

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
NAME OF PROVIDER OR SUPPLIER Serenethos Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 22822 Myrtle Street Hayward, CA 94541	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50474</p> <p>Based on observation, interview, and record review, the facility failed to maintain a working wall clock for one of one sampled resident (Resident 19) in her room.</p> <p>This failure placed Resident 19 at risk for confusion and disorientation.</p> <p>Findings:</p> <p>During a record review of Resident 19's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) Section C, dated 4/21/24, the record showed Resident 19's Brief Interview of Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score was 9 out of 15 indicating her cognition was moderately impaired.</p> <p>During a concurrent observation and interview on 5/6/24 at 9:47 a.m. with Resident 19, the wall clock in Resident 19's room showed the time was 6:15. Resident 19 stated she doesn't look at the clock in the room because it was not working and instead, she would look at the clock in the lobby to know what the time is. Resident 19 also stated she goes to dialysis every Monday, Wednesday, and Friday at 12:00pm.</p> <p>During a concurrent observation and interview on 5/6/24 at 12:32 p.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated the wall clock in Resident 19's room was wrong and showed the time was still 6:15. LVN 3 stated having a wrong clock inside Resident 19's room puts Resident 19 at risk for confusion of the time and day. LVN 3 stated she does not check the residents' rooms and surroundings when she makes her rounds in the morning.</p> <p>During an observation and interview on 5/8/24 at 10:51 a.m., with Resident 19, the wall clock in Resident 19's room was still not fixed and showed the time was 12:35. Resident 19 stated, It would be nice to have it fixed and have correct time instead of checking the clock in the lobby.</p> <p>During an interview on 5/8/24, at 3:31 p.m., with Director of Nursing (DON), DON stated it was important for residents to have a working clock so they can know the correct time. The DON stated having a wrong clock might get the residents confused when they see an incorrect time.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/9/24 at 2:36 p.m., with Licensed Vocational Nurse 1 (LVN 1), the clock in Resident 19's room was still observed to be wrong. LVN 1 stated the wall clock in Resident 19's room was not working and showed the time was 1:34. LVN 1 stated having a clock that is not working in a resident's room is not okay.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45875</p> <p>Based on observation, interview and record review, the facility failed to ensure two (2) of four (4) sampled residents (Resident 20 and Resident 18) received proper grooming including nailcare when:</p> <ol style="list-style-type: none"> 1. Resident 20 had long fingernails with black matter underneath 2. Resident 18 with contractures had long sharp nails digging into palms. <p>This failure placed residents at risk for getting infections from lack of proper hygiene and injuring themselves with long fingernails and compromised physical and psychosocial wellbeing.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 20's Admission Record, printed on 5/9/24, the Admission Record showed Resident 20 was admitted to the facility on [DATE]. <p>During a record review of Resident 20's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 2/20/24, Resident 20's Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) was 6 out of 15, which indicates impaired mental status. Review of section GG (Functional Abilities and Goal) indicated Resident 20 was dependent on staff for self-care including shower and personal hygiene.</p> <p>During a concurrent observation and interview on 5/6/24 at 10:52 a.m., Resident 20 was sitting outside his room in a wheelchair with long nails with black matter underneath. Resident 20 stated if someone can cut them for him, he would like that. Resident 20 also stated he likes it when his nails are kept clean.</p> <p>During an interview on 5/6/24, at 11:10 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated nails should be trimmed every week during showers. LVN 3 stated if nails are not trimmed there is a risk that a resident can scratch himself and get skin tear and the bacteria under the nails can cause infection.</p> <p>During an interview on 5/9/24, at 12:07 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 20 is needs total assistance with activities of daily living (ADLs, activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating). RN 1 also stated if nails are long and dirty infection can happen and can cause health issues.</p> <p>During a review of Resident 20's Care Plan-Self-care deficit, dated 12/3/23, the care plan indicated to assist resident 20 in ADLs including bathing /showering.