STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555901	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anberry Transitional Care	1000 West Yosemite Avenue Merced, CA 95341

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 48424 Based on interview and record review the facility failed to inform and provide written information on how to formulate an advance directive (a legal document that outlines a person's wishes regarding their medical care in the event they become unable to make decisions for themselves due to illness or injury) for 87 of 87 residents when staff did not document information on how to obtain an advance directive in resident charts. This failure violated the rights of 87 residents to be informed on how to formulate and obtain an advance directive. Findings: During an interview on 12/11/24 at 10:28 a.m. with the Medical Records Director (MRD), the MRD stated the facility did not help residents obtain an advance directive, they refer the resident to someone else such as their primary physician to get an advance directive completed. The MRD stated the facility will only keep a resident's advance directive on file in their chart if a resident came in with one. The MRD stated if a resident did not have an existing advance directive when they came into the facility no education or information on how to obtain an advance directive will be documented in the resident's chart. During an interview on 12/11/24 at 10:34 a.m. with Social Services Director Assistant (SSDA) 1, SSDA 1 stated if a resident or their family wanted an advance directive the resident or their family would get directed to follow up with the Long Term Care Ombudsman (LTCO) in order to have the LTCO help them obtain an advance directive. SSDA 1 stated no documentation was put in resident's charts regarding advance directives. SSDA 1 stated it was important to ensure proper documentation was present regarding how to obtain an advance directive because an advance directive ensured a resident's wishes for end of life were followed. During an interview on 12/11/23 at 10:47 a.m. with the Intake Coordinator (IC), the IC stated if a resident came into the facility and did not have an advance directive but would like one, the facility staff would direct the resident to go to their primary physician for assistance in obtaining one. The IC stated staff did not keep documentation in resident charts regarding communication to the resident or their family on how to obtain an advance directive. The IC stated documentation on how to obtain an advance directive was important because an advance directive would allow a resident's last wishes to be honored if they became too ill to make their own decisions. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555901	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Anberry Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 West Yosemite Avenue Merced, CA 95341	

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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 - Many	During an interview on 12/13/24 at 4:31 p.m. with the Assistant Director of Nursing (ADON) the ADON stated it was not a practice of the facility to document on any resident's chart whether or not they provided education and information to residents on how to obtain an advance directive. During a review of the facility's policy and procedure titled, Advance Health Care Directive (AHCD), dated 4/30/22, indicated, . 6. If the resident is not able to discuss an advance health care directive due to his/her condition, the social service designee is to review when the resident and/or representative is ready to discuss his/her wishes .7. Social Services designee is to document discussions with the resident and/or representative in the resident's medical record . 49949

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48424 Based on interview and record review the facility failed to notify residents and residents' representatives (RP-person designated to make decisions for a resident) in writing of a resident's transfer to the hospital for four of eight residents (Resident 2, 16, 33, and 41) when the facility did not provide written notice to the resident or their RP when they were transferred to the hospital. This failure violated the rights of Residents 2, 16, 33, and 41 to be informed in writing of the reason for transfer to the hospital. Findings: During an interview on 12/24/24 at 2:39 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she had never sent a notification in writing to the resident or their RP whenever a transfer to the hospital occurred. LVN 1 stated if residents had an RP, nurses would call them, but no written notice was ever given to the RP regarding reason for transfer to the hospital. LVN 1 stated if residents or their RP's were not given a written notice for the reason for the hospitalization they may be unaware as to why the resident was sent to the hospital During an interview on 12/13/24 at 4:38 p.m. with the Assistant Director of Nursing (ADON), the ADON stated none of the nurses in the facility notified the resident or their RP in writing during transfers to the hospital, they would only call them. The ADON stated nurses needed to notify the resident or their RP in writing of transfer to the hospital because having notification in writing informed the decision maker of any changes in condition and allowed them to be aware of all the changes occurring to the resident. During a review of the facility's policy and procedure titled Admission/Transfer/Discharge, undated, indicated . Prior to a transfer or discharge, this facility shall: Notify the resident, and if known, a family member or legal representative, 30 days in advance of the transfer or discharge or as soon as the discharge date is known. The resident/family member/legal representative will also be informed of the reason for the transfer or discharge. Exceptions to this would be a medical emergency, an improvement in the resident's condition and situations where the health and safety of other individuals is involved . Documentation regarding notification, orientation, preparation, etc., shall be contained in the resident's clinical records. Documentation will be made by appropriate personnel in the Nursing, Social Services, Activities, and Specialized Rehabilitation Departments . 48739 49949

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 48424 Based on interview and record review the facility failed to provide residents and residents' representatives (RP- a person designated to make decisions for a resident) written information regarding the bed hold policy for four of eight sampled residents (Resident 2, 16, and 41) when no written notices about the facility's bed hold policy was given to residents or their RPs upon the residents' transfer to the hospital. This failure violated the right for residents and RPs to be notified in writing of the facility's bed hold policy. Findings: During an interview on 12/12/24 at 9:01 a.m. with the Business Office Manager (BOM), the BOM stated whenever residents were transferred to the hospital the business office would call the RP to let them know of the bed hold policy, but she would not send them a notification in writing. The BOM stated a written bed hold notification was only given to residents and their RPs on admission and no written notice was given upon transfer to the hospital. The BOM stated she was not aware RPs needed written information regarding bed holds to be given to them upon a residents transfer to the hospital. During an interview on 12/13/24 at 4:31 a.m. with the Assistant Director of Nursing (ADON) the ADON stated it was not a practice of the facility staff to notify residents and RPs in writing of the bed hold information upon a resident's transfer to the hospital. The ADON stated it was important to provide written notification because it helped ensure residents could read the information at their own pace and so they could be aware of their rights to return to their own bed in the facility. During a review of the facility's policy and procedure titled, Bed Hold, dated 1/31/22, indicated, . Documentation in the medical record should indicate how the resident or the resident's representative was notified on the transfer and right to hold their bed . A copy of the bed hold consent is to be sent with the resident to the acute hospital. A copy is to be sent to the resident or their representative . 49949

