starting dose is 1 mg or 2 mg orally before each meal. The recommended dose range is 0.5 mg to 4 mg before meals, with a maximum daily dose of 16 mg. The patient's dose should be doubled up to 4 mg with each meal until satisfactory glycemic control is achieved. At least one week should elapse to assess response after each dose adjustment. Instruct patients to take repaglinide tablets within 30 minutes before meals. Repaglinide tablets may be dosed 2, 3, or 4 times a day in response to changes in the patient's meal pattern . Review of facility's policy and procedure titled, Administering Medications, copyright 2001, indicated, .4. Medications are administered in accordance with prescriber orders, including the required time frame. 5. Medication administration times are determined by the resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food interactions . 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . 3a. During medication pass observation on 10/15/24 at 12:13 PM, LVN 3 prepared to administer 4 units of Humulin R (also known as regular insulin, is a short-acting insulin used to treat diabetes) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) based on Resident 219's glucose (blood sugar) level of 206. During preparation, LVN 3 wiped the top of the vial, pushed the needle on top of the vial and immediately draw 4 units of Humulin R insulin from the vial. During insulin administration, LVN 3 held the back of Resident 219's right upper arm and injected the insulin in a 90 degree (0) and immediately removed the syringe from the injection site. During a follow up interview on 10/15/24 at 12:22 PM, LVN 3 stated, you don't need to pinch the site when injecting. 3b. During medication pass observation on 10/15/24 at 12:25 PM, LVN 3 went to Resident 24's room and saw the speech therapist sitting with a lunch tray in front of the resident. During concurrent interview, LVN 3 stated the speech therapist started to feed Resident 24 and that she will proceed with the blood sugar check since resident just started eating which will not affect the result. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During further observation on 10/15/24 at 12:29 PM, LVN 3 obtained Resident 24's blood sugar level which was 202 and prepared to administer 4 units of Insulin Lispro (a fast-acting insulin used to control high blood sugar in adults and children with diabetes) per sliding scale (refers to the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges). During preparation, LVN 3 wiped the top of the vial, pushed the needle on top of the vial and immediately draw 4 units of Insulin Lispro from the vial. During insulin administration, LVN 3 directly injected the insulin on the right upper quadrant of the abdomen in a 900 angle and immediately removed the syringe from the injection site. During a follow up interview on 10/15/24 at 12:36 PM, LVN 3 stated she knows that Resident 24 had already eaten but did not think it will have an effect on the blood sugar result and insulin administration. Review of Resident 24's active orders in the EHR, indicated, the following (ff) orders: Order date 10/6/24: Check blood glucose at bedtime. Order date 10/6/24: Insulin Lispro Injection 100 unit/ml (Insulin Lispro) Inject as per sliding scale: if 70-150 = 0 Do Not Hold if NPO. Give the ff insulin in addition to nutritional insulin; 151-200 = 2; 201-249 = 4; 250-300 = 6; 301-350 = 8; 351-400 = 10; BG (blood glucose) >400, give 12 units, subcutaneously with meals for DM2. During concurrent interview on 10/15/24 at 12:41 PM. LVN 3 stated, there is no order in the EHR for Resident 24's blood glucose to be checked before meals. I only see the bedtime order. LVN 3 added, there should be a separate order for the blood glucose check every meal. During an interview on 10/16/24 at 10:18 AM, ADON stated there should be an order in place for blood sugar checks and it should be done before meals, not during meals. During further interview, ADON was asked about their policy and procedure on insulin administration. ADON stated, the amount of air to be injected in the vial should be the same as to the dose of insulin to be drawn from the vial. Injecting of air and drawing insulin from the vial should be done within eye level. In addition, ADON stated to gently pinch the injection site, inject the insulin in a 45 or 90 degree angle depending on the injection site, leave the syringe for at least 5 to 10 seconds, then release and remove the syringe. ADON further stated that a 450 angle technique is followed when injecting on the upper and/or back of the arm while the 900 angle is followed when injecting on the abdomen. Review of facility's policy and procedure titled, Insulin Administration, updated 8/15/24, indicated, .Steps in the Procedure (Insulin Injections via Syringe) . 2. Check blood glucose per physician order or facility protocol . 6. Gently roll the insulin vial between the palms of both hands to resuspend the insulin . 10. Create a vacuum in the vial by injecting air into the vial in the amount equal to the dose of insulin . 18. Light grasp a fold of skin and insert the needle into the skin at a 900 angle. For very thin residents, insert at a 450 angle to avoid intramuscular injection. 19. Depress the plunge rand remove the needle after approximately five (5) seconds . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the American Diabetes Association article titled, Insulin Administration, dated 1/1/23, indicated, . INJECTION TECHNIQUE . Dose preparation .For all insulin preparations, except rapid- and short-acting insulin and insulin glargine, the vial or pen should be gently rolled in the palms of the hands (or shaken gently) to resuspend the insulin. An amount of air equal to the dose of insulin required should first be drawn up and injected into the vial to avoid creating a vacuum . After the insulin is drawn into the syringe, the fluid should be inspected for air bubbles. One or two quick flicks of the forefinger against the upright syringe should allow the bubbles to escape. Air bubbles themselves are not dangerous but can cause the injected dose to be decreased. Injection procedures - Injections are made into the subcutaneous tissue. Most individuals are able to lightly grasp a fold of skin, release the pinch, then inject at a 90 angle. Thin individuals or children can use short needles or may need to pinch the skin and inject at a 45 angle to avoid intramuscular injection, especially in the thigh area. Routine aspiration (drawing back on the injected syringe to check for blood) is not necessary. Particularly with the use of insulin pens, the needle should be embedded within the skin for 5 s after complete depression of the plunger to ensure complete delivery of the insulin dose . Injection site - Insulin may be injected into the subcutaneous tissue of the upper arm and the anterior and lateral aspects of the thigh, buttocks, and abdomen (with the exception of a circle with a 2-inch radius around the navel) . Site selection should take into consideration the variable absorption between sites. The abdomen has the fastest rate of absorption, followed by the arms, thighs, and buttocks .