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a review of Resident 18's Admission Record, printed on 5/9/24, the Admission Record showed Resident 18 was originally admitted to the facility in January 2019. The Admission record also indicated that Resident 18 has multiple medical diagnoses including cerebral infarction (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain).</p> <p>During a record review of Resident 18's MDS, dated [DATE], Resident 18's BIMS was 2 out of 15, which indicates severely impaired mental status. Review of section GG (Functional Abilities and Goal) indicated Resident 18 was dependent on staff for self-care including shower and personal hygiene.</p> <p>During an observation on 5/6/24, at 9:57 a.m., Resident 18 was observed. Resident 18 was noted to have right hand contracture and with long fingernails with black matter underneath digging into contracted palms. Resident 18 nodded with his head from left to right side indicating, no, when asked if he liked long sharp fingernails.</p> <p>During a concurrent interview and observation on 5/6/24 at 10:06 a.m. with Certified Nursing Assistant (CNA) 3, Resident 18's fingernails were observed. CNA 3 stated Resident 18 cannot cut his fingernails by himself and must be trimmed every week. CNA 3 stated nails should be kept clean and short. CNA 3 also stated Resident 18 can scratch himself and staff when holding on to staff's hands during care.</p> <p>During an interview on 5/9/24 at 12:07 p.m. with RN 1, RN 1 stated if nails are long and dirty infection can happen and can cause health issues.</p> <p>During a review of Resident 18's Care Plan-Self-care deficit, dated 7/19/22, the care plan indicated to assist resident 18 in ADLs including bathing /showering.</p> <p>During a review of the facility's undated Policy and Procedure (P&P) titled, Activities of Daily Living, Supporting, on March 2018, the P&P indicated, Policy Statement . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>26917</p> <p>Based on the observations and interviews conducted, it was concluded that the facility failed to provide pharmaceutical services to meet the needs of each resident. This conclusion was drawn due to the discovery of expired medications found in the medication storage areas. Expired medications can no longer be considered viable or safe to administer, and thus will not meet the needs of the residents who require effective and safe pharmaceutical care.</p> <p>Findings:</p> <p>During an observation on 5/7/24, several expired medications were found in the medication cart at 01:40 PM. The following expired medications were stored at room temperature and identified:</p> <p>*Insulin Lispro 100unit/ml for Resident 8 with an open date of 4/2/24</p> <p>*Novolog pen 100unit/ml for Resident 8 with an opened date of 4/3/24</p> <p>*Novolog 100unit/ml for Resident 17 with an opened date of 4/2/24</p> <p>Based on stability studies insulin that had been opened and stored at room temperature can be stored up to 30 days. The above indicated that the open date exceeded 30 days.</p> <p>During an observation on 5/7/24 at 02:05 PM, revealed that there was expired refrigerated medication in the form of a Pfizer Covid Vaccine, which had an expiration date of 5/4/24. It is important to note that administering expired vaccines may result in reduced efficacy.</p> <p>During an observation on 5/7/24 at 2:05 PM in the medication room, an inspection of the E-kit containing injectables and antibiotics revealed several expired medications. It was noted that the Emergency Drug Kit Usage report indicated the E-kit had been opened, and a medication was last used on 1/24/24. The following expired medications were found inside the E-kit:</p> <p>Atropine 1mg/ml (expired: 4/24)</p> <p>Gentamycin 80mg/2ml (expired: 12/23)</p> <p>Naloxone 0.4mg/ml (expired: 2/24)</p> <p>Hydralazine HCL 20mg/ml (expired: 3/24)</p> <p>Haloperidol 5mg/ml Vial (expired: 4/24)</p> <p>GlucaGen Hypokit (expired: 3/31/24)</p> <p>Diphenhydramine Vial (expired: 4/24)</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>45875</p> <p>Based on interview and record review the facility failed to act upon consultant pharmacist's recommendations for clarification of indication of use for trihexyphenidyl (a medicine that improves muscle control and reduces stiffness in Parkinson's disease and other conditions) for one of five sampled residents (Resident 12).</p> <p>This deficient practice resulted in Resident 12 receiving unnecessary medication without proper indication and had the potential to negatively impact the resident's well-being.</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record Report, printed on 5/9/24, the report indicated Resident 12 was admitted to the facility in March 2023.