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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 - Some	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** 48739 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (CP - a detailed approach to care customized to an individual resident's needs) for two of 16 residents (Residents 231, and 235) when Resident 231 and Resident 235 did not have care plans for oxygen administration. This failure put Residents 231 and 235 at risk for harm due to improper monitoring, documentation and administration of oxygen use. Findings: During a concurrent observation and interview on 12/09/24 at 11:56 a.m. in Resident 231's room, Resident 231 was observed in a gown, sitting in a wheelchair with oxygen infusing via a nasal cannula (a tube that delivers oxygen through the nose to people who have low oxygen levels). Resident 231 stated she had been in the facility for two days. Resident 231 stated she was in the facility due to having a mini stroke (stroke -(damage to tissues in the brain due to a loss of oxygen to the area). During a review of Resident 231's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/13/24, the AR indicated Resident 231 was admitted to the facility from the acute care hospital on 12/6/24 with diagnoses of chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 231's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/11/24, the MDS section C indicated Resident 231 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 11 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 231 was moderately impaired. During an interview on 12/12/24 at 2:46 p.m. with the Minimum Data Set Nurse (MDSN), the MDSN stated the Admission Nurse (AN) should have started a care plan. The MDSN stated whoever took the order for oxygen use should have entered an oxygen care plan. The MDSN stated an oxygen care plan was important to assess and monitor the resident for shortness of breath if the resident was using oxygen. The MDSN stated staff needed to know the safety and precautions of oxygen use in residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/12/24 at 2:59 p.m. with the AN, Resident 231's Care Plan, undated was reviewed. The Care Plan indicated there was no oxygen use care plan in place for Resident 231. Resident 231's Order Summary Report was reviewed. The Order Summary Report indicated, . oxygen @ (at) 2L/min via n/c (nasal cannula), prn (as needed), to keep sats (oxygen saturation - the amount of oxygen circulating in the blood) at or above 90% as needed . The AN stated Resident 231 should have had a care plan for oxygen administration. The AN stated care plans are triggered by physician orders. The AN stated if a resident came in with oxygen and there was an order, she would have put in a care plan on admission. The AN stated residents should have had a care plan if they required oxygen as needed or continuous flow. The AN stated care plans were important as they gave a breakdown of what was to be done for the resident. The AN stated care plans addressed interventions to be administered and what the goals were for the resident. The AN stated if there was not a care plan in place for the resident, staff would not have met goals set for the resident, interventions would not be administered for the resident. During an interview on 12/12/24 at 5:50 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated care plans were important for staff to know how to give the right care to the resident. LVN 3 stated there was the potential for the resident to not receive the right care if the resident's care plan was not specific to the resident. During an interview on 12/12/24 at 3:38 p.m. with LVN 2, LVN 2 stated the care plan should have been in place for Resident 231 for staff to follow the plan of care for the resident and to be sure staff was doing what they needed to for Resident 231. LVN 2 stated a care plan for oxygen use would have also included oxygen safety for staff and the resident. LVN 2 stated if there was no care plan in place, resident's care would not have been followed appropriately which could have caused a negative outcome. During a concurrent observation and interview on 12/10/24 at 11:20 a.m. with Resident 235 in Resident 235's room, Resident 235 was observed dressed in bed wearing oxygen tubing with a nasal cannula. Resident 235 stated she was on oxygen which was usually set at a rate of 2 L/min. Observed Resident 235's oxygen flow rate set at 4.5 L/min. Resident 235 stated her oxygen flow seemed high. During a review of Resident 235's AR dated 12/12/24, the AR indicated Resident 235 was admitted to the facility from the acute care hospital on 11/21/24 with diagnoses of emphysema (a chronic lung disease in which the air sacs may be destroyed, making it difficult to breath. Also referred to as chronic obstructive pulmonary disease - COPD), pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest, dysphagia (difficulty swallowing), acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), atrial fibrillation (an irregular and often very rapid heart rhythm), intestinal obstruction (a blockage that keeps food or liquid from passing through the small intestine or large intestine), and surgical aftercare following surgery on the digestive system. During a review of Resident 235's MDS dated [DATE], the MDS section C indicated Resident 235 had a BIMS score of 15 which suggested Resident 235 was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/12/24 at 2:46 p.m. with the MDSN, the MDSN, Resident 235's Care Plan, undated was reviewed. The Care Plan indicated there was no care plan for oxygen administration for Resident 235. The MDSN stated the Admission Nurse (AN) should have started a care plan. The MDSN stated whoever took the order for oxygen use for Resident 235 should have entered an oxygen care plan. The MDSN stated an oxygen care plan was important to assess and monitor the resident for shortness of breath if the resident was using oxygen. The MDSN stated staff needed to know the safety and precautions of oxygen use in residents. During a concurrent interview and record review on 12/12/24 at 2:59 p.m. with the AN, Resident 235's Care Plan, undated was reviewed. The Care Plan indicated there was no oxygen use care plan in place for Resident 235. Resident 235's Order Summary Report was reviewed. The Order Summary Report indicated, . oxygen @ 2L/min via n/c, prn, to keep sats at or above 90% as needed . The AN stated Resident 235 should have had a care plan for oxygen administration. The AN stated care plans are triggered by physician orders. The AN stated if a resident came in with oxygen and there was an order, she would have put in a care plan on admission. The AN stated nurses should have checked the physician's orders for oxygen administration for Resident 235 and put in a care plan. The AN stated Resident 235 should have had a care plan if she required oxygen as needed or continuous flow. The AN stated care plans were important as they gave a breakdown of what was to be done for the resident. The AN stated care plans addressed interventions to be administered and what the goals were for the resident. The AN stated if there was not a care plan in place for the resident, staff would not have met goals set for the resident and interventions would not be administered for the resident. During an interview on 12/12/24 at 5:50 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated care plans were important for staff to know how to give the right care to the resident. LVN 3 stated there was the potential for the resident to not receive the right care if the resident's care plan was not specific to the resident. During an interview on 12/12/24 at 3:38 p.m. with LVN 2, LVN 2 stated the care plan should have been in place for Resident 235 for staff to follow and to be sure staff was doing what they needed to for Resident 235. LVN 2 stated a care plan for oxygen use would have also included oxygen safety for staff and the residents. LVN 2 stated if there was no care plan in place, Resident 235's care might not have been followed appropriately which could have caused a negative outcome. During a review of the facility's job description document titled, MDS Coordinator, undated, the job description indicated, . manages resident assessment schedule to ensure timely completion of assessments and comprehensive care plan . initiates, develops and completes a comprehensive assessment and written care plan in collaboration with the interdisciplinary team that identifies the resident centered medical problems and/or needs and goals to be accomplished for each problem and/or need identified . completes resident interviews and bedside assessment needed for completion of the comprehensive assessment and care plan . ensure that all nursing services personnel are aware of the care plan and that care plans are used in providing daily nursing services to the resident . review nurses' notes and monitor residents to determine if the care plans are being followed . During a review of the facility's job description document titled, Admission Nurse, dated 4/8/2016, indicated, . responsible for the complete admission assessment, order reconciliation and communication with the attending physician of each resident admitted to the facility . plans, implements and evaluates resident care specific to each resident admitted . initiates the resident care plan after completing the admission assessment . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's job description titled, Charge Nurse, Licensed Vocational Nurse, LVN, undated, indicated, . participates in the development of an individualized plan of care . implement plan of care consistently, effectively . with focus on resident centered outcomes . During a review of the facility's policy and procedure (P&P) titled, Care Plans, dated 7/1/2015, indicated, . to standardize the development and update of resident care plans that outline care to be provided to the resident . based on comprehensive assessment the interdisciplinary team (IDT) will develop quantifiable objectives for the highest level of functioning the resident may be expected to attain . the comprehensive care plan is initiated at the time of admission to the facility . the resident's care plan will identify the professional services that are responsible for each element of the resident's care . 49949