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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. 49264 Based on observation, interview, and record review the facility failed to ensure that one of 18 sampled Residents (Resident 269) was free of significant medication errors when Resident 269 was given Acetaminophen (a pain medication) beyond the parameters ordered by the medical provider. This failure has the potential to lead to Acetaminophen adverse effects (undesired effect of a drug) including abdominal pain, nausea/vomiting, or liver damage. Findings: A review of Resident 269's face sheet (front page of the chart that contains a summary of basic information about the resident), dated 10/18/24, indicated that Resident 269 was admitted in 2024 for multiple diagnosis including Fracture, Left femur (break in the upper leg bone) and Fracture .of left humerus (break in the left upper arm bone). A review of Resident 269's medication administration record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 10/17/24, indicated that Resident 269 had two orders for Acetaminophen. The first order indicated Acetaminophen . 500 MG [milligrams, metric unit of measurement used for medication dosage and/or amount] . Give 2 tablet by mouth three times a day for Left should pain DNE [do not exceed] 3g/24hours [Grams, metric unit of measurement used for medication dosage and/or amount, in 24 hours] of APAP [another name for Acetaminophen] from all sources. The second order indicated Resident 269 can receive 325 MG (Acetaminophen) .2 tablet by mouth every 4 hours as needed .DNE 3g/24hours of APAP from all sources. During a concurrent interview and record review 10/17/24 at 11:52 AM with Licensed Vocational Nurse (LVN) 1, Resident 269's MAR, dated 10/17/24, was reviewed. The MAR indicated that Resident 269's Acetaminophen was given as ordered-1000 MG three times a day on October 12, 13, 14, and 16, 2024. The MAR further indicated that Resident 269 received an additional 650mg of Acetaminophen on October 13, 2024 at 2108 (9:08 PM) and October 14, 2024 at 0110 (1:10 AM). LVN 1 stated that for the dates of October 13 and October 14, Resident 269 exceeded the ordered maximum dose of Acetaminophen. LVN 1 stated that this was not okay because Resident 269's medication orders indicated that Resident 269 should not exceed 3000mg in 24 hours. LVN 1 further stated that she would be concerned about any effects on the liver or kidney when taking too much Acetaminophen. During a concurrent interview and record review 10/17/24 at 2:09 PM with the Interim Director of Nursing (IDON), Resident 269's MAR, dated 10/17/24, was reviewed. The MAR indicated that Resident 269's Acetaminophen was given as ordered-1000 MG three times a day on October 12, 13, 14, and 16, 2024. The MAR further indicated that Resident 269 received an additional 650mg of Acetaminophen on October 13, 2024 at 2108 (9:08 PM) and October 14, 2024 at 0110 (1:10 AM). The IDON stated that on October 13 and October 14, Resident 269 was given Acetaminophen that went over the parameter. The IDON further stated that taking too much Acetaminophen can have an effect on liver function. A review of a facility policy titled Administering Medications, dated 2001, indicated that Medications are administered in accordance with prescriber orders, including any required time frame.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41545 Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were labeled and stored according to manufacturer's instruction and facility policy and procedure; expired biologicals were removed from the active storage area; and medication cart was locked when left unattended. These deficient practices had the potential to compromise the integrity and effectiveness of the drugs and biologicals; and may jeopardize the health and safety of residents. Findings: 1A. During an observation on [DATE] at 10:25 AM, in resident's room, a medicine bottle was observed in plain sight in Resident 52's bedside drawer. The medication bottle indicated, FETILIDE 500 MCG (Generic for Dofetilide) ., a medication used to treat an irregular heartbeat (arrhythmia). During concurrent interview, Resident 52 stated she had asked the doctor to have her keep this medication at the bedside so she can take it on time to prevent her heart rate to increase. During concurrent interview and record review on [DATE] at 3:31 PM, Licensed Vocational Nurse (LVN) 3 reviewed Resident 52's active orders and did not find an order or documentation indicating resident can keep her medication (Dofetilide) at the bedside. LVN 3 stated, there was no order or assessment in the chart. I don't see it here. LVN 3 added, there should be an order to store or keep medications at the bedside. Review of facility's policy and procedure titled, Administering Medications, copyright 2001, indicated, .27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary planning team, has determined that they have the decision-making capacity to do so safely . 