</p> <p>During a concurrent interview and record review on 5/9/24 at 12:55 p.m. with Registered Nurse (RN) 1, the Pharmacy Consultation Report for March 2024 and resident's current orders were reviewed. The Pharmacy Consultation Report, printed on 3/31/24, indicated the following comments: [Resident 12] is receiving trihexyphenidyl, since 3/3/23: for fall syndrome. The pharmacist recommendations read as: Please clarify the medical diagnosis/indication to support the use of this medication. Do update facility records [Physician order sheet, MAR and or ICD 10 code) to reflect this rationale for current use of this medication. Is this medication used for drug-induced extrapyramidal symptoms?. The recommendations have not been reviewed by physician as of 5/9/24.</p> <p>During a concurrent interview and record review with Pharmacy Consultant (PC) on 5/9/24 at 1:00 p.m., Residents 12's March 2024 Pharmacy recommendations were reviewed. PC stated they requested clarification for the use/indication for the use of trihexyphenidyl 5 mg tablet Q Day as it is being given for fall syndrome which is not the correct indication for the use of the medication. Pharmacy consultant stated facility has 30 days to act upon the recommendation from the date they received the recommendations from the pharmacy. PC also stated the lowest most effective dose for the resident should be used to minimize side effects. PC was unable to provide information on when the recommendations were sent to the facility. PC also stated she usually sends it at the end of the month or early next month.</p> <p>During a concurrent interview and record review with RN 1 on 5/9/24 at 2:22 p.m., Resident 12's Physician's Orders and Medication Administration Record were reviewed. The Physician Orders and MAR indicated Resident 12 was still receiving trihexyphenidyl 5 mg tablet Q Day at the original dose for fall syndrome. RN 1 was unable to find any documentation if facility acted upon pharmacy recommendations for Resident 12. RN 1 stated she does not think, fall syndrome is not an acceptable diagnosis for the use of the medication and wants the physician to look at it. RN 1 also stated it is important to have correct dosage, diagnosis, and correct medication otherwise it can be misleading.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's undated Policy and Procedure (P&P) titled, Medication Regimen Review and Reporting, the P&P indicated The consultant pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are communicated to those with authority and/or responsibility to implement the recommendations and responded to in an appropriate and timely fashion. 6. Resident Specific MRR recommendations and findings are documented and acted upon by the nursing care center and /or Physician 8. The consultant pharmacist and the nursing care center follows up on the recommendations to verify that appropriate action has been taken.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>26917</p> <p>Based on observations, interviews, and a review of records, it was found that the facility failed to maintain a medication error rate of less than 5%. During the medication pass, eight medication errors were observed out of twenty five opportunities for five of six residents, resulting in an error rate of 32%.</p> <p>Findings:</p> <p>A review on 5/7/24 of the facility policy titled Medication Administration General Guidelines. The policy indicates that during a medication pass, residents should be identified before administering medication using at least two distinct identifiers. These identifiers may include the resident's ID band, checking the photo attached to the medical record, or verifying the resident's ID with another nursing care center staff member. It is important to note that resident room numbers or physical locations should not be used as identifiers.</p> <p>In summary, the policy requires healthcare providers to confirm each resident's identity using two unique methods before administering medication, ensuring that the proper individuals receive their prescribed medications.</p> <p>During an observation on 5/7/24, between 8:45 AM and 9:00 AM, LVN 1 did not utilize the required minimum of two resident identifiers when administering medications to three residents (Resident 30, Resident 23, and Resident 7) during that time frame.</p> <p>To adhere to the facility's policy on medication administration, healthcare providers must identify residents using at least two distinct identifiers before administering medications. In this instance, LVN 1 did not follow the established guidelines, potentially compromising patient safety and medication accuracy.</p> <p>During an interview on 5/7/24 conducted at 11:45 PM, Licensed Vocational Nurse 1 (LVN 1) reported that her primary method of verifying a patient's identification before administering medication was relying on her memory. She added that she sometimes consults the patient's photo as a secondary measure to ensure proper identification.</p> <p>While relying on memory might work in some cases, it is not a foolproof method for patient identification, as it is prone to errors and lapses.