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on interview and record review, the facility failed to revise and implement a person-centered comprehensive care plan (CP- road map for the care of a resident and a necessary tool in following the nursing process) for one of eight sampled residents (Resident 45) when the care plan was not updated to reflect discharge from hospice (end of life) service. This failure had the potential for Resident 45's needs to not be meet. Findings: During an interview on 12/10/24 at 9:38 p.m. in Resident 45's room with Family Member (FM) 1, FM 1 stated her mother was no longer on hospice services. During a concurrent interview and record review on 12/11/24 at 11:23 a.m. with License Vocation Nurse (LVN) 5, LVN 5 stated Resident 45 had been on hospice but was discharged from hospice on 11/16/24. LVN 5 stated the care plan for hospice should have been updated on the same day Resident 45 was discharged from hospice. LVN 5 stated the business office and primary physician were notified when Resident 45 was discharged from hospice. LVN 5 stated she received a verbal order from the hospice agency to discharge Resident 45 on 11/16/24. LVN 5 stated she documented the conversation on Resident 45's chart. LVN 5 stated the care plan for hospice should have been discontinued. LVN 5 stated Resident 45's care plan should have been updated when there was a change in condition (CIC-refer to a resident's health or functioning that is either short term or significant) LVN 5 stated a discharge from hospice was considered a changed in condition. LVN 5 stated Resident 45's care plan tells the nurses how to care for her and it was something the nurses needed to follow. LVN 5 stated, It should be updated because it is the care plan we are following. LVN 5 stated an incorrect care plan could have led to lack of communication for staff. LVN 5 stated care plans were individualized and specific to each resident's needs. LVN 5 stated licensed nurses should have updated the care plan. LVN 5 stated it was not done for Resident 45. During an interview on 12/11/24 at 11:56 a.m. with Minimum Data Set Nurse (MDSN) 2, MDSN 2 stated Resident 45 had a significant change in condition and the care plan should have been updated when she was discharged from hospice. MDSN 2 stated it was important for care plan to be updated when Resident 45 was no longer receiving hospice services. MDSN 2 stated Resident 45's care plan was used for communication with other healthcare team members, and it should have been done. During an interview on 12/13/24 at 3:26 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the MDSN should have updated and reviewed the care plan when there was a change in condition. The ADON stated updating care plan was part of the job description for licensed nurses. The ADON stated Resident 46's care plan was not patient specific and individualized when it was not updated. The ADON stated all care plans were specific to each resident's care. The ADON stated Resident 45's care plan should have been updated when she was discharged from hospice, and it was not done. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident's Admission Record (AR-a document with personal identifiable and medical information), dated 12/12/24 the AR indicated, Resident 45 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (a neurological condition that causes paralysis or weakness on one side of the body/0 and hemiparesis (condition that causes weakness or an inability to move on one side of the body) following cerebral infraction (a serious condition that occurs when blood flow to the brain is blocked, leading to brain cell death), hypertension (high blood pressure- is when the pressure in your blood vessels is too high (140/90 mmHg or higher), anxiety (feeling of fear, dread, and uneasiness that can be a normal reaction to stress), severe protein-caloric malnutrition (a condition that occurs when someone doesn't consume enough protein, calories, and other essential nutrients), muscle weakness and pain. During a review of Resident 45's Physician Order (PO), dated 11/16/24, the PO indicated, .Created Date 11/16/24 00:16 [line] Communication Method: Verbal .Order Summary: Admit to [Hospice Agency Name] hospice: Dx: Hemiplegia following cerebral infection [infraction] affecting left non-dominant side. [line]Discontinue: 11/16/24 .Discontinue Date/Reason: pt requesting bx (biopsy) from oncology, hospice dc [discharged] . During a review of Resident 45's [Facility Name] Transitional Care- Progress Note (PN), dated 11/15/24, the PN indicated, .Note Text: Per hospice RN [nurse name] patient came off hospice today d/t patient is pending a biopsy on 11/18/24 with an oncologist . During a review of Resident 45's Care plan (CP) dated 12/13/24, the CP indicated, .[box] Resolved:1 The resident was admitted to [hospice Agency Name] Hospice: Dx: Hemiplegia following cerebral infarction affecting left non-dominant side .Resolved date: 11/28/2024. During a review of the facility's policy and procedure titled, Care Plans dated revision date 7/1/2014, the Care Plans indicated, .2. The care plan will be reviewed and revised by the IDT [Interdisciplinary Team (IDT) meeting is a collaborative meeting where professionals from different disciplines work together to plan and coordinate resident care] after each resident's assessment, quarterly and more often as warrant by the changes in the resident's condition .4. The resident's care plan will be updated as changes occur including, but not limited to .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview and record review, the facility failed to meet professional standards of practice for four of 16 sampled residents (Resident 46, Resident 231, Resident 233, and Resident 235) when: 1. Resident 46, Resident 231 and Resident 235's oxygen tubing were not labled with the date the tubing was changed. This failure put Residents 46, 231 and 235 at risk of infection. 2. The Attending Physician (AP) was not notified when Resident 233's medication for hypertension (high blood pressure) was not given due to low blood pressure levels. This failure put resident 233 at risk of harm due to low blood pressure levels. 3. Resident 235's physician order (a set of instructions written by a doctor for clinicians to follow when caring for a resident) for oxygen flow rate was for 2 L/min (liters per minute - a unit of measurement) and it was set at 4.5 L/min. This failure resulted in Resident 235 receiving too much oxygen and had the potential to result shortness of breath and respiratory distress (difficulty breathing) for Resident 235. Findings: 1. During a concurrent observation and interview on 12/09/24 at 11:50 a.m. in Resident 46's room, Resident 46 had no date on his nasal cannula tubing (a device that gives you additional oxygen through your nose). During a concurrent observation and interview on 12/10/24 at 4:41 p.m. in Resident 46's room, LVN 6 confirmed no date was on the nasal cannula tubing. LVN 6 stated the nasal cannula tubing should have been labeled with a date. LVN 6 stated, it was important to date the nasal cannula tubing to ensure when it was last changed. LVN 6 stated, night nurses were responsible for changing the nasal cannula tubing weekly. LVN 6 stated, Resident 46 was at risk for an infection when the nasal cannula was not changed weekly. During a review of Resident 46's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/13/24, the AR indicated Resident 46 was admitted on [DATE], with diagnoses of transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), candidiasis (a type of fungal infection) of skin and nails, type 2 diabetes mellitus, resistance to multiple antibiotics, dependent on oxygen, muscle weakness, anxiety (feeling of fear, dread, and uneasiness that can be a normal reaction to stress), sleep apnea (a sleep disorder characterized by repeated episodes of pauses in breathing during sleep). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555901	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Anberry Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 West Yosemite Avenue Merced, CA 95341	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/23/24 the MDS section C indicated Resident 46 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 46 was moderated impaired in cognition. During a concurrent observation and interview on 12/09/24 at 11:56 a.m. with Resident 231 in Resident 231's room, Resident 231 was observed in a gown sitting in a wheelchair with oxygen (O2) infusing via a nasal cannula (a tube that delivers oxygen through the nose to people who have low oxygen levels). Resident 231's O2 nasal cannula was observed to not have the date the oxygen tubing was changed. Resident 231 stated she had been in the facility for two days. During a review of Resident 231's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/13/24, the AR indicated Resident 231 was admitted to the facility from the acute care hospital on 12/6/24 with diagnoses of chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 231's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/11/24, the MDS section C indicated Resident 231 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 11 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 231 was moderately impaired. During a concurrent observation and interview on 12/10/24 at 8:55 a.m. with Licensed Vocational Nurse (LVN) 2 in Resident 231's room, Resident 231's oxygen tubing was observed to be not labled with a date. LVN 2 verified Resident 231's oxygen tubing was not dated. LVN 2 stated Resident 231's oxygen tubing should have been dated so staff would know when it was changed. LVN 2 stated if Resident 231's oxygen tubing was not changed weekly, Resident 231 could get an infection. During a concurrent observation and interview on 12/10/24 at 11:20 a.m. in Resident 235's room, Resident 235 was observed dressed in bed, wearing oxygen tubing with a nasal cannula Resident 235's oxygen tubing did not have a date label. During a review of Resident 235's AR dated 12/12/24, the AR indicated Resident 235 was admitted to the facility from the acute care hospital on 11/21/24 with diagnoses of emphysema (a chronic lung disease in which the air sacs may be destroyed, making it difficult to breath. Also referred to as chronic obstructive pulmonary disease - COPD), pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest, dysphagia (difficulty swallowing), acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), atrial fibrillation (an irregular and often very rapid heart rhythm), intestinal obstruction (a blockage that keeps food or liquid from passing through the small intestine or large intestine), and surgical aftercare following surgery on the digestive system. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 235's MDS dated [DATE], the MDS section C indicated Resident 235 had a BIMS score of 15 which suggested Resident 235 was cognitively intact. During a concurrent observation and interview on 12/10/24 at 11:52 a.m. with LVN 5 in Resident 235's room. Resident 235's oxygen tubing was not labeled with a date. LVN 5 stated Resident 235's oxygen tubing should have been labeled with the date it was changed. LVN 5 stated Resident 235's oxygen tubing should have been dated so staff would know when the tubing was changed. LVN 5 stated the oxygen tubing should have been changed weekly so no dirt or particulates were in the tubing. LVN 5 stated residents could aspirate the dirt or particles in the tubing which would be a risk of infection to residents. During an interview on 12/13/24 at 12:21 p.m. with the Infection Prevention Nurse (IP), the IP stated a date on the oxygen tubing would let other staff know when the tubing was last changed. The IP stated if there was no date on the tubing, staff could not assume when the tubing was changed. The IP stated Resident 46, Resident 231and Resident 235's oxygen tubing should have been dated due to a risk of infection for Residents 46, Resident 231and Resident 235. During a review of the facility's job description document titled, Charge Nurse, undated, the document indicated, . implement plan of care consistently, effectively . with focus on resident centered outcomes . follow facility policies and procedures to ensure a safe, caring, comfortable and clean environment . During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 1/3122, indicated, . humidifiers and oxygen devices (cannulas or mask) are to be marked with black sharpie the date and nurse's initial . nasal cannulas are to be changed weekly or as needed if soiled. The date and initials of the nurse who changed these items is to be marked with a black sharpie . 2. During an observation on 12/11/24 at 12:20 p.m. in Resident 233's room, Resident 233 was observed wearing a gown, sitting in his wheelchair. LVN 4 was observed taking Resident 233's blood pressure, with a reading of 96/59. LVN 4 was observed to not give Resident 233's high blood pressure medication. During a review of Resident 233's AR, dated 12/13/24, the AR indicated, Resident 233 was admitted on [DATE] from the acute care hospital with diagnoses of heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid), hypertension (high blood pressure), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 233's MDS, dated [DATE], the MDS section C indicated Resident 233 had a BIMS score of three, which indicated Resident 233 had severe impairment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 12/12/24 at 3:38 p.m. with LVN 2, Resident 233's physician Order Summary Report, undated was reviewed. The Order Summary Report indicated, . hydralazine hcl oral tablet 25 mg (milligram - a unit of measurement) . give one tablet by mouth two times a day for HTN (hypertension) hold if SBP (systolic blood pressure [when the heart muscle contracts] < (less than) 100 and notify MD (physician) . Resident 233's Medication Administration Record (MAR), dated 12/1/24 to 12/31/23 was reviewed. The MAR indicated Resident 233's medication for hypertension was held on 12/11/24 and 12/12/24. LVN 2 stated there was no documentation from the nurse that Resident 233's physician was notified when Resident 233's medication was not given. LVN 2 stated if the physician was not notified, the nurse was not following physician orders. LVN 2 stated a negative outcome could occur with Resident 233 if his medication was not given due to low blood pressure and the physician was not notified. During an interview on 12/13/24 at 12:21 p.m. with the IP, the IP stated nurses should have followed physician orders. The IP stated if staff did not follow physician orders, they could have caused harm to Resident 233. The IP stated an adverse (harmful) reaction could have occurred with Resident 233 if staff did not follow physician orders. During a review of the facility's job description document titled, Charge Nurse, undated, the document indicated, . implement plan of care consistently, effectively . with focus on resident centered outcomes . carries out physician orders as prescribed . follow facility policies and procedures to ensure a safe, caring, comfortable and clean environment . keep physician and/or other health care professionals (Nurse Practitioner, Physician Assistant, podiatrist, dentist, etc.) informed of resident's condition; and notify physician and/or other healthcare professions immediately of significant changes of condition . administers medications as ordered and monitors for signs and symptoms of adverse effects . follows up on resident change of conditions. Documents all findings and communicates with the physician . notify physician and/or other health care professionals if orders are not carried out and document event appropriately . During a review of the facility's P&P titled, Documentation, Nursing, dated 1/31/22, indicated, . licensed nurses are to document throughout their shift, capturing all changes in condition, treatments, responses to treatment and overall observation of the resident . nurses notes are written for any episodic issue, physician communication or other nursing measure that requires documentation in the medical record . During a review of the facility's P&P titled Physician Orders, dated 12/01/15, indicated, . the facility may also fax to the physician a blank (except when sending statistical information) facsimile order form on which the physician may write an order or instructions and return to the facility via facsimile . the facility may fax a MD Notification form to physician with information regarding resident condition on which the physician may write an order/response and return to the facility . 3. During a concurrent observation and interview on 12/10/24 at 11:20 a.m. in Resident 235's room, Resident 235 was observed dressed in bed, wearing oxygen tubing with a nasal cannula. Resident 235 stated she is receiving oxygen at a rate of 2 L/min. Oxygen was being administered at 4.5L/min. Resident 235 stated the oxygen rate seemed high. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 235's AR dated 12/12/24, the AR indicated Resident 235 was admitted to the facility from the acute care hospital on 11/21/24 with diagnoses of emphysema (a chronic lung disease in which the air sacs may be destroyed, making it difficult to breath. Also referred to as chronic obstructive pulmonary disease - COPD), pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest, dysphagia (difficulty swallowing), acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), atrial fibrillation (an irregular and often very rapid heart rhythm), intestinal obstruction (a blockage that keeps food or liquid from passing through the small intestine or large intestine), and surgical aftercare following surgery on the digestive system. During a review of Resident 235's MDS dated [DATE], the MDS section C indicated Resident 235 had a BIMS score of 15 which suggested Resident 235 was cognitively intact. During a concurrent observation and interview on 12/10/24 at 11:52 a.m. with LVN 5 in Resident 235's room, Resident 235's oxygen rate was observed to be set at 4.5L/min. LVN 5 stated Resident 235's oxygen rate should have been set to 3L/min. During a concurrent interview and record review on 12/10/24 at 11:54 a.m. with LVN 5, Resident 235's Order Summary Report, undated was reviewed. The Order Summary Report indicated, . oxygen @ (at) 2L/min via n/c (nasal cannula), prn (as needed), to keep sats (oxygen saturation - the amount of oxygen circulating in the blood) at or above 90% as needed . LVN 5 stated during report she received information that Resident 235's oxygen rate was to be set at 3L/min. LVN 5 stated she was not sure why Resident 235's rate was changed. LVN 5 stated Resident 235's oxygen rate should have been set to 2L/min. LVN 5 stated Resident 235's oxygen rate should have been checked every day during shift change after nurses received report, and during each medication pass to the Resident 235. LVN 5 stated it was important to follow physician orders to prevent adverse events occurring with residents. During an interview with LVN 2 on 12/12/24 at 3:38 p.m., LVN 2 stated she expected nurses to follow physician's orders. LVN 2 stated if staff did not follow physician orders, residents could have a negative outcome. During an interview on 12/13/24 at 12:21 p.m. with the IP, the IP stated nurses should have been following orders for Resident 235's oxygen rate. The IP stated staff could cause more harm to residents if oxygen was not given as ordered by the physician especially for residents with certain diagnoses such as COPD. The IP stated an adverse reaction could occur to residents if staff did not follow physician orders. During a review of the facility's job description document titled, Charge Nurse, undated, the document indicated, . implement plan of care consistently, effectively . with focus on resident centered outcomes . carries out physician orders as prescribed . follow facility policies and procedures to ensure a safe, caring, comfortable and clean environment . administers medications as ordered and monitors for signs and symptoms of adverse effects . performs prescribed treatments and documents all findings in the resident's medical record . notify physician and/or other health care professionals if orders are not carried out and document event appropriately . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anberry Transitional Care	1000 West Yosemite Avenue Merced, CA 95341

