STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555871	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Subacute and Care	151 Claydelle Ave El Cajon, CA 92020

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record review, the facility failed to ensure call lights (device used to communicate a need for help) were within residents' reach for two of two sampled residents (10 and 26). The concerns for the call light within reach had been an ongoing issue during the Resident Council (RC) Meetings from August 2024 through November 2024. In addition, the facility failed to provide the appropriate call bell for one resident (17) with contractures (stiffening/shortening at any joint, that reduces the joint's range of motion). These failures had the potential to not meet the needs of the residents when needing help. Cross reference to F-656. Findings: 1a. Resident 10 was readmitted to the facility on [DATE], with diagnoses which included epilepsy (condition that affects the brain and causes frequent seizures) and the need for assistance with personal care, per the facility's Admission Record. Resident 10's attending physician completed Resident 10's history and physical (H & P) dated 2/19/25. The H & P indicated that Resident 10 did not have the capacity to understand and make decisions. On 3/10/25 at 12:41 P.M., an observation was conducted in Resident 10's room. Resident 10 was lying in bed. Resident 10 appeared to be mouthing words, but no sound was coming from his mouth. Resident 10's call light was dangling on the bed's side rails. On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that resident's call light should be within reach to ensure resident safety when they needed help. Per the facility's undated policy tiled, Call light/ Bell, It is the policy of this facility to provide the resident a means of communication with nursing staff .5 .Place the call device within resident's reach before leaving room . 1b. Resident 26 was readmitted to the facility on [DATE], with diagnoses which included respiratory failure, epilepsy (condition that affects the brain and causes frequent seizures) and the need for assistance with personal care, per the facility's Admission Record. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 26's attending physician completed Resident 26's history and physical (H & P) dated 2/13/24. The H & P indicated that Resident 26 was not able to make his own decisions. On 3/10/25 at 9:09 A.M., an observation was conducted in Resident 26's room. Resident 26 was lying in bed, with a soft pad (call device) hanging from the bed frame. The soft pad was out of reach for Resident 26. On 3/10/25 at 10:15 A.M., a joint observation of Resident 26's call device and an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated that the call device was not in Resident 26's reach. LN 1 stated it was important to place the call device within resident's reach for the resident to access, and call for help. On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that resident's call light should be within reach to ensure resident safety when they needed help. Per the facility's undated policy tiled, Call light/ Bell, It is the policy of this facility to provide the resident a means of communication with nursing staff .5 .Place the call device within resident's reach before leaving room . 2. A review of the Resident Council (RC) Meeting minutes from August 2024 through November 2024 was conducted. The meeting minutes were as follows: 8/16/24 - Unsampled resident (247) requested call light button within reach before leaving the room. 11/15/24 - Unsampled resident (247) indicated the call light button issue was unresolved. - Unsampled resident (248), call light was left on the floor. - Unsampled resident (249), call light was out of reach. On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that resident's call light should be within reach to ensure resident safety when they needed help. Per the facility's undated policy tiled, Call light/ Bell, It is the policy of this facility to provide the resident a means of communication with nursing staff .5 .Place the call device within resident's reach before leaving room . 45909 3. A review of Resident 17's Admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses which included a history of communication deficit and brain damage. A review of Resident 17's Minimum Data Set (MDS- nursing facility assessment tool) dated 1/8/25 indicated that Resident 17 had an impairment of both upper and lower extremities. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview conducted with Licensed Nurse (LN) 12 on 3/10/25 at 11:16 A. M. inside Resident 17's room, Resident 17's hands were contracted (tightened muscles that cause the joints to shorten and become stiff, preventing normal movement). LN 12 stated that Resident 17 had a push button call light that she was not able to press. In addition, LN 12 stated that Resident 17 should have been provided a soft pad call light to accommodate Resident 17's needs. During an interview with the Director of Nursing (DON) on 3/13/25 at 9:09 A.M., the DON stated that all residents, regardless of their mental orientation, should be provided with the appropriate call light to provide dignity and access when residents or family members called for assistance. The DON acknowledged that Resident 17 should have been provided with the soft pad call light that was more appropriate for Resident 17's condition. The facility's undated policy titled Accommodation of Needs indicated, It is the policy of this facility to provide accommodation of reasonable needs to the residents while in the facility.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 45909 Based on observation, interview and record review, the facility failed to protect residents' rights to confidentiality of protected health information (PHI - includes name, diagnoses, treatment of patients) for multiple residents when a vital signs sheet (VSS - form/record that included residents medical information) was found in the medical cart's trash bin. This failure had the potential to unnecessarily expose residents' PHI to individuals such as visitors and/or other residents. Findings: During a concurrent medication observation and interview on 3/12/25 at 8:24 A.M. with Licensed Nurse (LN) 11, a VSS was observed upward to view, inside LN 11's medication cart's open trash bin. LN 11 stated that the VSS contained residents' names, diagnoses and treatment. LN 11 further stated that the VSS should have been shredded to protect residents' PHI from unauthorized individuals. During an interview with the Director of Nursing (DON) on 3/13/25 at 9:08 A.M., the DON stated that resident PHI should be kept confidential. The DON further stated that the VSS should had been thrown away in the facility's confidential bin for proper shredding, to protect residents' PHI. The facility's policy titled, Access to Electronic Health Record Policy dated 8/2016, indicated Policy .1. The facility is responsible for safeguarding all resident data, ensuring it is protected from accidental or malicious destruction, or modification