1B. During medication pass observation on [DATE] at 10:13 AM, LVN 3 prepared Adult Tussin DM (used to treat cough and congestion caused by the common cold or minor throat or bronchial irritation) 10 milliliters (ml) for Resident 50. The Adult Tussin DM bottle was opened and undated. During concurrent interview, LVN 3 stated, they're supposed to write an open date, either put a yellow sticker label or write the open date directly on the bottle. 1C. During medication pass observation on [DATE] at 12:08 AM, Registered Nurse (RN) 1 prepared two medications for Resident 43 including Sevelamer Carbonate (a phosphate binder medication used to control high blood level of phosphorous, a mineral found in food, in people with kidney disease who are on dialysis) 800 mg 1 tablet. The medication label indicated, take 2 tablets by mouth three times daily with meal. The medication label did not indicate a note or change of direction. During concurrent interview, RN 1 reviewed the order and stated, to administer 1 tablet only. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 43's Order Summary Report dated [DATE], indicated, Sevelamer Carbonate Tablet 800 MG Give 2 tablet by mouth with meals for hypocalcemia was discontinued on [DATE]. The Order Summary Report also indicated a new order was entered on [DATE] for Sevelamer Carbonate Tablet 800 MG Give 2 tablet by mouth with meals for hypocalcemia. 1D. During an inspection of the Medication Cart (Med Cart) 1 and concurrent interview with LVN 1, on [DATE] at 10:47 AM, in station 1, one bottle of multi-dose insulin vial (Humulin R) was opened and undated. LVN 1 stated, it needs to be discarded 28 days after opening, therefore there should be an open date. 1E. During further inspection and concurrent interview with LVN 1, on [DATE] at 10:55 AM, in station 1, acknowledged the following were stored in the locked compartment of Med Cart 1: a. Multiple controlled drugs (a drug or chemical whose manufacture, possession, or use is regulated by a government) of discharged residents and those that were discontinued remained and were stored in the locked compartment. b. Resident's money in a plastic (Ziploc) bag was stored in the locked box together with the controlled drugs. During a concurrent interview, LVN 1 stated that resident's valuables including money, should not be in the medication cart because of infection control concerns and that it should be kept in a safe by the social services. During an interview on [DATE] at 11:23 AM, ADON stated, resident's money is given to social services, DON, or whoever has a locked box for safe keeping. ADON added, it should not be stored in the medication cart and that the locked compartment are only for narcotic drugs (controlled drugs). Review of facility's policy and procedure titled, Controlled Substances, revised [DATE], indicated, .13. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed. 16. The director of nursing services maintains and disseminates to appropriate individuals a list of staff who have access to medication storage areas and controlled substance containers . 2. During inspection of the medication cart and concurrent interview with LVN 1, on [DATE] at 10:50 AM, in station 1, one bottle of Assure Dose Control Solution (a testing solution to ensure your blood glucose monitor produces accurate results) was stored beyond the manufacturer's expiration date, Exp. [DATE]. LVN 1 acknowledged and stated, the control solution was past the expiration date. According to the manufacturer's information sheet for Assure Dose Control Solution, .Storage and Handling: . Use before the expiration date printed on the bottle. Use the control solution within 90 days (3 months) of first opening. It is recommended that you write the date of opening on the control solution bottle label (Date Open) as a reminder to dispose of the opened solution after 90 days . 3. During an observation on [DATE] at 10:03 AM, in resident's room, LVN 2 left the medication cart unlocked in the hallway during medication pass. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:09 AM, Assistant Director of Nursing (ADON) stated, the medication cart should not be left unlocked and unattended. Review of facility's policy and procedure titled, Medication Labeling and Storage, revised February 2023, indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls . Medication Storage . 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 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. 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others . Medication Labeling - 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices . 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial . 12. The nursing staff must inform the pharmacy of any changes in physician orders for a medication.