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 1/31/22, indicated, . oxygen will only be administered by physician's order . oxygen shall be administered to residents only by a licensed nurse . licensed nurses are to document on the MAR (Medication Administration Record) each shift that oxygen is used at the ordered flow rate . check the operation of the oxygen delivery system when monitoring the flow rate . 49949

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review the facility failed to provide personal hygiene for one of eight sampled residents (Resident 46) when Resident 46's fingernails were long and not cut. This failure had the potential to result in Resident 46 to develop skin infections or sustain skin injuries. Findings: During a concurrent observation and interview on 12/10/24 at 12:01p.m. in Resident 46's room, Resident 46 had long yellow fingernails. Resident 46 stated he did not like his fingernails long and wanted them cut or filed. Resident 46 stated he was a diabetic and long fingernails could have caused infections when he scratched his skin. Resident 46 stated he did not remember the last time staff cut or trimmed his fingernails. During a concurrent observation and interview on 12/13/24 at 8:17 a.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 46's fingernails were long and should have been trimmed or cut. CNA 6 stated Resident 46's long fingernails were dirty and could have contained bacteria. CNA 6 stated Resident 46's long fingernails could have prevented him from holding a spoon and affected his meal intake. CNA 6 stated Resident 46 was a diabetic and he was not able to cut his long fingernails. CNA 6 stated he should have told the nurse about Resident 46's request to cut his long fingernail. During a concurrent observation and interview on 12/13/24 at 8:35 a.m. with the Infection Preventionist (IP), the IP stated Resident 46's fingernails were long. The IP stated nurses should have cut Resident 46's fingernails. The IP stated, We cut them straight across and CNA should have filed them down. The IP stated Resident 46 was at risk for scratching himself and causing an infection to his skin. The IP stated Resident 46's overall hygiene was affected. The IP stated the nurses should have cut them monthly or as needed when they noticed the fingernails were too long. The IP stated nurses did not cut Resident 46's fingernails and she did not remember the last time they were cut. During an interview on 12/13/24 at 10:04 a.m. with the Assistant Director of Nursing, ADON, the ADON stated, Residents with long fingernails were at risk for an infection when they scratch their skin. The DON stated Resident 46 could have injured himself with long fingernails. The ADON stated staff should have cut them every 2 weeks or as needed. The ADON stated Resident 46's fingernails should have been cut as soon as staff notice his fingernails were long. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 46's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/13/24, the AR indicated Resident 46 was admitted on [DATE], with diagnoses of transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), candidiasis (a type of fungal infection) of skin and nails, type 2 diabetes mellitus (a chronic condition that happens when you have persistently high blood sugar level), resistance to multiple antibiotics, dependent on oxygen, muscle weakness, anxiety (feeling of fear, dread, and uneasiness that can be a normal reaction to stress), sleep apnea (a sleep disorder characterized by repeated episodes of pauses in breathing during sleep). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/23/24 the MDS section C indicated Resident 46 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 46 was moderated impaired in cognition. During a review of Resident 46's Care plan (CP), dated 12/13/24, the CP indicated, .[box]Focus: The Resident has a ADL Self Care Performance Deficit R/T [related to] .[box]Interventions: .Nail care provided by Licensed staff as needed . During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL) dated 1/31/2022, the P&P indicated, .Residents are to be provided assistance as needed to maintain good personal hygiene including .e. cleaning and cutting of finger and toenails .

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 49949 Based on observation, interview, and record review the facility failed to ensure nursing staff information data posting contained or demonstrated the total numbers and actual hours worked by Registered nurses (RN), license vocational nurses (LVN) and Certified nurse aides, were posted daily. This failure resulted in 87 out of 87 residents and their family members not being able to identify who was responsible for their care, how many licensed and unlicensed staff were on shift, and the total number of hours staff were working. Findings: During an observation on 12/13/24 at 2:35 p.m. in the hallway, the Census and Direct Care Services Hours Per Patient Day (DHPPD) did not contain the total number of actual hours worked for RNs, LVNs and CNAs. During an interview on 12/13/24 at 3:04 p.m. with the Administrator (ADM) the ADM stated, We have only CNA hours posted and no nursing hours posted. The ADM stated, the posting sign had CNA actual hours and no licensed nurse actual hours posted. The ADM stated he was not aware the hours needed to be posted. The ADM stated there were no posted numbers of RNs, LVNs and CNAs working. During an interview on 12/13/24 at 3:56 p.m. with the Staff Coordinator (SC), the SC stated, The hours for everyone is on there, but it is not specific. The SC stated she and ADM were responsible for inputting the posting hours. The SC stated, You can't tell how many hours were worked by the RN, LVN and CNA. The SC stated the hours on the DHPPD were for the total hours worked by the combined staff. The SC stated she was not aware she needed to post the RN, LVN and CNA hours separately. During a review of the facility's policy and procedure (P&P) titled, Nursing Staffing Ratio Posting, dated review date 1/31/22, the P&P indicated, It is the policy of this facility to post the daily nurse staffing ratios in a clear and readable format that is readily available to the staff, residents and interested members of the public .The Staff Coordinator, designated by the facility administrator, is responsible for the following on a daily basis: 1. Collect and document the required staffing information on the facility staff posting form: a. Facility name b. The current date c. The total number of staff bodies and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. i. Registered nurse ii. Licensed vocational nurses iii. Certified nurse aides .

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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 48424

Based on observation, interview and record review, the facility failed to ensure two of seventeen sampled residents (Resident 32 and 236) were free from unnecessary medications when:

1. Monitoring for behaviors and non-pharmaceutical interventions were not implemented for Resident 236 while administering anti-psychotic medications (a medication used to treat a collection of symptoms that affect your ability to tell what's real and what is not).

2. Resident 32 did not have monitoring orders for her anxiety and bipolar disorder in place upon her admission to the facility on [DATE].

These failures placed Resident 32 and Resident 236 at risk for receiving unnecessary antipsychotic medications and had the potential of preventing them from maintaining their highest practicable mental, physical, and psychosocial well-being.

Findings:

1. During an observation on 12/9/24 at 12:25 p.m.in Resident 236's room, Resident 236 was observed eating his meal. Resident 236 began speaking very loud in his native language ([NAME]) and appeared angry when introduction made.

During a review of Resident 236's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/13/24, the AR indicated Resident 236 was admitted to the facility from the acute care hospital on 11/27/24 with diagnoses of urinary tract infection (UTI - an infection in the bladder/urinary tract), type 2 diabetes mellitus (when the blood sugar levels in the body are too high), legal blindness (loss of vision), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and depression (feeling of sadness and loss of interest).

