STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555914	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
We Care Skilled Nursing Facility	21863 Vallejo 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)
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** 50474 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan and meet the needs of three of three sampled residents (Resident 1, 9 and 14) when: 1. The facility did not develop a care plan to address Resident 1's peripherally inserted central catheter (PICC, a tube used to deliver medications and other treatments directly to the large central veins near the heart) care. 2. The facility did not develop a care plan to address Resident 9's weight loss of 2.4lbs (pounds) in one week due to very low food and fluid intake. 3. The facility did not develop a care plan to address Resident 14's hearing loss. These failures had the potential to result in Residents 1, 9, and 14 not receiving appropriate care, monitoring, and treatment. Findings: 1. During a record review of Resident 1's Admission Record', printed on 2/27/25, the Admission Record indicated Resident 1 was admitted to the facility in December 2024 with diagnosis of cellulitis (bacterial skin infection) of right and left lower limbs. During an observation on 02/24/25 at 10:22 a.m. with Resident 1, Resident 1 was lying in his bed and was observed to have a PICC line on his left upper arm. During an interview on 2/27/25 at 1:58 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was admitted to the facility with a PICC line on left upper arm. The DON stated Resident 1 was not on any intravenous (through the vein) therapy. The DON stated Resident 1 had history of refusals for his PICC line to be removed or the dressing to be changed since Resident 1 was admitted to the facility. The DON stated Resident 1 wanted to keep his PICC line for future use. The DON stated the last dressing change she provided for Resident 1 was back in January 2025. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	During a concurrent record review and interview on 2/28/25 at 9:29 a.m. with the Assistant Director of Nursing (ADON), Resident 1's progress notes and care plan were reviewed. The ADON stated they did not create a comprehensive care plan and there was also no Interdisciplinary Team (IDT, a team that includes staff members from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners.) meetings that addressed Resident 1's PICC line care when Resident 1 was admitted to the facility. The ADON futher stated there were also no documentations from the licensed nurses that Resident 1 been refusing the PICC line removal or PICC line dressing change. The ADON stated a care plan and IDT should have been developed because it was important to monitor Resident 1's PICC line for any complications including infection on the PICC line site. During a record review of the facility's policy and procedure (P&P), titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The interdisciplinary team in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .The comprehensive, person centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment . 2. During a record review of Resident 9' Admission Record', printed on 2/27/25, the Admission Record indicated Resident 9 was admitted to the facility in February 2025 with multiple diagnoses including urinary tract infection (an infection of the urinary tract, which includes the kidneys, ureters, bladder, and urethra) and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination. Symptoms usually begin gradually and worsen over time. As the disease progresses, people may have difficulty walking and talking. They may also have mental and behavioral changes, sleep problems, depression, memory difficulties, and fatigue.) During a record review of the Registered Dietician's (RD) Progress Notes, dated 2/18/25, the Progress Notes indicated, Resident 9 had a notable weight loss of 2.4lbs in one week likley due to very low PO (by mouth) intake. The RD's progress notes indicated Resident 9 was only consuming 0-25% of her meals and it was not enough to meet Resident 9's needs. During an interview on 2/26/25 at 11:12 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 9 needed another person to feed and encourage her during meal times because Resident 9 did not eat and drink very well. During an interview on 2/28/25 at 10:31 a.m. with the ADON, ADON stated Resident 9's weights should have been monitored upon admission and every week. ADON also stated when Resident 9 was admitted , they were aware that Resident 9 was high risk for malnutrition and weight loss due poor eating and drinking habit. ADON stated she did not know that Resident 9 had an actual weight loss of 2.4lbs in one week. ADON further stated they did not have any IDT meetings and they did not develop a care plan to address Resident 9's very low PO intake and weight loss. ADON stated they should have developed a comprehensive care plan for Resident 9 to monitor if the goals in resolving weight loss and was being met by the facility. (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 record review of the facility's P&P, titled, Weight Assessment and Intervention, dated March 2022, the P&P indicated, 1. Care planning of weight loss or impaired nutrition is multidisciplinary effort and include the physician, nursing staff, the dietician, the consultant pharmacist, and the resident or the resident's legal surrogate . 