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Peninsula Post-Acute	1609 Trousdale Drive Burlingame, CA 94010

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 49373 Based on observation, interview, and facility document review, the facility failed to ensure one kitchen staff competency for manual warewashing (warewashing: cleaning and sanitizing of utensils and food-contact surfaces of equipment) using the three-compartment sink. The failure to ensure staff competency for 1 of 8 kitchen staff regarding manual warewashing had the potential to result in contamination of food and/or utensils and equipment leading to illness caused by pathogens (harmful organisms). Findings: Review of the policy and procedure titled 3-Compartment Procedure for Manual Dishwashing, dated 2023, showed if the dish machine is not working properly manual dishwashing will be initiated. All items should be rinsed, scraped, or soaked before washing. The first compartment is used for washing. Fill the first compartment with detergent and hot water. The second compartment is used for rinsing. Fill the sink with clean, clear hot water, 110 -120 degrees Fahrenheit (F, temperature scale) and the temperature should be recorded. Items should be thoroughly rinsed to remove detergent and the water should be replaced if it becomes cloudy or dirty, or when temperature falls below 110 degrees F. The third compartment is used for sanitizing. Fill the third compartment with clean, clear water then add sanitizer. Immerse all washed items in the sanitizer solution. During a concurrent kitchen observation in the presence of the Registered Dietitian (RD) and Dietary Supervisor (DS) and interview on 10/15/24 at 9:38 AM, Dietary Aide (DA) 1 stood in front of the three-compartment sink and described how items such as dishes, cooking utensils, and cooking equipment would be cleaned using the three-compartment sink in the event the dish machine could not be used. DA 1 stated the first sink was for scraping food, the second sink was for washing with soap/detergent, and the third sink was for rinsing in plain water without anything added to the water. DA 1 did not mention sanitizing as part of the procedure. DS stated mostly a Dietary Aide would use the 3-compartment sink to wash items if the dish machine was not working. During an interview on 10/15/24 at 12:30 PM, DS stated the procedures for manual warewashing including scraping, washing, rinsing, and sanitizing. DS further stated the first sink was for washing, the second sink was for rinsing, and the third sink was for sanitizing.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49373 Based on observation, interview, and record review, the facility failed to ensure meals were plated in accordance with the approved menu when the incorrect scoop size was used for serving green beans to residents for a lunch meal. This failure to follow the planned menu had the potential to result in residents' diets not being given in accordance with the prescriber's order and diet specifications, resulting in residents not receiving the amount of nutrients to meet their nutritional needs to 49 residents who received regular textured green beans according to the menu and the lunch tray tickets. Findings: Review of the facility provided document titled Fall Menus spreadsheet dated 10/14/24, showed the serving size for regular textured Southern [NAME] beans was 1/2 cup. According to the facility's lunch tray tickets dated 10/14/24, showed 49 residents had a diet allowing regular textured green beans and did not have a dislike for beans/green beans. Review of the undated facility document titled Scoop Measurements, showed the gray color scoop (number 8) measures 1/2 cup, and the green color scoop (number 12) measures 1/3 cup. During a kitchen observation on 10/14/24 at 12:00 PM, [NAME] 1 used a green scoop to serve green beans during trayline. During an interview on 10/15/24 at 1:43 PM, DS acknowledged [NAME] 1 used an incorrect scoop size according to the menu to serve green beans and she used a green scoop (number 12), intended for 1/3 cup portions, instead of the gray scoop for 1/2 cup portions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49373 Based on observation, interview, and facility document review, the facility failed to provide palatable food for a lunch meal including: 1. Meatballs; and 2. Pureed green beans. The failure to provide palatable food had the potential to reduce residents' food and nutrient intake leading to weight loss and/or nutritional medical complications for 34 residents who received meatballs or pureed green beans according to diet orders on the lunch meal tickets out of 56 residents who received food from the kitchen. Findings: 1. Review of the facility policy and procedure (P&P) titled Meal Service dated 2023, showed the Food and Nutrition Services staff member will take the food temperature prior to service of the meal with a thermometer. It may be necessary to take the temperature in more than one location on the food item to confirm the proper temperature has been reached. The food temperatures will be recorded. The minimum hot holding temperature on steam table is 140 degrees F. Temperatures of the food when the resident receives it is based on palatability. The goal is to serve hot food hot. The document also showed the recommended temperature for hot entrees at delivery to the resident should be at or over 120 degrees F. Review of the facility's job description titled [NAME] prepared by Human Resources on 10/2016, showed the [NAME] essential duties included but were not limited to preparing tasteful meals, and recording food temperatures for meals. Review of the facility provided document titled Fall Menus spreadsheet dated 10/14/24 and used as the menu for lunch on 10/14/24, showed all regular textured diets received a meatball sandwich. Review of the lunch meal tickets dated 10/14/24, showed 34 residents received a regular textured diet. However, the tray tickets showed 2 of the 34 residents did not like beef, so according to the menu and tray tickets, 32 residents received meatballs for lunch. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation in the kitchen and interview on 10/14/24 at 11:45 AM with [NAME] 1 and the Dietary Supervisor (DS) , trayline was started for the lunch meal. [NAME] 1 started to plate the first tray. When DS was asked what the holding temperatures of the food were on trayline, DS stated the food temperatures were not measured before trayline was started. DS informed [NAME] 1 to measure the food temperatures on the trayline and handed her a thermometer. [NAME] 1 inserted the thermometer with cover over probe in a meatball. [NAME] 1 stated the thermometer was not working. When [NAME] 1 was informed, the thermometer probe cover was on, she removed it and started to measure the food temperature. [NAME] 1 measured the temperatures of two meatballs and stated the temperatures were 125 degrees Fahrenheit (F, temperature scale) and 126.4 degrees F. The surveyor also measured the temperature of meatballs with a calibrated thermometer the temperature of one meatball towards the bottom of the pan was 133 degrees F. The temperatures of three meatballs toward the top of the pan were 113.6 degrees F, 118.6 degrees F, and 102.2 degrees F. During a concurrent observation and interview with the Registered Dietitian (RD) on 10/14/24 at 1:22 PM, a regular texture meal was sampled immediately following the delivery of the last resident tray. The temperature of the food was measured. A meatball temperature measured with a calibrated thermometer was 105.1 degrees F. The RD stated the meatball was cool in the mouth, not cold but lower than ideal, The RD further stated all food temperature should be checked before trayline begins. 2. Review of the facility provided document titled Fall Menus Spreadsheet dated 10/14/24 and used as the menu for lunch on 10/14/24, showed regular textured diets received Southern [NAME] Beans and pureed diets received pureed Southern [NAME] Beans. Review of the lunch meal tickets dated 10/14/24, showed 2 residents received a pureed diet. Review of the facility's undated Recipe: Pureed Vegetables, showed to prepare the vegetables per the regular recipe, puree the vegetables (using a food processor or blender) to a paste consistency before adding any liquid. Gradually add a warm liquid such as low sodium broth if needed. Taste and adjust seasoning as needed. Review of the facility's job description titled [NAME] prepared by Human Resources on 10/2016, showed the [NAME] essential duties included but were not limited to preparing tasteful meals, and preparing pureed foods. During a concurrent observation and interview with the RD and DS on 10/14/24 at 1:22 PM, a regular and a pureed texture meal was sampled immediately following the delivery of the last resident tray. The regular green beans tasted like green beans and were not overly seasoned. The pureed green beans were extremely salty and did not taste like green beans. The RD stated the pureed green beans were a little salty. The RD tasted the regular green beans and said the regular and the pureed tasted different. When DS tasted the pureed green beans, she stated they tasted salty.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 34975 Based on observation, interview and record review, the facility failed to ensure the facility's electronic medical record was designed to provide physicians with diet order selections, for residents with renal (kidney) insufficiency/failure, that was consistent with current standards of practice and terminology used by the approved diet manual of the Food and Nutrition Services Department. This failure had the potential for 3 residents (Resident 34, 43, and 54), out of a facility census of 56, who were prescribed a Renal diet (a diet aimed at keeping levels of fluids, electrolytes, and mineral balanced in the body in individuals with chronic kidney disease or who are on dialysis) to receive inappropriate nutrient levels for their individual medical status. Findings: Review of the facility Policy and Procedure (P&P) titled Therapeutic Diets revised 2017, showed the terminology of physician ordered diets should match the terminology used by the Food and Nutrition Services department. Review of the facility's 2023 Diet Manual for Long Term Care Facilities showed it was approved by the RD on 10/15/24 but was not yet approved by the Medical Director. The diet manual included the following protein restricted diets, designed for those with acute or chronic renal failure: 40 gm (gram, unit of measurement) Protein Diet; 60 gm Protein Diet; 80 gm Protein Diet; 80 gm Protein, Low Potassium, Low Salt, in combination with Controlled Carbohydrate (a diet used to stabilize blood sugar) and; 120-125 gm Protein, Low Salt, Moderate Potassium (3 gms). The standard of practice would be to consult with the healthcare team to determine the amount of nutrients appropriate to a resident with renal deficiency/failure. According to the National Kidney Foundation, for kidney patients, the amount of nutrients such as protein, potassium, phosphorous, and sodium are dependent the individual such as body size, nutritional status, and dialysis status. It is important to consult with a healthcare team to determine appropriate nutrient amounts. National Kidney Foundation. www.kidney.org. Accessed 25 October 2024. Review of the facility's Fall Menus spreadsheet dated 10/14/24, listed the Renal Diets as: 1) 60 gm Protein, Low Potassium, Low Salt; 2) 80 gm Protein, Low Potassium, Low Salt and 3) 80 gm Protein CCHO, Low Potassium, Low Salt. A record review of lunch meal tickets dated 10/14/24, showed Resident 32's diet type was Renal. A record review for Resident 32 showed the physician prescribed diet ordered on 8/1/24 was Liberal Renal. The Order Summary showed Liberal Renal, extra bowl of gravy served at every meal, and low potassium. There was no approved guidance of the term Liberal Renal. Resident 43's diet type was CCHO, Renal. A record review for Resident 43 showed the physician prescribed diet ordered on 9/13/24 was CCHO, Liberal Renal. The Order Summary showed CCHO, Liberal Renal, double protein with meals, no concentrated sweets. Review of the Progress Notes documented by the RD on 10/10/24, showed Resident 43 had End Stage Renal Disease and was on dialysis. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review for Resident 54 showed the physician prescribed diet ordered on 10/16/24 was CCHO, Liberal Renal. The Order Summary showed CCHO, Liberal Renal diet, no concentrated sweets (a therapeutic diet limiting foods and drinks with added sugar or high-calorie sweetener; this diet is not a current standard of practice.). During an interview on 10/18/24 at 9:30 AM, the Registered Dietitian (RD) navigated through the computer software to show what diets were available for doctors to order for residents. There was only one diet choice available, Liberal Renal, for residents with renal disease. The RD stated he thought the Liberal Renal diet was the same as the Renal diet shown on the meal tickets. RD stated to his understanding the Liberal Renal Diet was low in phosphorous and protein. The electronic medical record did not give physician's options to order diets that were consistent with standards of practice, or the facility approved diet manual. During a consecutive interview and document review with the RD, on 10/18/24 at 9:30 AM, the 2023 Diet Manual for Long Term Care Facilities the RD confirmed Liberal Renal was not in the diet manual. When asked what diet in the diet manual would match the Liberal Renal diet, RD stated questions regarding the diet manual should be referred to the Dietary Supervisor. During an interview on 10/18/24 at 1:05 PM, despite the physician orders not indicating the amount of protein, or low salt, the Dietary Supervisor stated when an order was received for a Renal diet, the 80 gram protein, Low Potassium Low salt, diet on the Fall Menus spreadsheet was followed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49373 Based on observation, interview, and facility document review, the facility failed to ensure food was stored, prepared, and served in a safe and sanitary environment when: 1. The fish served was not cooked to the appropriate temperature; 2. The fish was not thawed properly; 3. The resident's refrigerator contained unlabeled, undated and expired items; 4. Proper hand hygiene and glove use was not followed; 5. The microwave was not clean; 6. The plate warmer was not clean; and 7. The food carts were not cleaned appropriately; These failures had the potential to result in contamination of food, food preparation equipment, and utensils used for food, leading to food borne illness (any illness resulting from eating contaminated/spoiled foods) for 56 residents who received food from the kitchen. 1. During a kitchen observation on [DATE] at 12:02 PM, the Dietary Supervisor (DS) removed a pan of fish from the oven and placed a piece of fish on a plate for a resident's lunch. The tray holding the resident's plate was placed in the cart to serve to the resident. DS stated the fish temperature was not measured before it was placed on the resident's plate. DS measured the temperature of a piece of fish on pan. The initial temperature of the fish was 126.6 degrees Fahrenheit (F, a temperature scale). The surveyor also measured the temperature of two pieces of fish on the pan with a calibrated thermometer and the temperatures were 109.1 degrees F and 117.9 degrees F. DS removed the resident's tray with the fish from the serving cart and placed all pieces of fish back in the oven. When DS removed the fish from the oven she rechecked the temperature of one piece of fish, which was 137.1 degrees F. DS placed the piece of fish on the resident's plate which was placed on the food cart to serve to the resident. During an interview on [DATE] at 1:17 PM, DS stated the recommended cooking temperature for fish was 145 degrees F and confirmed the fish was cooked to 137 degrees F. Review of facility's policy and procedure (P&P) titled Meal Service, dated 2023, showed meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner, and served at the appropriate temperatures. The food will be served on trayline at the recommended temperatures to cook potentially hazardous foods (PHF, food capable of supporting bacterial growth associated with foodborne illness) to specific time and temperature standards. For fish, the standard is 145 degrees F for 15 seconds. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent kitchen observation and interview on [DATE] at 9:24 AM with [NAME] 2, raw fish fillets were laid out on four large metal pans sitting on the countertop. The fish appeared frozen but slightly thawed with clear fluid surrounding the fish in the pan. [NAME] 2 stated the fish was frozen and was thawing. A concurrent observation and interview with [NAME] 2 on [DATE] at 10:30 AM, showed the pans of raw fish remained on the countertop. [NAME] 2 stated he planned to place the fish in the oven about 11:15 AM. During an interview on [DATE] at 1:17 PM, DS confirmed thawing fish on the countertop was not acceptable. DS stated, proper ways of thawing fish are using running water and the use of microwave. Review of facility's P&P titled Thawing of Meats, dated 2023, showed thawing meat properly can be done in four ways: 1. In a refrigerator at 41 F or colder 2. In a microwave if foods are to be cooked immediately following the thawing process 3. Submerge under running, potable water at a temperature of 70 F or lower, with a pressure sufficient to flush away loose particles 4. Foods can be thawed as part of the cooking process. 3. A concurrent observation and facility document review on [DATE] at 11:40 AM, showed a residents' refrigerator located in the hallway across from the therapy room. A document posted on the outside of the refrigerator read To all residents and families . Please make sure ALL items are labeled clearly with RESIDENT'S NAME (not room numbers) and CURRENT DATE. Any items not properly labeled will be thrown away or any items older than 3 days will be thrown out . The following items were noted in the residents' refrigerator: a. Four individual containers of yogurt, two with a manufacturer's expiration date of [DATE], and two with a manufacturer's expiration date of [DATE]. The yogurts were inside a Ziploc bag labeled with one discharged resident's name; b. An individual sized carton of a protein drink with no resident's name and a manufacturer's expiration date of [DATE]. c. An opened 48 fluid ounce container of almond milk with no resident's name, no open date or use by date label; d. Two individual serving size nutrition shakes with no resident's name; and e. An opened 64 fluid ounce carton of oat milk with no resident's name and a manufacturer's expiration date of [DATE]. During an interview on [DATE] at 11:40 AM, DS stated the items observed in the refrigerator including expired yogurt, expired protein drink, opened almond milk, opened and expired oat milk, and the individual nutrition shakes were all items belonging to residents. DS stated all resident items stored in the refrigerator should have a label indicating the resident name and an open date if opened. DS further stated, she was responsible for monitoring the refrigerator for expired items and expired items should be discarded. DS stated she monitored the refrigerator every Friday. DS confirmed the refrigerator should be monitored daily to ensure no expired items were stored in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's P&P titled Foods Brought in by Family/Visitors, revised [DATE], showed perishable food containers are labeled with the resident's name and the use-by date. The nursing staff will discard perishable foods on or before the use-by date. Review of facility's P&P titled Labeling and Dating of Foods, dated 2023, showed newly opened food items will need to be labeled with an open date and used by the date that follows the various storage guidelines. 