</p> <p>A review of the nursing home facility's policy titled Medication Administration General Guidelines, it is stipulated that during medication administration, at least 4 ounces of water or an acceptable alternative liquid should be provided with oral medications. Exceptions to this standard amount may be considered if fluid restrictions apply or if product manufacturers specify different requirements.</p> <p>Adhering to these guidelines ensures that residents can comfortably and safely swallow their oral medications, promoting the effectiveness of prescribed treatments and maintaining overall resident well-being.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observed medication pass on 5/7/24 at 8:40 AM, LVN 1 administered six different oral medications to Resident 30 without offering any water. Resident 30 took the medications and attempted to swallow them but experienced difficulty after a few minutes. Resident 30 then requested water from the nurse to assist in swallowing the pills, as it was evident that he was struggling with their mouth slightly open and having trouble ingesting the medications.</p> <p>To prevent such occurrences in the future, it is crucial that healthcare providers offer water when administering oral medications, especially when multiple pills are involved. Ensuring residents can swallow their medications comfortably and safely is essential for their overall well-being and medication efficacy.</p> <p>During an interview on 5/7/24 at 11:45 AM, Licensed Vocational Nurse 1 (LVN 1) stated that she did not provide water with medications for Resident 30. However, LVN 1 acknowledged the importance of offering water to residents when administering medications, as it aids in the swallowing process and helps prevent potential discomfort or complications.</p> <p>Recognizing the significance of providing liquids with oral medications is an essential aspect of ensuring proper medication administration and promoting patient safety.</p> <p>A review on 5/7/24 of the facility's policy titled Medication Administration General Guidelines, it is stated that during the medication pass, when a nurse administers medication, the resident must be closely observed to ensure the complete ingestion of the prescribed dose.</p> <p>This policy aims to guarantee the safe and effective administration of medications by monitoring residents throughout the process. Adherence to these guidelines is crucial for preventing medication errors and promoting resident well-being.</p> <p>During an observation on 5/7/24 at 10:33 AM, LVN 1 was administering medications to a Resident 23 who appeared visibly confused and was communicating incoherently. Despite Resident 23's state of confusion, the nurse left six pills in a medication cup at the bedside and proceeded to leave the area. Subsequently, Resident 23 independently took two out of the six pills and ingested them without any supervision from the nurse.</p> <p>Given Resident 23's apparent confusion and lack of supervision during medication administration, this incident raises concerns regarding medication safety and adherence to facility protocols. To ensure resident safety and proper medication management, it is essential for healthcare providers to directly observe and assist residents throughout the entire process of taking their prescribed medications, especially when cognitive impairment or confusion is present.</p> <p>During an interview conducted at 11:45 AM, Licensed Vocational Nurse 1 (LVN 1) admitted to leaving medications at the bedside of Resident 23 and walking away. LVN 1 acknowledged that this action was not appropriate and committed to improving her practice in the future.</p> <p>It is essential for healthcare providers to maintain patient safety by closely monitoring medication administration and avoiding situations that could lead to errors or misuse.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the clinical record on 5/7/24 for Resident 23, the attending physician had prescribed acetaminophen 650 mg every six hours to be administered on an as-needed basis for mild pain. This medication is typically used for the relief of mild to moderate pain or fever. The as needed instruction indicates that the resident should receive acetaminophen only when required, rather than on a scheduled or regular basis. It's important to follow the prescribing physician's instructions for administering acetaminophen and to monitor the resident's response to the medication to ensure its effectiveness and safety.</p> <p>During an observation at 8:47 AM, Licensed Vocational Nurse 1 (LVN 1) prepared acetaminophen 650 mg for Resident 23. LVN 1 mentioned that she administers acetaminophen to Resident 23 on a routine basis. However, during the medication administration, LVN 1 did not inquire about Resident 23's pain level or any pain-related symptoms.