2. Individualized care plans shall address to extent possible .a. identified cause of weight loss .b. goals and benchmarks for improvement .c. time frames and parameters for monitoring and reassessment. 32717 3. During a review of Resident 14's Admission Record (AR), the AR indicated, Resident 14 was initially admitted to the facility in September 2024 with diagnoses that included muscle weakness, difficulty walking and end stage renal disease (ESRD, the final stage of long-term kidney disease when the kidneys are no longer sufficiently able to remove waste products and excess water to support the body's needs). During a review of Resident 14's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 10/20/24, the MDS indicated Resident 14 had moderate difficulty hearing (speaker has to increase volume and speak distinctly). Resident 14's most recent MDS dated [DATE] also indicated moderate difficulty hearing and a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 14. A score of 13-15 is an indication of intact cognitive status. During an interview and concurrent review of Resident 14's comprehensive care plan on 2/26/25 at 9:35 a.m. with ADON, ADON stated Resident 14 had already been hard of hearing since being admitted from an independent living facility, but the personal inventory effects did not indicate Resident 14 was admitted with hearing aids. ADON stated a comprehensive care plan was not initiated to address inability to hear especially that the MDS already indicated Resident 14 had moderate difficulty hearing. During an interview and concurrent record review on 2/26/25 at 9:44 a.m. with Social Services Director (SSD), SSD stated Resident 14 was admitted to the facility for long term stay. SSD stated Resident 14 was sent to the hospital and returned to the facility with moderate difficulty in hearing. SSD also stated having to write on a piece of paper when communicating with Resident 14. SSD stated she did not know whether Resident 14 had a hearing aid while at the independent living facility and had not followed up if Resident 14's insurance could pay for hearing aid. SSD stated Resident 14 was admitted in September 2024 with adequate hearing but after Resident 14 went to the hospital and returned in October 2024, Resident 14 had been hard of hearing. SSD stated having told the DON about the change but could not show documentation that it was discussed with Nursing Department. SSD stated the normal process was for Nursing to flush the resident's ear to make sure there were no foreign objects in the ear, inform the doctor and the resident's responsible party, and set up appointment with audiology doctor. SSD stated none of these was done for Resident 14. During an interview on 2/26/25 at 10:03 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she had to speak loudly into Resident 14's right ear during care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 2/26/25 at 10:05 a.m. with Resident 14, while in the activity room, Resident 14 stated it was bothersome that she could not have normal conversation where people did not have to be within inches from her face. Resident 14 was staring at the TV but said it was not loud enough.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on observation, interview and record review, the facility failed to ensure for one of four sampled residents (Resident 14), reviewed for communication deficit, received proper treatment to maintain hearing ability when hearing loss was not addressed by ht facility. This failure had the potential to result in the delayed access to hearing services. Findings: During a review of Resident 14's Admission Record (AR), the AR indicated Resident was initially admitted to the facility in September 2024 with diagnoses that included muscle weakness, difficulty walking and end stage renal disease (ESRD, the final stage of long-term kidney disease when the kidneys are no longer sufficiently able to remove waste products and excess water to support the body's needs). During a review of Resident 14's Minimum Data Assessment (MDS, an assessment tool used to direct resident care) dated 9/18/24, the MDS indicated Resident 14 had adequate hearing. During a review of another MDS dated [DATE], the MDS indicated Resident 14 had moderate difficulty hearing (speaker has to increase volume and speak distinctly). Resident 14's most recent MDS dated [DATE] also indicated moderate difficulty hearing and a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 14. A score of 13-15 is an indication of intact cognitive status. During an observation and concurrent interview on 2/24/25 at 11:46 a.m. with Resident 14, Resident 14 asked this writer to repeat what was said and to speak louder. Resident 14 stated not being able to hear. During a confidential group interview on 2/25/25 at 10:18 a.m., Resident 14 looked on while appearing confused when another resident spoke. Resident 14 stated not being able to hear what the other resident had said. During an interview and concurrent review of Resident 14's comprehensive care plan on 2/26/25 at 9:35 a.m. with Assistant Director of Nursing (ADON), ADON stated Resident 14 had already been hard of hearing since being admitted from an independent living facility, but the personal inventory effects did not indicate Resident 14 was admitted with hearing aids. ADON stated a comprehensive care plan was not initiated to address inability to hear especially that the MDS already indicated Resident 14 had moderate difficulty hearing. (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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 2/26/25 at 9:44 a.m. with Social Services Director (SSD), SSD stated Resident 14 was admitted to the facility for long term stay. SSD stated Resident 14 was sent to the hospital and returned to the facility with moderate difficulty in hearing. SSD stated having to write on a piece of paper when communicating with Resident 14. SSD stated she did not know whether Resident 14 had a hearing aid while at the independent living facility and had not followed up if Resident 14's insurance could pay for hearing aid. SSD stated Resident 14 was admitted in September 2024 with adequate hearing but after Resident 14 went to the hospital and returned in October 2024, Resident 14 had been hard of hearing. SSD stated having told the DON about the change but could not show documentation that it was discussed with Nursing Department. SSD stated the normal process was for Nursing to flush the resident's ear to make sure there was no foreign objects in the ear, inform the doctor and the resident's responsible party, and set up appointment with audiology doctor. SSD stated none of these was done for Resident 14. During an interview on 2/26/25 at 10:03 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she had to speak loudly into Resident 14's right ear during care. During an observation and concurrent interview on 2/26/25 at 10:05 a.m. with Resident 14, while in the activity room, Resident 14 stated it was bothersome that she could not have normal conversation where people did not have to be within inches from her face. Resident 14 was staring at the TV but said she could not hear what the lady on the screen said because the volume was not turned up.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 32717 Based on interview and record review, the facility failed to provide treatment and services to prevent urinary tract infection for one of one sampled resident (Resident 70), when staff did not follow-up on Resident 70's complaint of painful urination. This failure had the potential to result in delayed treatment. Findings: During a review of Resident 70's Admission Record (AR), the AR indicated Resident 70 was admitted to the facility in December 2024 with diagnoses that included chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), muscle weakness, and diabetes mellitus (a chronic/long-term disease in which the body cannot regulate the amount of sugar in the blood). During review of Resident 70's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 12/27/24, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 12. A score of 8-12 is an indication of moderate impairment whereas 13-15 indicates intact cognitive status. The MDS also indicated Resident 70 was frequently incontinent of urine and was dependent on staff for toileting hygiene (ability to maintain perineal [the area of the body between the anus and the vulva in females, and between the anus and the scrotum in males] hygiene, adjust clothes before and after voiding or having a bowel movement). During an interview on 2/24/25 at 11:31 a.m. with Resident 70, Resident 70 stated how it hurts so much when trying to pass urine. Resident 70 stated the staff knew about it. During an interview on 2/27/25 at 2:03 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 70's urine smelled strange and she had told Licensed Vocational Nurse (LVN) 2 about it on 2/25/25. CNA 2 also stated Resident 70 complained of painful urination. During an interview and concurrent review of the clinical record on 2/27/25 at 2:22 p.m. with LVN 2, LVN 2 stated, on 2/25/25, she sent a text message to Resident 70's Attending Physician (AP) regarding Resident 70's status. LVN 2 stated, AP ordered urine specimen collection, but