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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** 40610 Based on interview and record review, the facility failed to implement a care plan (detailed plan with information about a patient's treatment, goal, and interventions) related to having a call light within reach for two of two sampled residents (10 and 26). In addition, the facility failed to implement a physician's order related to the administration of wound treatment and measurement of wound for one resident (37). These failures had the potential to not meet the goals of treatment and needs for Resident 10, Resident 26, and Resident 37. Cross reference to F-558 Findings: 1. Resident 10 was readmitted to the facility on [DATE], with diagnoses which included epilepsy (condition that affects the brain and causes frequent seizures) and the need for assistance with personal care, per the facility's Admission Record. Resident 10's attending physician completed Resident 10's history and physical (H & P) dated 2/19/25. The H & P indicated that Resident 10 did not have the capacity to understand and make decisions. On 3/10/25 at 12:41 P.M., an observation was conducted in Resident 10's room. Resident 10 was lying in bed. Resident 10 appeared to be mouthing words but no sound was coming from his mouth. Resident 10's call light was dangling from the bed side rails. A review of Resident 10's care plan related to falls, dated 2/13/25, indicated, Be sure the call light is within reach . On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that the care plan related to ensuring the resident's call light was within reach, should had been implemented to ensure safety of the residents. Per the facility's undated policy tiled, Care Planning/ Care Conference, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident .5. The resident's plan of care will be implemented as appropriate . 2. Resident 26 was readmitted to the facility on [DATE], with diagnoses which included respiratory failure, epilepsy (condition that affects the brain and causes frequent seizures) and the need for assistance with personal care, per the facility's Admission Record. Resident 26's attending physician completed Resident 26's history and physical (H & P) dated 2/13/24. The H & P indicated that Resident 26 was not able to make his own decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 9:09 A.M., an observation was conducted in Resident 26's room. Resident 26 was lying in bed. A soft pad (call device) was hanging from the bed frame. The soft pad was out of reach for Resident 26. A review of Resident 26's care plan related to falls, dated 2/13/24, indicated, Be sure the call light is within reach . On 3/10/25 at 10:15 A.M., a joint observation of Resident 26's call device and an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated that the call device was not in Resident 26's reach. LN 1 stated it was important to place the call device within resident's reach for the resident to access and call for help. On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that the care plan related to ensuring the resident's call light was within reach, should had been implemented to ensure safety of the residents. Per the facility's undated policy tiled, Care Planning/ Care Conference, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident .5. The resident's plan of care will be implemented as appropriate . 43674 3. Resident 37 was admitted to the facility on [DATE] with diagnoses which included metastatic prostate cancer (prostate cancer that has spread from the prostate gland to other parts of the body) per undated Admission Records. A joint record review was conducted on 3/13/25 at 10:48 A.M., with the Minimum Date Set (MDS) Coordinator. Resident 37's pressure ulcer care plan, initiated on 1/1/25 was reviewed. This care plan included interventions: Administer treatments as ordered and monitor for effectiveness . Assess/Record/monitor wound healing. Measure length, width and depth . Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (medical doctor; physician) . A concurrent interview and record review was conducted on 3/13/25 at 2 P.M., with the MDS Coordinator. Resident 37's initial admission assessment on 12/31/24 indicated that Resident 37 had an open wound however, there was no documented measurement until 1/7/25. Resident 37's treatment order for the left buttocks dated 1/9/25 indicated Cleanse with NS (Normal Saline), pat dry. Apply Medihoney and Xeroform, and cover with dry dressing . There was no documented evidence that treatments were completed on 1/15/25 through 1/18/25 and on 1/21/25. Resident 37's treatment order for the left buttocks dated 1/21/25 indicated Cleanse with Dakins, pat dry. Apply Medihoney and Xeroform, and cover with dry dressing . There was no documented evidence that treatments were completed on 2/24/25 and 2/27/25. The MDS Coordinator stated that a measurement of the wound should have had been completed on the initial assessment and treatment of the left buttock should have been completed as ordered. The MDS Coordinator acknowledged that Resident 37's care plan interventions related to administration of treatments, measurement of wound during admission, and reporting changes in skin/wound status to the physician were not consistently implemented and should have been. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's undated policy and procedure, titled Comprehensive Resident Centered Care Plan indicated .The IDT team will also develop and implement a baseline care plan . that meet professional standards of quality care .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review, the facility failed to provide treatment in accordance with the facility's policy and procedure when a Licensed Nurse (LN) 2 did not auscultate (listening to the stomach with a stethoscope when administration of air to check the placement of the gastrostomy tube [g-tube, a tube inserted through the stomach that brings nutrition or medications directly to the stomach]) before giving a resident (26) his tube feeding (TF) formula. This failure had the potential for Resident 26 to have respiratory aspiration of gastric contents, that may cause a life-threatening aspiration pneumonia (bacterial infection in your lungs, it can happen when you aspirate, or inhale, something other than air into your respiratory tract). Findings: Resident 26 was readmitted to the facility on [DATE], with diagnoses which included respiratory failure, epilepsy (condition that affects the brain and causes frequent seizures) and with a g-tube, per the facility's Admission Record. Resident 26's attending physician completed Resident 26's history and physical (H & P) dated 2/13/24. The H & P indicated Resident 26 was not able to make his own decisions. A review of Resident 26's physician order dated, 3/7/24, indicated, Enteral feed: check placement/ patency via air, auscultation (listening to the stomach via stethoscope while injecting 30 cc [cubic centimeter, unit of measurement] of air into the g-tube with a syringe before giving medication and starting TF). On 3/10/25 at 9:09 A.M., an observation and an interview of Resident 26 was conducted