</p> <p>During an interview at 11:30 AM with LVN 1 said that she routinely gives the acetaminophen 650 mg routinely. She said that she did not ask Resident 23 if had pain. She also said that she did not think Resident 23 had any pain. LVN 1 acknowledged that she was giving the acetaminophen routinely instead of on a as needed basis as prescribed by the physician.</p> <p>According to the manufacturer's insert for Insulin Lispro, when administering a subcutaneous injection, it is essential to hold the needle in place for a minimum of five seconds. This step ensures that the insulin is appropriately distributed into the subcutaneous tissue, allowing for optimal absorption and effectiveness. Adhering to the manufacturer's instructions, as well as those of the healthcare provider, is crucial for the safe and effective administration of Insulin Lispro and other medications.</p> <p>During an observation on 5/7/24 at 11:30 AM, Licensed Vocational Nurse 1 (LVN 1) administered two units of Insulin Lispro to Resident 4 via subcutaneous injection. However, LVN 1 immediately removed the needle from the skin after delivering the injection, instead of holding it in place for at least 5 seconds, as recommended by the manufacturer's insert and standard injection protocol.</p> <p>By failing to hold the needle in place for the recommended duration, LVN 1 may have compromised the proper distribution and absorption of the insulin dose, potentially affecting its effectiveness and the resident's blood sugar control.</p> <p>During an interview on 5/7/24 conducted at 11:45 AM, Licensed Vocational Nurse 1 (LVN 1) confirmed that she did not hold the insulin syringe in place for the recommended five seconds during the subcutaneous injection. She admitted to immediately withdrawing the needle from the resident's skin after administering the insulin.</p> <p>During an observation on 5/7/24 at 3:40 PM, LVN 2 administered nine units of Lispro insulin to Resident 8 via subcutaneous injection. However, LVN 2 immediately removed the needle from the skin after delivering the injection, instead of holding it in place for at least five seconds as recommended by the manufacturer's insert.</p> <p>During an interview conducted on 5/7/24 at 4 PM, LVN 2 acknowledged that she had forgotten to hold the needle in after injecting the Lispro insulin into Resident 8. LVN 2 stated that she was aware of the recommended practice of holding the Lispro insulin needle in Resident 8 for a few seconds after injecting insulin, but had forgotten to do so in this instance.</p>		

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NAME OF PROVIDER OR SUPPLIER Serenethos Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 22822 Myrtle Street Hayward, CA 94541	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42766</p> <p>Based on observation, interview, and facility document review, the facility failed to ensure food was stored and prepared in a safe and sanitary manner when:</p> <ol style="list-style-type: none"> 1. A trash can in the dishwashing area was left uncovered. 2. The microwave was not clean. 3. Two packs of unopened corn Tortilla and one pack of opened Tortilla with a few left in the plastic bag, had expired. 4. A half full bag of premium golden light brown sugar with no received date and still in its paper sack. 5. A half full bag of salt still in its paper sack. <p>These failures had the potential to result in contamination of food causing food borne illness for 30 residents who received food from the kitchen out of a facility census of 31.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on [DATE] at 9:20 a.m. with Registered Dietician (RD), in the dishwashing area of the kitchen close to the back door, there was an uncovered gray round trash can that was almost filled up with trash. No staff was observed in the vicinity using the trash can. RD confirmed the trash was supposed to be covered with a lid. <p>According to the FDA (Food and Drug Administration) Food Code 2022, dated [DATE], Section ,d+[DATE]. 113 indicated Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled.</p> <p>During an interview on [DATE] at 9:45 a.m. with RD, RD stated the trash can should have been covered because they don't want to attract insects and pests.</p> <ol style="list-style-type: none"> 2. During a concurrent observation and interview on [DATE] at 9:55 a.m. with RD, in the food preparation area of the kitchen, the microwave had black residue scattered inside it, on the inside walls of the microwave. Also, the interior part of the microwave door and the external control panel had a greasy residue. The microwave cover on top of the microwave was covered with a greasy residue. [NAME] 1 and RD confirmed that the microwave and the microwave cover were dirty. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the FDA Food Code 2022, dated [DATE], Section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</p> <p>3. During a concurrent observation and interview on [DATE] at 10 a.m. with RD, on the shelf in the dry goods storage room, were two unopened tortillas in plastic bags, had a received date label of [DATE]. RD confirmed they have expired, stated they were only good for one month. Also, on the shelf was one bag of opened tortillas, with opened date of [DATE]. RD confirmed that it had expired and was good only for one week.