During a review of Resident 236's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/3/24, the MDS section C indicated Resident 236 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of five (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 236 was severely impaired.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/12/24 at 3:35 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 236's Order Summary Report, undated was reviewed. The Order Summary Report indicated, . quetiapine fumarate (a medication used to treat schizophrenia [a disorder that affects a person's ability to think, feel, and behave clearly], bipolar disorder [a disorder associated with episodes of mood swings ranging from depressive lows to manic highs] and depression) tablet 25 mg (milligrams - a unit of measurement) give 0.5 tablet by mouth at bedtime for BPSD (behavioral and psychological symptoms of dementia) M/B (manifested by) highs and lows . LVN 2 stated monitoring for highs and lows were observed for highs if Resident 236 was happy and wanted to participate in activities. LVN 2 stated lows were if Resident 236 wanted to sleep and did not want to participate in anything but just felt down. During a concurrent interview and record review on 12/12/24 at 3:38 p.m. with LVN 2, Resident 236's Medication Administration Record (MAR), dated 12/1/24-12/31/24 was reviewed. The MAR indicated no behavior monitoring was implemented for the administration of quetiapine. LVN 2 stated there was no behavior monitoring implemented for Resident 236 for quetiapine administration. During a concurrent interview and record review on 12/13/24 at 12:21 p.m. with the Infection Preventionist (IP), Resident 236's Physician Summary Report, undated was reviewed. The Physician Summary Report indicated . monitor behavior of BPSD M/B highs and lows every shift . Resident 236's MAR, dated 12/1/24 to 12/31/24 was reviewed. The MAR indicated no monitoring for behaviors were implemented. The IP stated there was no monitoring of Resident 236's behavior. The IP stated it was important to monitor Resident 236's behaviors if he was on an anti-psychotic to be sure the medication was therapeutic (healing effect, making healthier). The IP stated if the medication was not therapeutic, the physician might need to adjust the dose or give an alternative form of therapy. During a review of the facility's policy and procedure (P&P) titled Care of Residents with Dementia, dated 1/31/22, indicated, . the interdisciplinary team is to care plan all individual interventions that will be carried out with the resident, including . non-pharmacological behavior interventions and possibly pharmacological treatment . During a review of the facility's P&P titled, Medications, Psychotherapeutic Drugs, dated 1/31/22, indicated, . to provide a therapeutic environment using only those medications with a therapeutic value to individual residents . the interdisciplinary team should identify any resident who exhibits behavioral symptom(s) and is to institute behavioral tracking . monitor order as appears on the Medication Administration (for residents prescribed a psychotherapeutic medication) . documentation in the medical record should include the interdisciplinary team's (IDT) review of the resident's behavioral symptoms and the non-pharmacological interventions that were ineffective . all residents on psychotherapeutic drugs is to have behaviors tracked and medication side effects charted on the medication administration record . the IDT is to review the behavioral data, effectiveness of the medication, and any side effects of the medication . a monthly tally of behaviors and side effects is to be documented for physician review . 2. During a review of Resident 32's AR, dated 12/13/24, the AR indicated Resident 32 was admitted to the facility on [DATE] with diagnoses of bipolar disorder (a mental health condition characterized by significant and persistent mood swings between periods of extreme happiness and sadness, anxiety (an emotional state characterized by feelings of fear, worry, unease, and apprehension, and type 2 diabetes mellitus (when the blood sugar levels in the body are too high) (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 interview and record review on 12/13/24 at 1:00 p.m. with Minimum Data Set Nurse (MDSN) 1, Resident 32's Order Summary Report, dated 10/14/24 was reviewed. The Order Summary Report indicated Resident 32 was prescribed duloxetine (medication which can treat sadness and anxiety), Seroquel (medication which can treat bipolar disorder) and Lorazepam (medication used to help treat anxiety). No behavioral monitoring was in place for Resident 32 in the month of October. MDSN 1 stated anytime a resident was prescribed psychotropic medications they also needed orders to monitor for any behaviors. MDSN 1 stated monitoring orders for Resident 32 were not in place upon her admission or in the month of October. MDSN 1 stated it was important to put in monitoring orders whenever a resident received psychotropic medications because it helped ensure the intended use of the medications was being achieved and it helped prevent any side effects from occurring. During a concurrent interview and record review on 12/13/24 at 3:22 p.m. with the Admissions Nurse (AN), Resident 32's Order Summary Report, dated 10/14/24 was reviewed. The Order Summary Report indicated no behavioral monitoring was in place for Resident 32 in the month of October. The AN nurse stated when residents were admitted with psychotropic meds nurses needed to obtain a doctor's order to monitor for any side effects from the psychotropic medication and for unresolved behaviors related to their diagnoses. The AN stated Resident 32 did not have any monitoring orders in place when she was admitted into the facility on [DATE] and no orders were placed in the month of October. The AN stated it was important to monitor for behaviors in order to know if the medications given were effective. During an interview on 12/13/24 at 4:24 p.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 32 should have had behavior monitoring orders in place when she was admitted . The ADON stated she did not know why the orders were missed. The ADON stated if nurses were not monitoring any of her behaviors, they would not have been able to know if Resident 32's behaviors were improving. During a review of the facility's P&P titled, Medications, Psychotherapeutic Drugs, dated 1/31/22, indicated, . to provide a therapeutic environment using only those medications with a therapeutic value to individual residents . the interdisciplinary team should identify any resident who exhibits behavioral symptom(s) and is to institute behavioral tracking . monitor order as appears on the Medication Administration (for residents prescribed a psychotherapeutic medication) . documentation in the medical record should include the interdisciplinary team's (IDT) review of the resident's behavioral symptoms and the non-pharmacological interventions that were ineffective . all residents on psychotherapeutic drugs are to have behaviors tracked and medication side effects charted on the medication administration record . the IDT is to review the behavioral data, effectiveness of the medication, and any side effects of the medication . a monthly tally of behaviors and side effects is to be documented for physician review . 48739

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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. 48739 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals (a substance such as vaccines or drugs derived from a living organism used for treatment) were stored and labeled in accordance with currently accepted professional standards of practice when: 1. The refrigerator in section 300-Medroom contained an antibiotic with an unreadable expiration date. Carts 200-Backside and 300-B contained : one of five inhalers (medications used to treat respiratory disease with a mist or spray that the patient breathes in through the nose or mouth) had an expiration date of 11/2/24, lactulose (a medication used to decrease the amount of ammonia in the blood) had an expiration date of 12/2/24, 11 of 143 pill packets had expired dates in November, 26 of 60 ferrous gluconate (a medication to treat low iron in the blood) expired 5/24, combined with new packets of pills individually packaged with date of 1/27 one of one bottle of folic acid (a mineral) did not have a readable expiration date on the bottle, one of four bottles of insulin (a medication used to lower the amount of sugar in the blood) had an expiration date of 12/4/24, and one of 161 pill packets (a packet that contains a set number of medication pills of the same brand in individual pop-out wrapping) was expired. These failures had the potential for residents to receive expired medications resulting in medication ineffectiveness (not producing any significant or desired effect), and adverse (unintended) reactions. 2. Medication cart was left unlocked while administering medications to residents. This failure had the potential for residents and non-licensed staff to have access to unprescribed (advise and authorize the use of a medicine or treatment) medication putting residents at risk of medication adverse reactions. 3. Two loose white pills were found on Resident 189's bedside table while she was out of her room. This failure had the potential to cause other residents, staff, or visitors, to enter Resident 189's room and take the unsecured medications, and for Resident 189 to not receive medications prescribed by her doctor to treat her medical condition Findings: 1. During a concurrent observation and interview on 12/12/24 at 9:17 a.m. with Licensed Vocational Nurse (LVN) 1 and the Infection Prevention Nurse (IP) in the medication room in section 300, the medication refrigerator was observed to have an antibiotic (a medication that fights bacterial infection) with an unreadable expiration date. The IP stated the expiration date was written over with another date in pen. The IP stated the expiration date was unreadable. The IP stated staff should not have written over the original expiration date but should have called the pharmacist to obtain an updated label. The IP stated expired medications could cause a reaction (an unplanned response) if used or be ineffective (not produce the desired effect). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/12/24 at 5:15 p.m. with LVN 3 at the nurses' station, cart 300-B was observed to contain one bottle of folic acid with an unreadable expiration date and one vial of insulin with and expired date of 12/9/24. LVN 3 stated the folic acid and insulin should not have been in the medication cart. LVN 3 stated if the expiration date was unreadable, the medication could have been expired. LVN 3 stated if residents received expired medication, the medication might not work, or the resident could have a bad side effect from the expired medication. During a concurrent observation and interview on 12/13/24 at 3:51 p.m. with LVN 9 in the East Wing, Cart 200-Backside was observed to have one of five inhalers with an expiration date of 11/2/24, one of one bottle of lactulose with an expiration date of 12/2/24, 26 of 60 individually packaged ferrous gluconate, and 11 of 143 pill packets with expiration dates of 11/2024. LVN 9 stated expired medications should not have been in the medication cart. LVN 9 stated expired medications might not have worked as intended on the resident. LVN 9 stated giving residents expired medications could have caused more harm than good to the resident. 2. During a concurrent observation and interview on 12/11/24 at 4:28 p.m. with LVN 7 in section 300 west hallway, LVN 7 was observed leaving the medication cart unlocked while administering resident medication in the resident's room. LVN 7 stated she could see the medication cart when she was giving medication to the residents. During an interview on 12/12/24 at 3:52 p.m. with LVN 2, LVN 2 stated medication carts should not have been unlocked when nurses stepped away to give resident medications. LVN 2 stated even if the medication cart was in the nurses' line-of-site, medication carts should have been kept locked so no unauthorized person could have taken medications from the medication cart. During a review of the facility's policy and procedure (P&P) titled, Medications Storage, dated 1/31/22, indicated, . store medications, drugs, and biologicals in a safe, secured and properly temperature controlled environment . all medications, drugs and biologicals are to be stored in a safe, secure and orderly manner . accessible to only licensed nurses and the pharmacist . medication labels are to be legible . medications are to be stored in the facility in a locked medication room or medication cart that is accessible to only authorized persons . During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 1/31/22, indicated, . medications are to be administered from containers, bubble packs or bottles that are clearly marked with the name of the medication, concentration, dose, route and expiration date . the medication cart should be under the licensed nurse's supervision at all times when administering medications. The cart is to be locked whenever the nurse walks away from the cart . 3. During a concurrent observation and interview on 12/9/24 at 11:38 a.m. with Licensed Vocational Nurse (LVN) 7 in Resident 189's room, two loose white pills were found on Resident 189's bedside table while she was out of her room. LVN 7 stated the two unknown pills should not have been left out and unsecured. LVN 7 stated anyone could have entered the room and taken the unknown pills. LVN 7 stated nurses were supposed to watch the resident take all their medications and if any weren't taken, the nurse would destroy or secure the medication. (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 12/13/24 at 9:00 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated if he ever saw any loose pills in the facility, he would let the nurses know in order for them to dispose of the medications. CNA 1 stated it was important for medications to always be secured because having loose pills lying around could cause another resident to take them and experience bad side effects. During an interview on 12/13/24 at 4:20 p.m. with LVN 8, LVN 8 stated if any unknown loose pills were found in a resident's room, he would ensure the medications were disposed of because other residents may wander in the room and take a potentially harmful medication. LVN 8 stated all nurses needed to ensure residents took all of their medications in front of them, otherwise medications could have been missed. During an interview on 12/13/24 at 4:24 p.m. with the Assistant Director of Nursing (ADON), the ADON stated no pills should have been left unsecured on a resident's bedside table. The ADON stated the nurse who administered the pills to Resident 189 should have ensured the resident took every pill to avoid having unknown medications lying around. The ADON stated it was important to ensure all prescribed medications were taken because if any medications were missed Resident 189 may not have gotten the therapeutic effect of their medication. The ADON stated loose pills may also attract other residents to wander in the room and take them. During a review of Resident 189's Admission Record AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/22/24, indicated Resident 189 was admitted with the following diagnoses: cellulitis (infection of the skin that causes redness and swelling), hyperlipidemia (when there are high levels of fats in the blood), Vitamin D deficiency (when the body does not have enough vitamin D which is responsible for strong bones and muscles), hypokalemia (condition where the potassium [minerals in the body that help muscles move] levels in the body are low), hypertension (when the force of blood circulating in your body is too high). During a review of the facility's policy and procedure titled, Medication Storage, dated 1/31/22, indicated, . 4. Medications are to be stored in the facility in a locked medication room or medication cart that is accessible to only authorized persons .