4. According to the 2022 Federal Food Code, Food employees shall clean their hands immediately when changing tasks and after engaging in other activities that contaminate the hands. Review of facility's P&P titled Glove Use Policy, dated 2023, showed the appropriate use of gloves is essential on preventing food borne illness. Gloved hands are considered a food contact surface that can get contaminated or soiled. The P&P also showed the glove use procedure: 1. Wash hands and forearms 2. Using clean, dry hands, place glove on each hand. 3. Wash hands when changing to a fresh pair. Gloves must never be used in place of hand washing. During a kitchen observation on [DATE] at 9:34 AM, DS picked up a thermometer that fell from the freezer to the floor and placed it back in the freezer without cleaning the thermometer and washing her hands, before putting on gloves. During a kitchen observation on [DATE] at 9:57 AM, DS picked up a plastic bag from the floor while wearing gloves but did not remove the gloves after touching the bag from the floor, or wash her hands before opening a drawer where the food scoops were stored. During an interview on [DATE] at 2:21 PM, DS acknowledged it was not appropriate to not remove gloves and wash hands after picking up items dropped on the floor. DS added, it could cause cross contamination (physical transfer of harmful bacteria from one person, object or place to another) when you do that. 5. During a concurrent kitchen observation and interview with DS on [DATE] at 9:38 AM, the microwave had noticeable orange and black residue on the internal top surface. DS stated, the cook is responsible for cleaning (the microwave) after the preparation of food. During a concurrent kitchen observation and interview on [DATE] at 11:21 AM, DS stated the microwave was just cleaned by [NAME] 1. [NAME] 1 confirmed she just cleaned the microwave. The inside top surface was wiped with a clean paper towel and noticeable orange and black residue transferred to the paper towel. Then DS confirmed the microwave was not clean. Review of the facility provided document titled Job Description: Cook, dated ,d+[DATE], showed one of the cook's essential duties is to maintain the kitchen and cooking area in a safe, orderly, clean, and sanitary manner. During a concurrent interview and record review on [DATE] at 9:43 AM with DS, the facility provided undated document titled Food Safety & Cleaning Schedule for Aides was reviewed. DS stated the cleaning schedule did not include the microwave. Then DS provided another document titled Food & Nutrition Services Department Cleaning Schedule and Check List, dated 2023, which showed to clean the microwave weekly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 Federal Food Code, equipment food-contact surfaces are to be clean to sight and touch. Nonfood-contact surfaces of equipment are to be kept free of an accumulation of food residue and other debris. In addition, the cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. 6. During a concurrent kitchen observation and interview on [DATE] at 9:48 AM with DS, the plate warmer had orange and brown residue on the inside surface. DS confirmed the inside surface of the plate warmer was not clean and it should be cleaned after each trayline food service. During a concurrent interview and record review on [DATE] at 9:43 AM with DS, the facility provided undated document titled Food Safety & Cleaning Schedule for Aides was reviewed. DS stated the plate warmer was not on the cleaning schedule. According to the 2022 Federal Food Code, food-contact surfaces of equipment are to be clean to sight and touch. Nonfood-contact surfaces are to be kept free of an accumulation of food residue and other debris. 7. Review of the facility's P&P titled Food Carts, dated 2023, showed the food cart cleaning procedure included 1. Brush or wipe off all loose soil. Clean out corners. 2.Prepare a hot solution of detergent following manufacturer's instructions. Clean cart inside and outside with a clean cloth. Be sure to get into corners, under shelves and brackets, and into seams or joints. Then rinse with clean warm water. 3.Prepare quaternary sanitizing solution (commonly used in water dilution to create a highly effective sanitizing solution) following manufacturer's-instructions and spray or wipe down cart .For heavily soiled carts, take cart outside and clean with a pressure washer and detergent following manufacturer's instructions. During a concurrent observation and interview on [DATE] at 10:02 AM with [NAME] 3, food carts were outside near the trash dumpster area. The carts were wet. [NAME] 3 stated she cleaned the food carts outside. [NAME] 3 stated she hosed them down, sprayed and wipe them with bleach, then hosed them down again. [NAME] 3 further stated the sanitizer bleach solution used was half bleach and half water. During a concurrent interview and facility document review on [DATE] at 11:32 AM with DS, the facility provided undated document titled Food Safety & Cleaning Schedule for Aides was reviewed. DS confirmed the cleaning schedule showed to wipe and sanitize food carts every meal and daily. In addition, the facility provided document titled Food & Nutrition Services Department Cleaning Schedule and Check List, dated 2023 was reviewed. DS confirmed on this cleaning schedule, it showed weekly cleaning of food carts. DS stated the weekly cleaning was deep cleaning. During an interview and document review on [DATE] at 10:22 AM, DS stated the concentration of the bleach solution used to sanitize the food carts should have been one tablespoon of bleach to one gallon of water. DS confirmed the concentration of the bleach solution used by [NAME] 3 was much stronger than needed. DS also stated bleach was used for a sanitizer when Quat (quaternary sanitizing solution) was not available. DS confirmed Quat was currently used in the kitchen and was available. DS confirmed according to the P&P Quat should be used to clean the carts. DS provided the container of bleach used. Review of the manufacturer's instruction on the container of bleach provided by DS showed in sanitizing work surfaces, dishes, glasses, utensils, refrigerators, and freezers, to mix one tablespoon of bleach to one gallon of water . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and facility document review on [DATE] at 1:52 PM with DS, the facility provided document titled Food Carts dated 2023 was reviewed. DS stated, when the weekly deep cleaning was done with a power washer, the daily cleaning should also be completed with detergent and sanitizer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555856	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peninsula Post-Acute	1609 Trousdale Drive Burlingame, CA 94010