in his room. Resident 26 was lying in bed, with TF formula ongoing, connected to Resident 26's g-tube. Resident 26 gestured a thumbs up when asked how he was doing. On 3/11/25 at 3:20 P.M., an observation of LN 2 preparing Resident 26's TF formula was conducted. LN 2 primed (the process of filling the tubing with solution/formula prior to attaching it to the resident) the tubing of the administration set. LN 2 primed the tubing with approximately 6 inches of air at the end of the tubing. LN 2 waited for Resident 26 to be transferred from the geri-chair (padded chair that is designed to help residents with limited mobility) to his bed. After Resident 2 was transferred back to his bed, LN 2 took the 60 ml syringe, connected the syringe to the g-tube, and administered some air to the resident's g-tube. LN 2 did not have a stethoscope and did not auscultate Resident 26's stomach upon administering air. After LN 2 checked the residuals from the g-tube, LN 2 connected the primed tubing with air, to Resident 26, then started the TF. On 3/11/25 at 3:24 P.M., an interview with LN 2 was conducted. LN 2 stated she did not auscultate Resident 26's stomach when she administered air to Resident 26's g-tube because she gave Resident 26 his medications via g-tube 30 minutes prior, in the nurses' station while Resident 26 was in his geri-chair. LN 2 stated she assumed it is still good. LN 2 stated she should have checked and auscultated Resident 26's g-tube to ensure the placement of g-tube and prevent aspiration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated LN 2 should have listened to the resident's stomach to ensure proper placement of the g-tube and for resident's safety. A review of the facility's undated policy titled, Enteral Feeding Administration, indicated, .7. Check enteral feeding tube placement before initiating feeding .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909 Based on observation, interview and record review, the facility failed to follow physician's order for one of seven sampled residents, when Resident 2's compression stocking (CS- worn to decrease swelling) was not worn. This failure had the potential to affect Resident 2's well-being. Findings: A review of Resident 2's admission record indicated Resident 2 was admitted to the facility on [DATE] with medical diagnoses which included heart failure, hypertension (elevated blood pressure), and edema (swelling). A review of Resident 2's physician order dated, 4/16/24, indicated, Apply ted hose (compression stocking) above the knee to Right Lower Extremity every day shift (morning shift work hours that begin at 7 am) for swelling for 12 hours. A concurrent observation and interview with Resident 2 was conducted on 3/10/25 at 9:20 A.M. inside Resident 2's room. A signage was posted on Resident 2's side of the wall, that indicated Leg compressors at 9 am, off in the evening at 2100 (9 pm). Resident 2 stated he did not know that he needed to wear a compression sock. During a follow-up observation and interview with Licensed Nurse (LN) 13 on 3/10/25 at 3:30 P.M., Resident 2 was observed not wearing a compression stocking on his right leg. LN 13 stated that the nursing staff should have applied the compression stocking on Resident 2's right leg as ordered, to decrease swelling. During an interview with the Director of Nursing (DON) on 3/13/25 at 9:11 A.M., the DON stated that physician's orders should be implemented by nursing staff. The DON further stated that the day shift staff should have applied Resident 2's CS as ordered to prevent Resident 2's leg from swelling. The facility's undated policy and procedure titled, Physician Orders, indicated, Policy .It is the policy of this facility to accurately transcribe and implement orders in addition to medication orders (treatment, procedures .)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43674 Based on interview and record review, the facility did not ensure wound treatment for one of one resident (Resident 37) was completed as ordered by the physician. This failure had the potential to affect Resident 37's care and well-being. Findings: Resident 37 was admitted to the facility on [DATE] with diagnoses which included metastatic prostate cancer (prostate cancer that has spread from the prostate gland to other parts of the body) per undated Admission Records. A review of Resident 37's treatment order for the left buttocks dated 1/9/25 indicated, Cleanse with NS (Normal Saline), pat dry. Apply Medihoney and Xeroform, and cover with dry dressing . A review of Resident 37's treatment order for the left buttocks dated 1/21/25 indicated, Cleanse with Dakins, pat dry. Apply Medihoney and Xeroform, and cover with dry dressing . A concurrent interview and record review of Resident 37's electronic treatment administration record (eTAR) was conducted on 3/13/25 at 2 P.M., with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated that the treatment administration record for the left buttocks did not include documentation that the wound treatments were completed for Resident 37 on 1/15/25 through 1/18/25, 1/21/25, 2/24/25, and 2/27/25. The MDS coordinator acknowledged that the wound treatments should have been consistently completed and documented. A review of facility's undated policy and procedure titled Physician Orders indicated, Policy: .It is the policy of this facility to accurately transcribe and implement orders . 6. Medication, treatment or related orders are transcribed in the eMAR (electronic medication administration record), eTAR accurately and verified via the double check system process.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review, the facility staff failed to consistently monitor and document urine output (UO) per the facility's policy, for three of three sampled residents (8, 37, and 40) with a urinary catheter (a tube inserted into the bladder to aid in urine flow). In addition, there was no urinary catheter order for Resident 40. This failure had the potential for Resident 8, Resident 37 and Resident 40 to have urinary retention and develop urinary tract infection (UTI). Findings: 1. Resident 8 was readmitted to the facility on [DATE], with diagnoses which included encephalopathy (a change in how the brain functions; may cause confusion, agitation) and UTI, per the facility's Admission Record. Resident 8's attending physician completed Resident 8's history and physical (H & P) dated 2/10/25. The H & P indicated Resident 8 did not have the capacity to understand and make decisions. On 3/10/25 at 11:45 A.M., an observation of Resident 8 was conducted in the dining room. A urinary catheter was attached to Resident 8's wheelchair. On 3/12/25 at 10:09 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that Resident 8 was confused and did not know what was going on. CNA 1 stated Resident 8 had a urinary catheter. CNA 1 stated CNAs should be monitoring and documenting Resident 8's output in Resident 8's clinical record. On 3/12/25 at 10:50 A.M., a joint review of Resident 8's clinical record and an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated that the clinical record of Resident 8 indicated the CNAs did not consistently measure his urine output. LN 1 stated the record indicated CNAs documented Resident 8's urine output as how many times he was changed, compared to measuring the urine output in milliliters (ml, unit of measurement), to ensure Resident 8 was not retaining urine in his bladder and to prevent Resident 8 from developing UTI. On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that staff should have consistently monitored and documented the urine output in mls, to ensure the residents have enough urine output and address if the residents did not have urine retention. A review of the facility's undated policy titled, Intake and Output, indicated, It is the policy of this facility to maintain an intake and output record when needed to monitor residents for adequate fluid balance .Weekly Assessment .2. I & O assessments will be documented in the resident's medical record . 