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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. 51134 Based on observation, interview, and record review, the facility failed to ensure menus were followed for 16 Residents (Resident 5, 7, 13, 18, 23, 28, 32, 33, 35, 36, 41, 44, 45, 52, 60, 281) when a dessert was served that was not on the planned and approved menu. This failure had the potential to result in 16 residents having a decreased intake of nutrients and lower satisfaction and interest of the meal as the resident could have been looking forward to receiving the planned and approved dessert menu item. Findings: During a review of Winter Menus for Monday 12/9/24, (undated), the Winter Menus indicated the lunch served on Monday included, .Southern Style Beef Pattie, Cream Gravy, Mashed Potatoes, Garlic Parmesan Spinach, Parsley Sprig Garnish, Wheat Roll, Margarine [butter] Ambrosia Pudding with 2 sl [slices] mandarin oranges/ 1 tsp [teaspoon] coconut . During an observation on 12/9/24 at 12:36 p.m., in the kitchen at tray line, resident trays at the end of tray line had different desserts placed on the resident trays. Sixteen Residents (Resident 5, 7, 13, 18, 23, 28, 32, 33, 35, 36, 41, 44, 45, 52, 60, 281) received gelatin with whipped topping on their trays instead of ambrosia pudding. During an interview on 12/9/24 at 12:52 p.m. with Dietary Aide (DA) 1, DA 1 stated these residents received a different dessert than what was on the menu because they had leftover gelatin from the day before. DA 1 stated the cook last night made less of the ambrosia pudding so they could use up the remaining gelatin dessert, so it didn't go bad. During an observation on 12/10/28 at 12:58 p.m. at the Resident Menu Board, the posted menu for the week stated lunch for Monday December 9 is, Southern Style Beef Pattie, Cream Gavy, Mashed Potatoes, Garlic Parmesan, Spinach, Wheat Roll, Ambrosia Pudding. During an interview on 12/12/24 at 10:20 a.m. with the Registered Dietitian (RD), the RD stated she expects the staff to follow menus. The RD stated she has not heard of staff changing the menu before. The RD stated, I understand the staff knows they are not supposed to make any changes or if something runs out, they would need to consult with the RD first. During an interview on 12/12/24 at 12:31 p.m. with the Director of Nutritional Services (DNS), the DNS stated the dessert change that occurred on Monday, 12/9/24, was an isolated incident. The DNS stated this menu change was an oversight. During a review of the facility's Policy and Procedure (P&P) titled, Menus, dated 5/1/2016, the P&P indicated, . 4. Menus will be written and posted in the facility at least one week in advance of service. Menus will be posted in the kitchen, dining rooms, and resident accessible areas 8. Menus will be planned with three meals per day consisting of breakfast, lunch and dinner . (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28773 51059

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51059 Based on observation, interview and record review, the facility failed to provide palatable and flavorful food when: 1. Broccoli was bland and without flavor for the regular diet. 79 Residents received broccoli at the facility. 2. Puree salad did not taste good. Five residents (Residents 2, 9, 63, 481, 482) were on the puree diet. These failures resulted in lack of flavor and palatability in vegetables and puree salad which can lead to residents having a decreased food intake and could result in weight loss and further compromise nutritional and medical status. There were 84 residents eating at the facility. Findings: During an interview on 12/9/24 at 1:10 p.m. with Resident 60 (R 60), R 60 stated the food was bland. During an interview on 12/10/24 at 12:32 p.m. with Resident 20 (R 20), R 20 stated the food did not taste good and he will not eat the food item if he does not like it. During a review of the facility menu titled, Winter Menus, the lunch menu on 12/10/24 indicated residents on regular, mechanical soft, dysphagia mechanical, no added salt and controlled carbohydrate diets received Pork with Pear Sauce, Sweet Potatoes, Seasoned Broccoli, Fresh [NAME] Salad with Dressing, Cranberry Crunch Square and Milk. The lunch menu indicated residents on puree diets received, Grinded Pork with Puree Pear Sauce, Sweet Potatoes, Seasoned Broccoli, Fresh [NAME] Salad with Dressing, Cranberry Crunch Square and Milk. During a review of the facility document titled, Diet Type Report, dated 12/9/24, showed there were 84 residents eating at the facility. 1. During a concurrent observation and interview on 12/10/24 at 12:43 p.m. with the Director of Nutritional Services (DNS) during a test tray of the regular and puree diets. Surveyors and DNS tasted the food items on the test trays. The broccoli was soggy and mushy, watery, bland, and dull green in color. DNS stated, limited salt and seasoning was added to the broccoli, and she needed to add additional salt and pepper to eat the food item. DNS stated the recipes do not call for many seasonings. DNS acknowledged the broccoli was bland and stated she was not sure why it was watery as they only use the steamer to cook it. During an interview on 12/12/24 at 12:31 p.m. with DNS, DNS stated excess moisture from cooking the broccoli made the food item soggy and additional salt seasoning would have made the food item taste better. DNS acknowledged that cooking with seasonings and salt helped improve flavor in the food. DNS stated, the goal should be to liberalize regular and therapeutic diets so residents will eat and enjoy their food. DNS stated she will have the RD discuss with the menu company. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's broccoli recipe titled, Healthcare Menus Direct, LLC Recipe: Seasoned Broccoli, dated 2024, the recipe indicated, 96 servings required only 1 tablespoon of salt seasoning. 2. During a concurrent observation of food preparation and interview on 12/10/24 at 10:48 a.m., with (DA 2) Dietary Aid 2, while making the puree salad, DA 2 put the salad in the robot coupe (food processor) then put the food in the blender. DA 2 stated she had to put the food in the robot coupe first to get enough liquid for the blender since the recipe does not call for any liquid when pureeing the salad. DA 2 stated they put salad dressing packets on the trays for the residents to use for the puree salad. During a review of the facility document titled Diet Type Report, showed there were five residents (Residents 2, 9, 63, 481, 482) on the puree diet. During a concurrent observation and interview on 12/10/24 at 12:43 p.m. with the Director of Nutritional Services (DNS) during a test tray of the regular and puree diets. Surveyors and DNS tasted the food items on the test trays. The puree salad tasted sharp and earthy and not very good. The salad dressing packet was very difficult for the DNS and surveyors to open. The puree salad tasted better with the Italian salad dressing however still not very palatable. DNS stated the recipe is without adding any liquid and the salad dressing is to be added at bedside. During an interview with CNA 1 on 12/11/24, CNA 1 stated she helps residents that are on puree diet with meals and trays. CNA 1 stated she will usually put salad dressing on the puree salads when the residents ask for it. CNA 1 stated if the trays do not have salad dressing, then she will go get some. CNA 1 stated the residents do not like the puree salads and will not eat it. During a review of the facility's document, Resident Council minutes (RCM), dated 10/28/24, the RCM's indicated, a dietary concern of, food not being good. During an interview on 12/12/24 at 10:06 a.m. with the Administrator (ADM), ADM stated he was unable to locate response forms for the last three months of resident council. ADM stated the activities director has been out on leave and resident council response forms were never completed. During an interview on 12/12/24 at 10:20 a.m. with the Registered Dietitian (RD), RD stated she is not involved in resident council and no changes in the menus or recipes have been made based on recent RCM's. RD stated, she would expect to be notified of any issues residents may have with food so menus and diets can be reviewed to determine changes. RD stated most food items in the kitchen use less salt seasoning since that is what is recommended by The American Heart Association (a nonprofit organization that aims to reduce the number of deaths and disabilities caused by cardiovascular disease). RD stated regular and therapeutic diets should be liberalized so residents can enjoy their food. RD stated she does do test trays and she relies on others to let her know if the residents do not like food items. RD does not ask kitchen staff or observe plate waste of puree salads and was not aware residents do not really eat that food item. RD stated she would discuss with the menu company about the lower sodium menu. During a review of document titled, Nutritional Breakdown of the Winter 2024-25 menus, showed for the regular diet there was 2,785 milligrams (mg) of sodium. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the Academy of Nutrition and Dietetics Nutrition Care Manual, dated 2024, showed that a reduction in sodium intake to 2000 mg to 3000 mg sodium per day has been effective in patients with heart failure. It showed a more liberalized approach to sodium intake may benefit older adults. It indicated that many institutions offer diet orders with varying degrees of sodium restriction and the most liberal sodium diet is the no-salt-packet diet and the no-added-salt (NAS) (3000 mg to 4000 mg sodium) diet limits high-sodium foods and eliminates the salt packet. It showed the low-sodium diet (1500 mg to 2300 mg sodium) restricts some high-sodium foods and replaces other higher-sodium foods with lower-sodium items. The facility regular diet provides 485 mg more than the upper range of what is considered a low sodium diet. During a review of the Position of the Academy of Nutrition and Dietetics: Individualized Nutrition Approaches for Older Adults: Long-Term Care, Post-Acute Care, and Other Settings, dated 2018, indicated the Pioneer Network's New Dining Practice Standards are supported by multiple health care organizations, including the Academy. It indicated the standards encourage liberalizing dietary restrictions that are not essential to a resident's well-being. It indicated food is an essential component of quality of life; an unpalatable or unacceptable diet can lead to poor food and fluid intake, resulting in malnutrition and related negative health effects. It indicated older adults may find restrictive diets unpalatable, resulting in reduced pleasure in eating, decreased food intake, unintentional weight loss, and malnutrition. 28773 51134