</p> <p>During an interview on [DATE] at 9:45 a.m. with RD, RD stated they don't want to have expired products because they might have spoiled and to prevent food borne illness.</p> <p>During a review of the facility's policy and procedures (P&P) titled Storage of Food and Supplies, dated 2017, the P&P indicated, All food products will be used per the times specified on the package . No food will be kept longer than the expiration date on the product.</p> <p>During a review of the facility's Dry Goods Storage Guidelines, dated 2018, the Guidelines indicated, Tortillas, corn and flour, Unopened on Shelf - 1 month; Tortillas, corn and flour, Opened on Shelf - 1 week.</p> <p>4. During an observation on [DATE] at 10:05 a.m. with RD, in the dry goods storage room, on the lower shelf, was a brown bag half full of premium golden light brown sugar still in its paper sack, with no received date and no opened date. RD stated they received date was torn off when it was opened. RD stated she does not know when they opened it. RD stated the sugar should be stored in a container.</p> <p>5. During an observation on [DATE] at 10:05 am, next to the sugar was a bag half full of salt still in its paper sack, with a received and opened date. RD stated the salt should also be in a container.</p> <p>During an interview on [DATE] at 9:45 a.m. with RD, RD stated the sugar, and the salt should be in containers with tight fitting lids to ensure they stay longer.</p> <p>During a review of the facility's P&P titled Storage of Food and Supplies, dated 2017, the P&P indicated, Dry bulk foods (flour, sugar, .spices, etc.) should be stored in seamless metal or plastic containers with tight covers, or in bins which are easily sanitized .All food will be dated - month, day, year .</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>26917</p> <p>Based on observation, interview, and document reviews it was found that the facilities' Quality Assessment Performance Improvement (QAPI) program was ineffective. Despite its purpose to proactively identify and prevent medication administration errors, it fell short. This was evident during a medication pass observation conducted during the survey, which revealed a concerning 32% medication error rate (See F759).</p> <p>Findings:</p> <p>During observations, interviews, and document reviews conducted on 5/7/24, regarding medication administration practices at a nursing home facility. The following is a summary of medication errors that were identified: The facility's policy requires healthcare providers to identify residents using at least two distinct identifiers before administering medications. However, LVN 1 did not follow this protocol for three residents, relying solely on memory for identification. Additionally, the policy mandates offering water or an acceptable liquid with oral medications, but LVN 1 failed to do so for Resident 30, leading to difficulties in swallowing the medications. Another medication error involved LVN 1 leaving medication unattended with a confused Resident 23, who then self-administered two pills without supervision, raising concerns about medication safety. LVN 1 also administered acetaminophen to Resident 23 routinely, despite it being prescribed as needed for pain relief. Both, LVN 1 and LVN 2 did not follow the manufacturer's instructions for administering insulin Lispro injections, as they did not hold the needle in place for the recommended five seconds after injection, potentially affecting proper insulin absorption and effectiveness.</p> <p>During an interview on 5/8/24 at 9:30 AM an interview was conducted with three members of the Quality Committee: the Acting Administrator, the Social Services Administrative Assistant, and the Nursing Supervisor. During this interview, it was noted that they had not identified any issues related to medication pass observations. Furthermore, they did not have any ongoing performance improvement projects specifically aimed at addressing medication errors. However, the Quality Committee members acknowledged the need for improvements in the medication administration process. They expressed concern over the survey results, which indicated a medication error rate of 32%. This statistic underscores the urgency of their commitment to enhancing the current procedures.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45875</p> <p>Based on observation, interview, and record review, the facility failed to ensure that staff followed the infection prevention and control policy and procedure (P&P) to prevent spread of infection for two of four sampled residents (Resident 30 and Resident 8) when:</p> <p>1) The nebulization mask (a medical device used to deliver medication in the form of mist, which is inhaled into the lungs) of Resident 30 was not dated or labelled and left exposed in the bedside table drawer touching other personal items and the drawer surface with brownish dusty material.