43674 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 37 was admitted to the facility on [DATE] with diagnoses which included metastatic prostate cancer (prostate cancer that has spread from the prostate gland to other parts of the body) per undated Admission Records. An observation was conducted on 3/10/25 10:25 A.M., in Resident 37's room. A urinary catheter bag was hanging from the side of Resident 37's the bed. A review of Resident 37's physician's order dated 3/3/25 indicated Monitor intake and output every shift for 30 days . A concurrent interview and record review was conducted on 3/13/25 at 2 P.M., with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated that Resident 37 had a urinary catheter and that there was a physician's order to monitor Resident 37's intake and output per volume in milliliter (mL). Resident 37's Medication Administration Record dated 3/3/25 through 3/11/25 was reviewed. There was no documentation that Resident 37's urinary output was consistently monitored on 3/4, 3/5, and 3/8 through 3/11/25. The record did not include Resident 37's urinary output per volume in mL. Instead, there was documentation that indicated the number of times Resident 37's urinary catheter was emptied. The MDS coordinator acknowledged that Resident 37's urinary output record should have been documented per volume in mL and not the urinary catheter's frequency of when it was emptied. An interview was conducted on 3/13/25 at 2:35 P.M., with the Director of Nursing (DON). The DON stated that Resident 37's urinary catheter's output monitoring should have been measured accurately. The DON acknowledged that documentation of urinary output should be per volume to ensure that the resident did not have urinary retention. A review of the facility's undated policy titled, Intake and Output, indicated, It is the policy of this facility to maintain an intake and output record when needed to monitor residents for adequate fluid balance .Weekly Assessment .2. I & O assessments will be documented in the resident's medical record . 3. Resident 40 was admitted to the facility on [DATE] with diagnoses which included anemia (the body does not produce enough red blood cells) and atrial fibrillation (irregular heart rhythm that begins in your heart's upper chambers - atria) per undated Admission Records. An observation was conducted on 3/10/25 12:28 P.M., in Resident 40's room. A urinary catheter bag was hanging from the side of Resident 40's bed. A review of Resident 40's physician's order dated 3/3/25 indicated, Monitor intake and output every shift for 30 days . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent interview and record review were conducted on 3/13/25 at 2 P.M., with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated that Resident 40 had a urinary catheter and that there was had a physician's order to monitor intake and output per volume in mL (milliliter). Resident 40's Medication Administration Record dated 2/7 through 3/11/25 was reviewed. There was no documentation that Resident 40's urinary output was consistently monitored on 2/15, 2/17, 2/18, 2/23, 2/25, 3/2 through 3/8, 3/10 and 3/11/25. The record did not include Resident 40's urinary output per volume in mL. Instead, there was documentation that indicated the number of times Resident 40's urinary catheter was emptied. The MDS coordinator acknowledged that Resident 40's urinary output record should have been documented per volume in mL and not the urinary catheter's frequency of when it was emptied. An interview was conducted on 3/13/25 at 2:35 P.M., with the Director of Nursing (DON). The DON stated that Resident 40's urinary catheter's output monitoring should have been measured accurately. The DON acknowledged that documentation of urinary output should be per volume to ensure that the resident did not have urinary retention. A review of the facility's undated policy titled, Intake and Output, indicated, It is the policy of this facility to maintain an intake and output record when needed to monitor residents for adequate fluid balance .Weekly Assessment .2. I & O assessments will be documented in the resident's medical record . 4. Resident 40 was admitted to the facility on [DATE] with diagnoses which included anemia (the body does not produce enough red blood cells) and atrial fibrillation (irregular heart rhythm that begins in your heart's upper chambers - atria) per undated admission records. A review of Resident 40's progress notes dated 2/1/25 indicated, .Received new order . to place FC (foley catheter) 16 F (16 French - size of FC). Orders were noted and carried out. A review of Resident 40's progress notes dated 2/7/25 indicated, .Resident arrived in facility .admitted from [name of hospital] .foley cath (catheter) patent and draining yellow urine output . A concurrent interview and record review were conducted on 3/13/25 at 2 P.M., with the Minimum Data Set (MDS) Coordinator. Resident 40's physician orders dated 1/23 to 2/11/25 were reviewed. Resident 40's health records did not include physician's orders for a urinary catheter. The MDS Coordinator acknowledged that a physician's order for a urinary catheter should had been obtained and entered in Resident 40's medical records. An interview was conducted on 3/13/25 at 2:35 P.M., with the Director of Nursing (DON). The DON stated the expectation was for staff to obtain a physician's order for a urinary catheter and enter the order in the resident's health record. The DON acknowledged that Resident 40 should have had a physician's order for a urinary catheter, to ensure appropriateness of treatment. A review of the facility's undated policy and procedure titled Physician Orders, Telephone Orders and Recapitulation Process Documentation in a Long Term Care Record indicated, .Policy: .1. Physician's orders shall be obtained prior to the initiation of any medication or treatment . Verbal and Telephone Orders .3. The facility personnel receiving the verbal or telephone order shall transcribe the order into the PCC system . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy and procedure titled Physician Orders indicated, Policy: .It is the policy of this facility to accurately transcribe and implement orders . (treatment, procedures .) only upon the written order of a person duly licensed . 