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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 49264 Based on interview and record review, the facility failed to furnish a completed written agreement for dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) services or transportation to dialysis that was being provided by an agency outside the facility. This failure has the potential for residents that require dialysis to not have services held to a standard agreed upon by the facility. Findings: During a concurrent interview and record review on 10/15/24 at 9:50 AM with the Administrator, a document titled INTERNAL AGREEMENT REQUEST PREP FORM NURSING HOME DIALYSIS TRANSFER AGREEMENT, dated 05/18/21. The documented indicated that This Agreement type is for nursing home residents who are transferred from a nursing home to a chronic dialysis facility for treatment .Once approved, agreement sent for signatures; you will receive a copy once all parties sign. The Administrator stated this is a request for an agreement but not an actual contract. During a concurrent interview and record review on 10/15/24 at 3:05 PM with the Administrator, a document titled Transportation Contract, dated 01/01/24, was reviewed. The document indicated that the facility was going to receive transportation services from an outside agency starting on 01/01/24 and terminating the contract on 12/31/24. The document further indicated that the contract was signed by Owner/CEO of the transportation agency on 01/01/24 but the signature for the Facility representative was blank. The Administrator stated that this is their current transportation contract but acknowledged that it is not a signed contract. During an interview on 10/16/24 at 9:37 AM with the Administrator, the facility's Dialysis contract was requested. The Administrator stated that it was still pending and not available for review at that time. During an interview on 10/17/24 at 10:33 AM with the Administrator, the facility's Dialysis contract was requested again. The Administrator stated that we don't have that on file, but stated that the facility is providing that [dialysis] service, to those that need it.

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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. 49264 Based on observation, interview, and record review the facility failed to follow infection control standards for one of 18 sampled residents (Resident 19) when Physical Therapist (PT) 1 and Occupational Therapist (OT) 1 were observed providing care without the necessary personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) used for a resident on enhanced barrier precaution (EBP, an approach where PPE is used during high contact resident care activities to reduce spread of drug-resistant organisms). This failure has the potential to spread infection in the facility or cause infection to a resident that is at higher risk for acquiring an infection. Findings: A review of Resident 19's face sheet (front page of the chart that contains a summary of basic information about the resident), dated 10/18/24, indicated that Resident 19 was admitted in 2024 with multiple diagnoses including QUADRIPLEGIA (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and RESISTANCE TO MULTIPLE ANTIBIOTICS. A review of Resident 19's Order Summary Report (a list of a medical provider's orders for care), dated 10/18/24, indicated that Resident 29 had an order for Indwelling Urinary (Foley) Catheter [a hollow tube inserted into the bladder to drain or collect urine] .For neurogenic bladder [lack of bladder control due to a brain, spinal cord or nerve problem]. During an interview on 10/16/24 at 2:08 PM with the Infection Preventionist (IP), the IP stated that EBP is used for residents with medical devices that are at higher risk for infection like indwelling devices like foley and urinary catheters. When a resident is on EBP, the IP stated that she expects staff to wear a gown and gloves while preforming high contact care activities. The IP further stated that she expects for there to be signage to notify staff and visitors of the EBP requirements. During a concurrent observation and interview on 10/16/24 at 4:12 PM with PT 1, PT 1 and OT 1 were observed repositioning and assisting Resident 19 with exercises. PT 1 and OT 1 were observed only wearing gloves. PT 1 stated that she and OT 1 were preforming range of motion exercises with Resident 19 and getting him up and transferred as well. PT 1 stated yes when asked if she was aware if Resident 19 had a foley catheter. During a concurrent observation and interview on 10/16/24 at 4:23 PM with the IP, PT 1 and OT 1 were observed transferring Resident 19 from the bed to a chair using a Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). The IP stated that when a resident is on EBP, staff should wear gown and gloves when doing activities like dressing, bathing, [or] transferring. When the IP was asked if PT 1 or OT 1 were wearing the appropriate PPE for EBP during the observed transfer, the IP stated right now I don't see .the PT said she forgot and she knows . that PPE should have been used. The IP further stated that there is no signage on the door indicating that Resident 19 was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility policy titled Categories of Transmission-Based Precautions, last revised September 2022, indicated that additional usage of PPE (enhanced barrier precautions) may be used for residents who do not meet criteria for contact precautions but are infected . with MDROs [Multi-Drug Resistant Organisms] (or have risk factors for MDRO acquisition.)