</p> <p>2)The nebulization mask and CPAP mask (continuous positive airway pressure machine is used in the treatment of sleep apnea. This device delivers continuous pressurized air through tubing into a mask that is worn while sleeping) for Resident 8 was not dated or labelled and left exposed at the bedside table without protective covering, touching high touch surface area.</p> <p>These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for residents.</p> <p>Findings:</p> <p>1. During a record review of Resident 30's, Admission Record, printed on 5/9/24, the record indicated Resident 30 was originally admitted to facility in July 2023.</p> <p>During a concurrent observation and interview on 5/6/24, at 11:08 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 30's nebulization mask was observed. The nebulization mask was noted to be uncovered and left exposed in the first drawer of bedside table touching multiple other personal items including comb, toothbrush, tooth paste, spit tray, and the bottom of the drawer surface. The bottom surface of the drawer was noted with brownish dust. The mask was also noted to be undated and unlabeled. LVN 3 stated the nebulization mask should be kept covered in a plastic bag and should be dated and labeled. LVN 3 also stated bacteria can grow in the mask and the patient can inhale and get infection.</p> <p>2. During a record review of Resident 8's, Admission Record, printed on 5/9/24, the record indicated Resident 8 was originally admitted to facility in April 2024.</p> <p>During a concurrent observation and interview on 5/6/24 at 11:12 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 8's nebulization mask and CPAP mask were observed. LVN 3 stated the nebulization mask is open and uncovered in the drawer of the nightstand with other resident belongings. LVN 1 stated the CPAP mask is left exposed on top of the bedside table exposed to air. LVN 3 also stated the CPAP mask and nebulization mask should be dated and labeled and should be stored in a plastic bag after use. LVN 3 also stated bacteria can grow in the mask and the patient can inhale and get infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/7/24 at 3:51 p.m. with Infection Preventionist (IP), IP stated after use, the nebulization mask should be cleaned and stored in a zip lock bag with date and room number. IP also stated for CPAP mask, it should be kept in the CPAP machine if that feature is available in the machine or kept protected in a plastic bag after use. IP also stated since it's being used every day in the nose, there is high risk for infection, bacteria can be accumulated and is a portal for bacteria and viruses and when residents wear it on nose, they are at risk for infection.</p> <p>During a review of facility's P&P titled, Administering Medication through a small volume, revised on October 2010, the P&P indicated, Steps in procedure .29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it.30. Change equipment and tubing every seven days, or according to facility protocol.</p> <p>During a review of facility's P&P titled, Policies and Practices- Infection Control, revised on July 2014, the P&P indicated, Policy statement . This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>42766</p> <p>Based on observation, interview, and facility document review, the facility failed to maintain the dish machine in safe operating condition when the temperature did not reach 120 (degrees) Fahrenheit (F).</p> <p>This failure had the potential for food preparation and food service utensils placed in the dish machine to not become fully cleaned and sanitized before being used.</p> <p>Findings:</p> <p>During an observation on 5/7/24 at 8:50 a.m. with [NAME] 1, [NAME] 1 loaded items into the dish machine and ran the machine. The dish machine was put through the wash and rinse cycle continuously two times and the wash and rinse cycle indicated 100 F on the temperature dial. [NAME] 1 stated it was 100 F, not reaching 120 F. [NAME] 1 ran the dish machine again through the wash and rinse cycle and in the last cycle, it indicated 115 F on the dial. [NAME] 1 stated it was supposed to reach 120 F.</p> <p>During an observation on 5/8/24 at 9:40 a.m., Dietary Supervisor (DS) ran the dish machine three times. The thermometer indicated 118 F. DS stated it was should have reached a minimum of 120 F.</p> <p>During a concurrent observation and interview on 5/8/24 at 9:48 a.m. with Maintenance Supervisor (MS), MS did another run of the dish washing machine and was watching the thermometer. The thermometer indicated 118 F on the dial. MS ran the machine two more times. MS stated it was 117 F on the first run, went up to 118 F on the second run, and still 118 F showing on the temperature dial for the third run.