5. Verbal orders must be recorded immediately in the resident's chart .A review of facility's undated policy and procedure titled Physician Orders indicated, Policy: .It is the policy of this facility to accurately transcribe and implement orders . (treatment, procedures .) only upon the written order of a person duly licensed . 5. Verbal orders must be recorded immediately in the resident's chart .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review, the facility failed to ensure dialysis (the process of cleaning the blood through a machine) access site was properly cared for one of two residents investigated for dialysis (246). This failure had a potential for Resident 246's dialysis access to clot. Findings: Resident 246 was admitted to the facility on [DATE], with diagnoses that included End Stage Renal Disease (kidney failure), per the Admission Record. On 3/10/25 at 9:29 A.M., Resident 246 was observed sleeping in her room, and did not respond to her name. There was a note by the wall indicating Resident 246 had a left arm dialysis access site. On 3/11/25 at 3:19 P.M., an observation of Resident 246 was conducted. Resident 246 arrived via stretcher to the facility, accompanied by transportation staff. Resident 246's left upper arm had a bandage wrapped around her dialysis access site. On 3/12/25 8 A.M, an observation of Resident 246 was conducted in her room. Resident 246 was lying in bed, with her eyes closed and did not respond when her name was called. Resident 246 had a bandage wrapped around her dialysis access site. On 3/12/25 8:42 A.M., an observation and interview with Resident 246 was conducted in her room. Resident was awake, with the bandage on her dialysis access site. Resident 246 stated that she did not know why she still had the bandage on her arm, and that she did not know if the access site bled. Resident 246 stated she had dialysis yesterday (3/11/25). A review of Resident 246 dialysis communication record (communication record between the dialysis center and the facility) was conducted. The dialysis communication record indicated the following special instructions from the dialysis center to the staff at the facility as follows: 3/6/25 - Remove bandage after 4 hours after dialysis. 3/8/25 - Remove bandage after 4 hours after dialysis. 3/11/25 - Remove bandage after 3 hours after dialysis . A review of Resident 246's physician order dated 3/4/25, indicated to remove the dialysis access dressings after 2 hours (after) the resident's dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 11:36 A.M, a joint observation of Resident 246's dialysis access site, an interview and joint record review with Licensed Nurse (LN) 1 was conducted. LN 1 stated that the bandage was still wrapped around Resident 246's dialysis access site. LN 1 stated that Resident 246's dialysis schedule were Tuesdays, Thursdays, and Saturdays. LN 1 stated that the LNs responsibility was to check the resident's access site for signs of bleeding, and infection. LN 1 stated the resident's dialysis access site dressing was removed at the dialysis center. LN 1 stated, I don't take it out. LN 1 stated she did not know about the special instructions from the dialysis center that Resident 246's dressings should have been removed after 4 hours. LN 1 stated, I didn't know about the communication. LN 1 stated it was important to remove the dressing from the access site, since it was a pressure dressing and could cause clotting of the access (site). On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 246's dialysis dressing should have been removed, and that the LNs should have verified the physician order, to monitor the dialysis access site and prevent clotting of Resident 246's dialysis access site. A review of the facility's undated policy titled, Renal Dialysis, Care of Resident, Hemodialysis Access Site, indicated, It is the policy of this facility to provide standards in the care of the residents on renal dialysis and the care of the vascular access site for hemodialysis, 1. Vascular access site care will be provided by Licensed nurse, with physician's orders .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45909 Based on observation, interview and record review, the facility failed to ensure controlled medications (CM -medications with high potential for abuse and addiction) were accurately accounted for when four out of 10 CMs were not documented on the Electronic Medication Administration Records (EMAR) and controlled drugs accountability sheet (CS-count sheet that monitors the storage and usage of controlled medications) to indicate the CMs were given to the resident. This failure had the potential for misuse or diversion of CMs. An observation of CM handoff (report that typically occurs at the end of the shift; includes necessary information to ensure safe transition of care) between Licensed Nurse (LN) 14 and LN 15 was conducted on 3/11/25 at 3:12 P.M. LN 14 counted 27 tablets of Lacosamide (medication used to treat seizures- abnormal electrical activity in the brain) 200 milligrams (mg-unit of measurement) documented as remaining on the CS. LN 15 counted 26 tablets of Lacosamide in the medication card (container card that packages medication). LN 14 counted 10 tablets of Briviact (medication used to treat seizures) 100 mg tablets documented as remaining on the CS. LN 15 counted nine tablets of Briviact in the medication card. LN 14 counted 16 tablets of Lorazepam (medication used to treat anxiety) 0.5 mg tablets documented as remaining on the CS. LN 15 counted 15 tablets of Lorazepam in the medication card. LN 14 counted 25 Oxycodone (pain medication) 5 mg tablets documented as remaining on the CS. LN 15 counted 24 tablets of Oxycodone in the medication card. During a concurrent interview and record review with LN 14 on 3/11/25 at 3:30 P.M., LN 14 stated that CMs taken out of the medication card should be immediately documented on the CS. Further, LN 14 stated that after CM administration, the time the CM was given should be documented on the EMAR. LN 14 acknowledged that she should have documented the CMs to provide accuracy on the CS, and she should have documented the exact time that residents took the CMs, on the EMAR. During an interview with the Director of Nursing (DON) on 3/13/25 at 10:05 A.M., the DON stated she expected all LNs to document on the CS, all CMs that were taken out of the medication cards. In addition, the DON stated she expected the LN to document the CM administered to the resident, on the EMAR. The DON acknowledged that the quantity of CM that were documented on the CS did not accurately match the quantity of CM tablets that were inside the medication cards. The facility's policy titled, Controlled Medications - Storage and Reconciliation dated 5/2007, indicated, Policy .6. When a controlled medication is administered, the licensed nurse administering the mediation immediately enters all the following information on the accountability record: Date and time of administration, amount administered and signature of the administering the dose, competed after the medication is actually administered.