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 21) food preferences were accommodated when halal (Halal food is prepared and processed in accordance with Islamic law and dietary standards outlined in the Quran) meat was not served. This failure had the potential to place Resident 21 at risk for not meeting his nutritional status and feeling worried and anxious about his health status. Finding: During an interview on 12/10/24 at 10:21 a.m. in Resident 21's room, Resident 21 stated he was not able to consume protein in the form of meat products. Resident 21 stated, he would like to have Halal meat and the facility was not able to accommodate to his food preferences. Resident 21 stated he was worried about his protein intake. Resident 21 stated he was ordering bone broth from online store so he can get some protein. Resident 21 stated, I want to consume meat and I want the facility to help me obtain my protein from halal meat. Resident 21 stated he has spoken to the Registered Dietitian (RD) and Certified Dietary Manager (CDM) about his request for halal meat. Resident 21 stated the facility was not able to accommodate his food preferences and asked his family to bring food to him. Resident 21 stated the facility was not able to provide halal meat, so he registered as a vegetarian. During an interview on 12/11/24 on 3:02 p.m. with the CDM, the CDM stated, Resident 21 wanted particular foods. The CMD stated in the past Resident 21 requested to consume fish. The CDM stated she was able to purchase food and provide halal meat for him. The CDM stated his family used to buy halal meat for him. The CDM stated she asked the family to bring food from home. The CDM stated the facility was able to warm the food for Resident 21. The CDM stated We can't just bring meat from outside source and cook for him. The CDM stated she saw Resident weekly and he agreed to lentils and eggs. The CDM stated it was important to honor resident food preferences to prevent weight loss. During an interview on 11/11/24 at 4:35 p.m. with the Administrator (ADM) the facility should have honored resident's preferences. The ADM stated the facility purchased halal meat from a reputable store. ADM stated it was important to accommodate food preferences for cultural reasons and to prevent weight loss. During an interview on 12/13/24 at 4:23 p.m. with the Registered Dietitian (RD), the RD stated, in the past Resident 21's family brought food from home. The RD stated she notified Resident 21 regarding the importance of consuming protein. The RD stated in the past Resident 21 requested his protein in the form of halal meat. The RD stated the facility was not able to accommodate his food preferences. The RD stated it was important to honor Resident 21's food preferences so he can enjoy his meals. The RD stated resident was at risk for weight loss when food preferences were not honored. The RD stated it was important to help honor Resident 21's food preferences to prevent weight loss. The RD stated the CDM was responsible to input the food preferences for Resident 21 in the tray card and to re-assess the food preferences quarterly (three months) and as needed when Resident requested. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anberry Transitional Care	1000 West Yosemite Avenue Merced, CA 95341

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 21's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/13/24, the AR indicated Resident 21 was admitted on [DATE], with diagnoses of type 2 diabetes mellitus (a chronic condition that happens when you have persistently high blood sugar level), heart failure (a serious condition that occurs when the heart can't pump enough blood and oxygen to the body), atrial fibrillation (type of irregular heartbeat, or arrhythmia, that occurs when the upper chambers of the heart beat irregularly and often very quickly), hypertension (high blood pressure) and muscle weakness. During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/17/23 the MDS section C indicated Resident 46 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 21 was cognition intact. During a review of Resident 21's Dietary Tray Card undated the Dietary Tray Card indicated, .[line] Notes: provided Dal two bowls .[line]Dislikes: Meat (all kinds of meat). During a review of the facility's policy and procedures titled, Resident Food Preferences dated review date 4/30/17, the P&P indicated, .To enhance the resident's eating experience by providing food that they enjoy and request .b. Resident preferences are to be entered into the electronic tray care system .7. Ethnic food preferences should be taken into consideration for all resident and ethnic foods should be made available .

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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 0807

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49949

Based on observation, interview and record review, the facility failed to provide one of eight sampled residents (Resident 60) fluid consistent with resident needs and preferences when Resident 60's standing order (a written instruction from a healthcare provider that authorizes nurses, pharmacists, or other healthcare professionals to perform specific tasks or administer treatments without the need for an individual order each time) included apple juice and Resident 60's dislikes included apple juice.

This failure placed Resident 60 at risk of not having sufficient fluid intake to maintain proper hydration.

Findings:

During a concurrent observation and interview on 12/9/24 at 1:09 p.m. in Resident 60's room, a cup of apple juice was on the lunch tray. Resident 60 stated, They don't always honor my food preferences. Resident 60 stated, I don't know why I have a standing order for apple juice. Resident 60 stated, I won't drink everyday but once in a while.

During a concurrent interview and record review on 12/11/24 at 12:39 p.m. in the dining room with the Certified Dietary Manager (CDM), the CDM confirmed Resident 60 had dislike of apple juice on her dietary tray ticket (DTT-menu based on the resident's diet order, standing orders and food preferences). The CDM stated Resident 60 had standing order for apple juice. The CMD stated she should have asked Resident 60 if she liked apple juice or disliked apple juice and removed it from the DTT. The CMD stated, she was responsible to update the DTT. The CDM stated it should have been updated to reflect Resident 60's juice preferences. The CDM stated Resident 60's food preferences were not honored.

During an interview on 12/13/24 at 4:31 p.m. with the Registered Dietitian (RD), the RD stated Resident 60 was okay with drinking apple juice. The RD stated the likes and dislikes food preferences should be honored every time the food was served. The RD stated the Dietary Tray Ticket was confusing when it had a standing order for apple juice, one of her dislikes. The RD stated Resident 60 could have not meet her nutritional intake in fluids when she did not drink the apple juice. The RD stated Resident 60 was selective about her fluids and it was important for the staff to get her fluids correct. The RD stated Resident 60 could have lost weight and had a decrease in quality of life. The RD stated when staff did not input her likes and dislikes correctly, they did not honor her food preferences.

During a review of Resident 60's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/13/24, the AR indicated Resident 60 was admitted on [DATE], with diagnoses of Ogilvie syndrome (condition characterized by severe dilation of the colon without any physical obstruction), hypotension (low blood pressure), pain, constipation, signs concerning food and fluid intake, shortness of breath and muscle weakness.

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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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 60's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/6//24 the MDS section C indicated Resident 46 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 60 was cognitively intact. During a record review of the facility's policy and procedure (P&P) titled, . Resident Food Preferences dated review date 4//30/17, the P&P indicated, .To enhance the resident eating experience by providing food that they enjoy and request .b. Resident preferences to be entered into the electronic tray care system

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	555901	A. Building B. Wing	12/13/2024

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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 - 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** 51134 Based on observation, interview, and record review, the facility failed to ensure food and ice were stored, distributed, and served safely when: 1. The ice machine was observed with black spots above the water trough (a compartment within the ice machine where water is stored before it is frozen into ice cubes) and pink residue on the ice grate (a compartment within the ice machine that determines the size of the ice cubes that are produced) and sensor (monitors ice levels) 2. Apple juice pitcher located in the nourishment room refrigerator was dated past the use by date; and 3. The nourishment room refrigerator had dry, sticky substance on bottom drawers and a door shelf. These failures resulted in a unit refrigerator and facility ice machine not being in clean safe operating condition, and juice kept past the use by date, which can lead to the growth of microorganisms and can result in foodborne illness for the 84 residents consuming food, juice, and ice at the facility. Findings: 1. During a concurrent observation and interview on [DATE] at 9:19 a.m. with Maintenance (MN) in the kitchen, after removal of the ice grate cover, a black substance that was observed as dots was seen on tubing located in the water trough. MN stated he could see the black dots and they come off when cleaned. A pink substance was observed on the paper towel used to wipe the ice grate. The surveyor used a white paper towel and wiped off the pink substance from the ice grate and sensor. The MN acknowledged the observed pink substance on the paper towel and stated the ice machine should be cleaned. MN stated the last time the ice machine was cleaned was [DATE]. During an interview on [DATE] at 9:21 a.m. with MN, MN stated the ice machine is cleaned and sanitized every six months. MN stated since the ice machine is due to be cleaned, it was cleaned about six months ago. During an interview on [DATE] at 10:20 a.m. with the Registered Dietitian (RD), the RD stated the ice machine is a main area of focus for sanitation. The RD stated she will notify maintenance if the ice machine needs to be cleaned before scheduled cleaning. The RD stated the ice machine was cleaned some time in September or October but was unable to provide ice machine sanitation review logs for September or October. During a record review of, Descaling/Sanitation Procedure, (undated), the Descaling/Sanitation Procedure stated, .This 2-step procedure descales/sanitizes all components in the water flow path and is used to descale/sanitize the ice machine between biannual detailed descaling/sanitizing procedures . (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 an observation on [DATE] at 8:54 a.m. in the 300-wing nourishment room refrigerator, one pitcher of apple juice was observed with a prep date label of [DATE] and a use by date label of [DATE]. During an interview on [DATE] at 8:58 a.m. with the Infection Preventionist (IP), the IP stated the pitcher of apple juice is expired and should be discarded immediately. IP stated nursing and dietary staff are responsible for monitoring use by dates and should discard items on the day they are expired. During an interview on [DATE] at 9:03 a.m. with the Director of Nutritional Services (DNS), the DNS stated nursing and dietary staff review use by date labels daily and are responsible for removing expired food items from unit nourishment refrigerators. During an interview on [DATE] at 2:42 p.m. with the DNS, the DNS stated, At the end of the day the dietary staff will stock and refresh items in the nourishment rooms. The DNS stated, if something expires that day, then staff will leave it until it expires. During an interview on [DATE] at 3:33 p.m. with DNS, DNS stated apple juice in a pitcher should be discarded after 7 days. During a review of the facility's daily log titled, 300- Wing Nourishment Room Stocking, the log indicted expired items are to be removed daily and refrigerator is to be cleaned daily. The log did not have a current date, nursing or dietary staff signatures for the day. During a review of the facility's policy and procedure (P&P) titled, Usage and Storage of Leftovers, dated [DATE], the P&P indicated, beverages are to be labeled and dated .and discarded at the end of the day. 3. During an observation on [DATE] at 8:54 a.m. in the 300-wing nourishment room refrigerator, when opening bottom drawers inside the refrigerator, the drawers were stuck together with a hard, sticky substance. The bottom of the refrigerator had a sticky substance and on the middle shelf of the door, observed spilled apple juice and the shelf was wet. During a concurrent observation and interview on [DATE] at 9:00 a.m. with the IP in the 300-wing nourishment room refrigerator, bottom of refrigerator was sticky and unable to open bottom drawers. IP stated dietary, maintenance and housekeeping clean the nourishment room. IP stated, everyone is responsible to clean, especially if something spills. IP stated it is, very sticky in drawers and should be cleaned. During an interview on [DATE] at 9:03 a.m. with the DNS, the DNS stated, every night someone cleans and sanitizes the refrigerators. The DNS stated, If juice or something spills it will be sticky because it wasn't cleaned right away so it gets sticky. Should be cleaned right away but [refrigerators] are cleaned every evening. During a review of the facility's daily log titled, 300- Wing Nourishment Room Stocking, the log indicted expired items are to be removed daily and refrigerator is to be cleaned daily. The log did not have a current date, nursing or dietary staff signatures for the day. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	28773 51059