</p> <p>During a concurrent observation and interview on 5/8/24 at 10:15 a.m. with RD, RD ran the dish machine through the wash and rinse cycles for 5 times. When writer watched the temperature gauge, it indicated it was not reaching 120 F and it reached a maximum of 118 F. RD stated the dish machine water temperature was between 116 F and 118 F.</p> <p>During a telephone interview on 5/8/24 at 10:19 a.m. with the service contractor (SC) that services the facility's dish machine, SC stated the brochure says 120 F minimum for the low temperature for the dish machine. SC stated he would send the manufacturer's instructions.</p> <p>During a review of the Dish Machine Temperature Log for May 2024, the log indicated the temperature for the wash cycle for breakfast on:</p> <p>5/1/2024 was 116 F</p> <p>5/2/2024 was 118 F</p> <p>5/3/2024 was 119 F</p> <p>5/4/2024 was 118 F</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5/5/2024 was 119 F</p> <p>5/7/2024 was 100 F and rinse cycle of 115 F</p> <p>5/8/2024 was 100 F</p> <p>During a review of the information plate attached to the front of the dish machine, the information indicated, Wash Temperature 120 F minimum and Rinse Temperature 120 F.</p> <p>During a review of the directions on the Dish Machine Temperature Log, dated 2018, which is used for documenting dish machine temperatures for May 2024, the log indicated to use manufacturer's guidelines on the machine for the range of wash and rinse temperatures.</p> <p>During a review of the facility's policy and procedures (P&P) titled Dishwashing, dated 2018, the P&P indicated, The dishwasher will run the dish machine until the temperature is within the manufacturer's recommendations . If you cannot achieve this temperature, alert the dietetic supervisor, or cook who will alert the maintenance personnel and stop washing dishes . Low-temperature machine: If you do not have the manufacturer's recommendations, use the machine at a range of 120 degrees F to 140 degrees F.</p>

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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45875</p> <p>Based on observation, interview, and record review, the facility failed to provide 80 square foot of space per resident for 8 residents who occupied 4 multi-bed bedrooms.</p> <p>This condition had the potential to result in lack of sufficient space for the provision of care both routine and emergency and for residents to have their personal belongings at bedside.</p> <p>Findings:</p> <p>During an observation on 5/7/24 at 2:00 p.m., the following rooms and corresponding square footage (sq. ft) per bed were identified:</p> <p>Room Activity Room Size Floor Area Capacity</p> <p>1 Resident room [ROOM NUMBER].17x11.17 sq.ft 158.28 sq.ft 2 beds</p> <p>5 Resident room [ROOM NUMBER].17x11.17 sq.ft 158.28 sq.ft 2 beds</p> <p>6 Resident room [ROOM NUMBER].17x11.17 sq.ft 158.28 sq.ft 2 beds</p> <p>12 Resident room [ROOM NUMBER].17x11.17 sq.ft 158.28 sq.ft 2 beds</p> <p>During random observations of care and services from 5/6/24 to 5/9/24, there was sufficient space for the provision of care for the residents in rooms 1, 5, 6, and 12. There was no heavy equipment kept in the rooms that might interfere with residents' care and each resident had adequate personal space and privacy. There were no complaints from the residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/or safety concerns in the four rooms. Granting of room size waiver recommended.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>42766</p> <p>Based on observation and interview, the facility failed to ensure an effective pest control program when flies were observed in the kitchen.</p> <p>This failure had the potential to cause food borne illness.</p> <p>Findings:</p> <p>During two observations and concurrent interviews on 5/8/24 at 11:40 a.m. and 11:52 a.m. in the kitchen, two flies were observed flying around in the dry goods storage area; two flies were observed flying around in the food preparation and the dishwashing areas, close to the back door, there was one fly on the back door screen. RD confirmed there were five flies. RD stated it was their delivery day and they left the door open for delivery of food items.</p> <p>During an interview on 5/8/24 at 12:35 pm, RD stated there was no fly trap in the kitchen.</p> <p>During review of the facility's policy an procedures (P&P) titled Pest Control, dated 2008, the P&P indicated, our facility shall maintain an effective pest control program . This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.</p> <p>According to FDA Food Code 2022, dated 1/18/2023, Section 6-202.13 indicated Insect Control Devices, Design, and Installation. Insect electrocution devices are considered supplemental to good sanitation practices in meeting the code requirement for controlling presence of flies and other insects in a food establishment.</p>