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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** 40610 Based on observation, interview, and record review, the facility failed to indicate the appropriate and measurable target behavior of antidepressant (medication used to treat depression, sad mood and lack of interest) for one of two sampled residents (Resident 8) reviewed for unnecessary psychotropic (mind-altering medications) medication use. This failure had the potential for unnecessary psychotropic medication use, side effects, and a decline for resident's psychological and mental well-being. Findings: Resident 8 was readmitted to the facility on [DATE], with diagnoses which included encephalopathy (a change in how the brain functions; may cause confusion, agitation) and UTI, per the facility's Admission Record. Resident 8's attending physician completed Resident 8's history and physical (H & P) dated 2/10/25. The H & P indicated Resident 8 did not have the capacity to understand and make decisions. A review of Resident 8's physician order dated 3/6/25 indicated the following order: - Escitalopram Oxalate Oral Tablet at bedtime for as evidenced by (AEB): Self isolation related to MAJOR DEPRESSIVE DISORDER (MDD, a mood disorder that causes a persistent feeling of sadness and loss of interest), . - ANTI-DEPRESSANT TARGET BEHAVIOR: Depression aeb verbalization of feeling sad, MONITOR EPISODES OF TARGETED BEHAVIOR, every shift . On 3/10/25 at 11:45 A.M., an observation of Resident 8 was conducted in the dining room. Resident 8 was yelling at the staff and requested to return to his room. On 3/12/25 at 10:09 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that Resident 8 was confused and did not know what was going on. CNA 1 stated there was no behavioral monitoring for Resident 8. CNA 1 stated, We were not informed to monitor, the information was not passed down to us. On 3/12/25 at 10:50 A.M., a joint review of Resident 8's clinical record and an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated that Resident 8 was confused and was unable to express that he was sad. LN 1 stated, I am not sure if the target behavior is appropriate for the medication. It is really hard for him because he is confused. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that the LNs should have checked the appropriate target behavior being monitored for Resident 8's anti-depressant medication. The DON stated it should have been corrected in the physician's order to prevent the use of unnecessary psychotropic medication. A review of the facility's policy titled, Psychotropic Medications, revised 12/2023, indicated, It is the policy of this facility to ensure that residents who have not use psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed .Procedure .3. The LN shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45909 Based on observation, interview and record review, the facility had a medication error rate of 6.45% when two medication errors occurred out of 31 opportunities during medication administration, for two out of four residents (Resident 65 and Resident 27). These failures resulted in medications not given in accordance with the physician's orders which resulted in residents not receiving the therapeutic effects of the medication. Findings: 1. During the medication pass observation on 3/12/25 at 8:15 A.M. with Licensed Nurse (LN) 11, LN 11 did not administer Lexapro (a medication to treat depression; feeling sad) to Resident 65. Resident 65's Physician Order dated, 2/27/25 indicated to give Lexapro 20 milligrams (mg -unit of measurement) 1 tablet by mouth one time a day for verbalization of feeling depressed. During an interview with the Director of Nursing (DON) on 3/13/25 at 10:40 A.M., the DON stated that Resident 65's Lexapro medication card (container card that stores medication) was inside the afternoon (labeled to store medications that were supposed to be administered in the afternoon) drawer and resulted in the LN missing to administer the morning dose. In addition, the DON stated that physician ordered medications should be given to residents. 2. During the medication pass observation and interview on 3/12/25 at 8:36 A.M. with LN 11, LN 11 administered 20 milliliters (ml-unit of measurement) of Potassium Chloride (KCL-medication supplement) liquid to Resident 27. Resident 27's physician order dated 5/7/24 indicated Give KCL liquid 20 milliequivalent (mEq-unit of measurement) per 15 ml. Give 20 mEq . one time a day for hypokalemia (low potassium). During a concurrent interview and record review with LN 11 on 3/12/25 at 3:30 P.M., LN 11 stated that she should have reviewed the physician order and should have administered KCL 15 ml to Resident 27. LN 11 acknowledged that Resident 27 received more than the medication prescribed, which may have caused harm to Resident 27. During an interview with the DON on 3/13/25 at 10:42 A.M., the DON stated that LNs should verify physician's orders before administering medications. The DON acknowledged that the LN should have checked the physician's order and administered the appropriate dose to the patient, to prevent overmedication. The facility's undated policy and procedures titled, Medication Administration indicated, .Procedures .2. Review and verify MD orders and follow 6 Rights of Medication Administration .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45909 Based on observation, interview and record review the facility failed to ensure safe and appropriate storage of medications when: 1. One out of one intravenous medication cart (IV cart - medications used through the vein) was left unlocked and unattended by a licensed nurse (LN). 2. A medication room key was left in the doorknob and left unattended by a LN. 3. Multiple medications were left unattended by a LN in the nursing station. These failures had the potential for unauthorized access of residents, visitors, and/or unlicensed staff to medications. Findings: 1. During a concurrent observation and interview with LN 1 in the facility hallway on 3/10/25 at 7:40 A.M., an IV cart was observed unlocked and unattended by a licensed staff. The drawers of the cart were able to be pulled open. The drawers contained IV medications, needles and tubing. LN 1 stated that the IV cart should have been kept locked to prevent unauthorized access to medication and supplies. During an interview with the Director of Nursing (DON) on 3/13/25 at 10:15 A.M., the DON stated that all treatment and medication carts should be kept locked to prevent residents, visitors and unlicensed staff from gaining access. The facility's undated policy and procedure titled, Medication Administration and Storage, indicated, . Procedures .7. Medication and treatment carts will be kept locked when unattended. 2. During a concurrent observation and interview with LN 1 on 3/10/25 at 11:10 A.M., a medication room key was observed inserted in the medication room doorknob. LN 1 stated that the medication room key should not have been left in the doorknob, to prevent unauthorized people gaining access to medications and supplies stored inside the medication room. During an interview with the DON on 3/13/25 at 10:17 A.M., the DON stated that the medication room key should be with the LN's all the time. The DON further stated that the medication room key should not have been left in the doorknob, to prevent unauthorized people from entering the medication room. The facility's undated policy and procedure titled, Medication Administration and Storage, indicated, . Procedures .4. The door to the medication room should be locked at all times when an authorized staff member is not present. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an observation on 3/10/25 at 11:25 A.M., multiple medications were observed stacked unattended, on top of the nursing station counter. During an interview with LN 1 on 3/10/25 at 2:45 P.M., LN 1 stated that the multiple medications were delivered by the pharmacy, and that the medications should have been brought inside the medication room for safekeeping. During an interview with the DON on 3/13/25 at 10:20 A.M., the DON stated that all medications should be immediately stored in the medication cart or medication room to ensure safety. The facility's undated policy and procedure titled, Medication Administration and Storage, indicated, . Procedures .5. Drugs and/or biologicals should not be left unsecured/unattended. Drug deliveries should be stored immediately after delivery and should not be unattended/unsecured.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43674 Based on observation, interview and record review, the facility failed to ensure food safety and sanitation practices were maintained in the kitchen according to standards of practice and policy when: 1. Expired food items were stored in the kitchen storage and used in the kitchen areas. 2. The Kitchen Supervisor (KS) did not remove gloves and perform hand washing after disposing the kitchen garbage. These failures exposed residents to contaminated food and unsanitary practices, which had the potential to place them at risk of developing a foodborne illness. Findings: 1. A kitchen observation and interview was conducted on [DATE] at 8:05 A.M., with the Kitchen Supervisor (KS). The following food items were observed: [brand name] classic yellow mustard - best by date (BB) [DATE]; Mango Cakes - use by date (UB) [DATE]; [brand name] Thousand Island salad dressing - BB [DATE]; [brand name] Blue Cheese Dressing - BB [DATE]; [brand name] Puree French Toast - BB , d+[DATE]-25; [brand name] California Wine - opened date (OD) [DATE]; [brand name] Vanilla Almond milk - BB [DATE]; [brand name] Chocolate Milk - BB [DATE]; [brand name] Hamburger Buns - BB [DATE]; [brand name] Sliced Bread - BB [DATE]; [brand name] milk - BB [DATE]; Sandwich prepared on [DATE]. The KS acknowledged that these food items with best by and use by dates on or after [DATE] were expired food items and included the wine and the prepared sandwiches. An interview was conducted on [DATE] at 10 A.M. and [DATE] at 9:35 A.M. with Registered Dietician Specialist (RDS). The RDS stated that the stored expired food items should have been disposed after the expiration date. The RDS acknowledged that expired food items can potentially affect resident's health. A review of facility's undated policy and procedure titled Dry Goods Storage Guideline indicated, .This storage length is to be followed unless you have manufacturer's recommendation indicating otherwise. A review of facility's undated policy and procedure titled Storage of Food and Supplies indicated, . Procedures for Dry Storage: 8.All food products will be used per the times specified in the Dry Food Storage Guidelines .No food will be kept longer than the expiration date on the product. 13. Bread will be delivered frequently and used in the order that it is delivered to assure freshness . Check manufacturer's recommendations . (continued on next page)

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	555871	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Subacute and Care	151 Claydelle Ave El Cajon, CA 92020

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Food and Drug Administration (FDA) Food Code 2022, section ,d+[DATE].17 (A) (B) (C) (D) indicates the day the original container is opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date .mark the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. 2. An observation and interview were conducted on [DATE] at 4:02 P.M. with the KS. The KS took trash and the trash bin out to the dumpsters and pushed the trash bin back to the kitchen. The KS reentered the kitchen, did not remove his soiled gloves or perform hand hygiene by washing his hands. The KS walked through the kitchen, passed the food preparation areas, and touched the faucets and sink area. Per the KS, he should have removed his soiled gloves and washed his hands when he reentered the kitchen. The Registered Dietician Specialist (RDS) acknowledged that the KS should have removed his gloves, performed hand washing, and put on the new gloves when he reentered the kitchen after he took the trash out to the dumpster. According to the 2022 US FDA Food Code. Annex 3 titled Garbage disposal: . The failure of food-handlers to wash hands in certain situations (such as after using the toilet, handling raw meat, cleaning spills, or carrying garbage), wear clean disposable gloves .is responsible for the foodborne transmission of these pathogens. Non-foodborne routes of transmission, such as from one person to another, are also major contributors in the spread of these pathogens . According to the 2022 US FDA Food Code, Section ,d+[DATE].11 titled Clean Condition .The hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared. Therefore, any activity which may contaminate the hands must be followed by thorough handwashing in accordance with the procedures outlined in the Code . According to the 2022 US FDA Food Code, Section ,d+[DATE].14 titled When to Wash .The hands may become contaminated when the food employee engages in specific activities. The increased risk of contamination requires handwashing immediately before, during, or after .activities . Employees must wash their hands after any activity which may result in contamination of the hands . A review of facility's undated policy and procedure titled Hand Hygiene, indicated .Purpose: .All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections . Procedure: . 1. Wash hands with soap and water for the following situations: a. When hands are visibly soiled .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview, and record review, the facility failed to ensure infection control procedures were followed when: 1. A Licensed Nurse (LN) 2 and two Certified Nursing Assistants (CNA) did not wear a gown when providing care for one resident (Resident 26) on enhanced barrier precautions (EBP - gown and gloves must be worn during high-contact resident care activities [example: residents with medical devices]). 2. Urinary catheter (tube inserted into the bladder to aid in urine flow) bag for two residents (37 and 40) was touching the floor. 