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48739 Based on interview, and record review, the facility failed to ensure accurate and complete medical records in accordance with professional standards of practices for one of nine sampled residents (Resident 59) when the Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) was not accurate and complete with section B (Medical Interventions) unmarked. This failure had the potential for Resident 59's decisions regarding treatment options and end of life wishes to not be honored. Findings: During a review of Resident 59's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 12/13/24, the AR indicated Resident 59 was admitted to the facility from the acute care hospital on 11/5/24 with diagnoses of heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), dysphagia (difficulty swallowing) and pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid). During a review of Resident 59's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/11/24, the MDS section C indicated Resident 59 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 59 was cognitively intact. During a concurrent interview and record review on 12/13/24 at 12:41 p.m. with the Infection Prevention Nurse (IP), Resident 59's POLST, dated 11/7/24 was reviewed. The POLST indicated Section- B Medical Interventions, which contained wishes for . Full Treatment - primary goal of prolonging life by all medically effective means . Selective Treatment - goal of treating medical conditions while avoiding burdensome measures . Comfort-Focused Treatment - primary goal of maximizing comfort . was not marked. The IP stated Resident 59's POLST was not complete. The IP stated section B should have been completed. The IP stated the POLST was important in case of an emergency, the facility would want to do what the resident wished for end-of-life care. The IP stated if staff did not do what the resident wished for end-of-life care, it could cause harm to the resident. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/13/24 at 2:28 p.m. with the Admission Nurse (AN), the AN stated a resident's POLST was important so staff would know what type of care to give a resident in an emergency. The AN stated if section B was not completed, the POLST would not be complete. The AN stated the POLST form would go with the resident if they were transferred out of the facility, so the receiving facility would know what the resident's wishes were for end-of -life care. During a review of the facility's job description document titled, Medical Records, undated, indicated, . initiate, facilitate and promote the accuracy of clinical records . ensures the quality of medical records by verifying their completeness, accuracy . create, implement and manage audit system of resident medical records to ensure accuracy and completion of documentation as ordered by the physician .

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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 48739

Based on observation, interview, and record review, two of two Licensed Vocational Nurses (LVN 4 and LVN 7) failed to implement and maintain infection control practices to provide a safe and sanitary environment to help prevent the development and transmission of infections when:

1. Licensed Vocational Nurse (LVN) 4 failed to don appropriate Personal Protective Equipment (PPE) prior to entering an isolation room.

2. LVN 7 failed to perform hand hygiene (the cleansing of hands with soap and water, antiseptic hand washes, and antiseptic hand rubs such as alcohol-based hand sanitizers) before and after administering medications.

3. LVN 7 failed to sanitize a glucometer (a device used to measure the amount of sugar in the blood, typically using a small drop of blood placed on a test strip) according to manufacturer's instructions before placing it back in the medication cart.

These failures put residents at risk of acquiring healthcare associated infections (infections that patients get while or soon after receiving health care) and blood born infections (viruses that are carried in the blood).

Findings:

1. During a concurrent observation and interview on 12/11/24 at 12:05 p.m. with LVN 4 in the 300-Wing hallway, LVN 4 was observed entering an isolation room without donning an isolation gown (a protective article used by medical personnel to avoid exposure to blood, body fluids, and other infectious [likely to spread infection] materials, or to protect patients from infection) to administer medication. LVN 4 verified the notice on the resident's door frame which indicated the appropriate PPE to don prior to entering the resident's room as: gloves, gown, and mask. LVN 4 stated the resident was in isolation due to an E. coli (a bacteria found in the gut) infection. LVN 4 stated she should have put a gown on before entering the resident's room. LVN 4 stated she could have spread the E. coli infection to other residents by not donning a gown prior to entering the resident's room.

2. During a concurrent observation and interview on 12/11/24 at 4:43 p.m. with LVN 7 in the 300-Wing hallway, LVN 7 was observed starting a nebulizer (a device that changes medication from a liquid to a mist so it can be inhaled into the lungs) on a resident in room [ROOM NUMBER]. LVN 7 was then observed pulling medications for another resident in room [ROOM NUMBER] without performing hand hygiene. LVN 7 stated she should have performed hand hygiene before and after giving medications from one resident to another. LVN 7 stated she could have spread infection if she did not perform hand hygiene.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview on 12/11/24 at 4:47 p.m. in the 300-Wing hallway, LVN 7 was observed wiping a glucometer after performing a blood glucose check and placing it back into the medication cart without letting it sit in the sanitizing solution for the appropriate dwell time (contact time). LVN 7 stated she wiped the glucometer and let it air dry for two minutes. LVN 7 stated she did not know about wrapping the glucometer in a burrito with the sanitation wipes for the two-minute dwell time. LVN 7 stated she had not been trained to perform that procedure when sanitizing the glucometer. During an interview on 12/12/24 at 3:48 p.m. with LVN 2, LVN 2 stated nurses should have been doing hand hygiene in-between residents. LVN 2 stated staff should have been doing hand hygiene before entering and exiting resident rooms. LVN 2 stated if hand hygiene was not performed, staff could transfer infection to other residents. LVN 2 stated signs were posted on resident's room doors if the resident was on isolation and what PPE was required before entering the room. LVN 2 stated the isolation signs were for anyone who entered the resident's room. LVN 2 stated donning the appropriate PPE stopped staff from getting the infection and spreading it to other residents. LVN 2 stated it did not matter how long staff was in the isolated resident's room. LVN 2 stated even if a nurse went into the isolated resident's room and gave medication, the nurse should have donned a gown. During a review of the facility's policy and procedure (P&P) titled, Isolation Precautions in Long Term Care, dated 4/30/22, indicated, . to prevent the spread of infections in the facility in order to keep residents, staff and visitor safe . the IP (Infection Preventionist) in collaboration with the physician will determine necessary isolation precautions . isolation is implemented and maintained . to prevent the spread of infection . wash hands before and after resident contact and after removing gloves . staff should wear a moisture resistant gown . During a review of the facility's P&P titled, Personal Protective Equipment, dated 4/30/22, indicated, . Personal Protective Equipment (PPE) is required for healthcare personnel who may be subject to hazardous environmental conditions that could cause injury, illness or impairment . this policy outlines the facility's actions in preventing the spread of community and healthcare associated infections . it is the policy that all employees will use the appropriate PPE when providing resident care or working in resident care areas . isolation carts are to be set up outside the resident's room with all PPE that is needed to enter the room and provide proper care . Infection Preventionist is to ensure that empolyees are properly trained on the use of PPE, donning & doffing procedures, and when to use specific types of PPE based on the exposure to hazards . gowns are also worn to prevent the transfer of infectious agents from the resident's skin, clothing, bedding and environmental surfaces to the HCP (healthcare provider) bare skin and clothing . hand hygiene should be performed following gown and glove removal . gowns should be worn when . entering a Contact Precaution room . During a review of the facility's P&P titled, Hand Hygiene, dated 4/30/22, indicated . to decrease the risk of transmission of infections between persons . hand washing/hygiene is considered the most important single procedure for preventing the spread of infections . prior and after resident care regardless of whether gloves were worn or not . (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Cleaning Point of Care Equipment (Blood Glucose Meter), dated 4/30/22, indicated, . to prevent the transmission of bloodborne pathogens by cleaning point of care equipment . it is the policy of this facility to clean all point of care equipment, including blood glucose meters, according to manufacturer's recommendations. Point of care equipment will not be used between two residents without being cleaned according to the manufacturer's recommendations . During a review of the glucometer manufacturer's manual section six titled, Caring for the Meter, undated, indicated, . the EVENCARE G3 Meter should be cleaned and disinfected between each patient . clean the meter surface with one of the approved disinfecting wipes . allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use . wipe the meter dry, or allow to air dry . During a review of the germicidal wipes manufacturer's documentation titled, Micro-Kill Bleach Germicidal Bleach Wipes technical data bulletin, dated 2023, indicated, . durable, low lint polyester cloth features a bleach solution equivalent to a 1:10 dilution of 6.5% bleach proven to kill 62 microorganisms . with a 3-minute contact time . During a review of the germicidal wipes manufacturer's documentation titled, Micro-Kill One Germicidal Alcohol Wipes technical data bulletin, undated, indicated, . is a durable polypropylene cloth that features a quaternary ammonium and alcohol solution to kill 25 microorganisms . with a 1-minute contact time .