3. A resident's (34) nasal cannula (tubing connected to the oxygen and to the resident for supplement) was not properly stored. These failures had the potential for cross contamination, spread of infection, and residents' decline of health. Findings: 1. Resident 26 was readmitted to the facility on [DATE], with diagnoses which included respiratory failure, epilepsy (condition that affects the brain and causes frequent seizures) and with a gastrostomy tube (g-tube, a tube inserted through the stomach that brings nutrition or medications directly to the stomach) per the facility's Admission Record. Resident 26's attending physician completed Resident 26's history and physical (H & P) dated 2/13/24. The H & P indicated Resident 26 was not able to make his own decisions. On 3/10/25 at 9:09 A.M., an observation and interview was conducted in Resident 26's room. An EBP sign was posted on Resident 26's door and there were personal protective equipment (PPE; safety gear includes the use of gown, gloves, mask, goggles) supplies in the cart. Resident 26 was lying in bed, with TF formula ongoing connected to Resident 26's g-tube. Resident 26 gestured a thumbs up when asked how he was doing. On 3/11/25 at 3:04 P.M., an observation was conducted in Resident 26's room. Three staff members (Licensed Nurse [LN] 2, Certified Nursing Assistants 2 and 3) were transferring Resident 26 from the geri-chair (padded chair for residents with limited mobility) to the bed. The three staff members were not wearing a gown. During the transfer, CNA 1 was holding Resident 26's feet and touched the CNA's scrub suit. LN 2 was helping Resident 26 position himself in the bed, while CNA 2 was controlling the remote of the lift (equipment used to help transfer a patient). On 3/11/25 at 3:24 P.M., an interview with LN 2 was conducted. LN 2 stated that they did not wear PPE while transferring Resident 26 from the chair to his bed. LN 2 stated that they had forgotten to wear PPE. LN 2 stated the staff were required to wear PPE when touching or providing care to residents with medical devices such as g-tube. LN 2 stated it was important (to wear PPE) to prevent transmission of infection to the resident and for infection control prevention. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/25 at 8:58 A.M., an interview with CNA 2 was conducted. CNA 2 stated that she helped CNA 3 the day before (on 3/10/25) to transfer Resident 26 from the chair to his bed. CNA 2 stated she did not know what the use of PPE was for, when transferring a resident from the chair to the bed. CNA 2 stated she did not know the purpose of that. On 3/11/25 at 4:18 P.M., an interview with the Infection Preventionist (IP) was conducted. The IP stated that when transferring a resident on EBP from a chair to the bed, as long as there was high contact activity, the expectation was for the staff to wear PPE to prevent cross contamination and infection. On 3/12/25 at 10:28 A.M., an interview with CNA 1 was conducted. CNA 1 stated that when transferring a resident on EBP, .they were told not to do so, but if we have to gown up, then we have to gown up. On 3/13/25 at 9:43 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the staff were expected to wear PPE when transferring a resident on EBP, to prevent spread of infection. A review of the EBP sign dated 8/2/24, utilized by the facility was conducted. The EBP sign indicated that use of gown and gloves were required when transferring a resident on EBP. A review of the facility's policy titled, IPCP Standard and Transmission Based Precautions, revised 9/2023, indicated, It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions .c. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precaution include: iii. Transferring . 43674 2a. Resident 37 was admitted to the facility on [DATE] with diagnoses which included metastatic prostate cancer (prostate cancer that has spread from the prostate gland to other parts of the body) per undated Admission Records. Observations were conducted on 3/10/25 at 10:25 A.M. and 2:24 P.M., and on 3/11/25 at 8:49 A.M. and 10:36 A.M., in Resident 37's room. During each observation, Resident 37's urinary catheter bag was hanging from the bed and touching the floor/mat. A concurrent observation and interview was conducted on 3/12/25 at 8:20 A.M., with Certified Nurse Assistant (CNA) 21. Resident 37's urinary catheter bag was hanging from the bed and touching the floor. CNA 21 stated that Resident 37's urinary catheter bag was touching the floor/mat and acknowledged that the urinary catheter bag should not touch the floor/mat, to prevent contamination and spread of infection. In a concurrent observation and interview on 3/12/24 at 8:24 A.M., with Licensed Nurse (LN) 21, LN 21 verified that Resident 37's urinary catheter bag was touching the floor/mat and acknowledged that the urinary catheter bag should not touch the floor/mat to prevent contamination and to protect the resident from infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/12/25 at 8:42 A.M., with the Director of Nursing (DON). The DON acknowledged that the urinary catheter bag should not touch the floor, to prevent infection and for the safety of the resident. The facility's policy and procedure titled Catheter Care, Indwelling, last reviewed 12/2019 indicated .Policy: It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and PRN (as needed) for soiling. Purpose: To promote hygiene, comfort and decrease risk of infection for catheterized residents. Procedures: .13. Keep foley drainage bag from touching the floor or landing mat . 2b. Resident 40 was admitted to the facility on [DATE] with diagnoses which included anemia (the body does not produce enough red blood cells) and atrial fibrillation (irregular heart rhythm that begins in your heart's upper chambers - atria) per undated Admission Records. Observations were conducted on 3/10/25 at 12:28 P.M. and 3/12/25 at 8:33 A.M., in Resident 40's room. Resident 40's urinary catheter was hanging from the bed and touching the floor/mat. A concurrent observation and interview was conducted on 3/12/25 at 8:35 A.M., with Certified Nurse Assistant (CNA) 21. Resident 40's urinary catheter bag was hanging from the bed and touching the floor/mat. CNA 21 acknowledged that the urinary catheter bag should not touch the floor/mat to prevent contamination and spread of infection. A concurrent observation and interview was conducted on 3/12/25 at 8:37 A.M. with Licensed Nurse (LN) 21. LN 21 verified that Resident 40's urinary catheter bag was touching the floor/mat and acknowledged that the urinary catheter bag should not touch the floor/mat to prevent contamination and to protect the resident from infection. An interview was conducted on 3/12/25 at 8:42 A.M., with the Director of Nursing (DON). The DON acknowledged that the urinary catheter bag should not touch the floor to prevent infection and for the safety of the resident. The facility's policy and procedure titled Catheter Care, Indwelling last reviewed 12/2019 indicated .Policy: It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and PRN (as needed) for soiling. Purpose: To promote hygiene, comfort and decrease risk of infection for catheterized residents. Procedures: .13. Keep foley drainage bag from touching the floor or landing mat . 45909 3. A review of Resident 34's Admission Record indicated, Resident 34 was in the facility on 4/2/24 with medical diagnoses which included asthma (condition with difficulty of breathing) and muscle weakness. Resident 34's physician order dated 4/2/24 indicated, May use oxygen supplement via nasal cannula (NC-device applied in the nose to deliver oxygen). During an observation conducted on 3/10/25 at 11:57 A.M. inside Resident 34's room, a NC was observed directly placed on top of slippers on Resident 34's personal storage rack. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with the respiratory therapist (RT) on 3/10/25 at 12:40 P.M., the RT stated Resident 34's NC should had been stored in a clean, plastic bag to prevent cross contamination (transfer of germs). During an interview with the Infection Preventionist (IP) on 3/11/25 at 4 P.M., the IP acknowledged that NCs should be kept in a storage bag when not being used, to protect the residents from infection. The facility's undated policy titled, Infection Control Policy/Procedure indicated, Procedures .2. The oxygen tubing will be stored appropriately if not in use