Resident 70 refused the procedure. LVN 2 stated AP ordered to continue to encourage Resident 70 to agree with urine collection. LVN 2 stated there was no documentation about Resident 70's change of condition in the clinical record. LVN 2 stated the policy was for the licensed staff to complete an SBAR (Situation, Background, Assessment and Recommendation, a standardized method of communication among healthcare providers to enhance patient safety, improve clarity in critical situations and reduce errors in communication), call the physician, and initiate a care plan, to alert everybody to follow-up. LVN 2 stated she did not complete an SBAR, there was no written physician's order for urine collection and there was no care plan in the clinical record. LVN 2 stated, at the time of the interview, no follow-up had been done. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview and concurrent record review on 2/27/25 at 2:27 p.m. with Director of Nursing (DON) and Assistant Director of Nursing (ADON), both stated, for any new concern regarding a resident, an SBAR should be completed and any order related to the concern should be entered into the system so that the following shift would be able to monitor, follow-up, and in this case, continue to encourage Resident 70's compliance. During a review of the facility's policy and procedure (P&P) titled S-BAR Communication, undated, the P&P indicated the facility will use SBAR technique for all critical communications, including shift hand-offs, patient status updates, and emergency situations to ensure clear and structured communications. An SBAR is used for nurse-to-physician communication regarding a patient's change in condition, and shift to shift hand-offs.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 50474 Based on observation, interview and record review, the facility failed to monitor and assist in maintaining a sufficient food and fluid intake and for one of 20 sampled residents (Resident 9), when Resident 9 was not offered sufficient fluid intake and weight loss was not addressed to maintain proper hydration and health. This failure had the potential to result dehydration (dangerous loss of body fluid causes by illness or inadequate fluid intake) and further decline in Resident 9's health condition. Findings: During a review of Resident 9's Admission Record', printed on 2/27/25, the Admission Record indicated Resident 9 was admitted to the facility in February 2025 with multiple diagnoses including urinary tract infection (an infection of the urinary tract, which includes the kidneys, ureters, bladder, and urethra) and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination. Symptoms usually begin gradually and worsen over time. As the disease progresses, people may have difficulty walking and talking. They may also have mental and behavioral changes, sleep problems, depression, memory difficulties, and fatigue.) During a review of Resident 9's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score zero to seven is an indication of severe cognitive impact.), dated 2/7/25, the record indicated Resident 9's BIMS score was 2. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.) dated 2/7/25, the MDS assessment section GG (Functional Abilities and Goal) indicated Resident 9 needed substantial or maximal assistance (helper does more than half the effort) to maintain eating and drinking. During a review of Resident 9's Care Plan, dated 2/3/25, the care plan indicated Resident 9 was at risk for dehydration or electrolyte imbalance related to dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior). During a review of Resident 9's record of fluid intake, dated 2/13/25 to 2/25/25, the record indicated the following amount of fluid that was consumed by Resident 9: 2/13/25 230 milliliters (ml) 2/20/25 300ml 2/14/25 560ml 2/21/25 340ml 2/15/25 600ml 2/22/25 840ml 2/16/25 600ml 2/23/25 840ml (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/17/25 600ml 2/24/25 840ml 2/18/25 700ml 2/25/25 960ml 2/19/25 720ml During a record review of the Registered Dietician's (RD) Progress Notes, dated 2/18/25, the Progress Notes indicated that Resident 9 had a notable weight loss of 2.4lbs (pounds) in one week was likely due to very low food and fluid intake. The RD's progress notes indicated Resident 9 was only consuming 0-25% of her meals and it was not enough to meet Resident 9's needs. The progess notes also indicated that RD had a recommendation for Resident 9 to maintain fluid intake between 1240ml-1485ml a day. During an observation and interview on 2/24/25 at 12:34 p.m. with Resident 9, Resident 9 was being fed by Resident 9's daughter and responsible party (RP) during lunch time. RP stated Resident 9 had an order for pureed diet (foods have a soft, pudding-like consistency) and regular liquid. RP stated Resident 9 needed assistance in feeding because of her dementia. During an interview on 2/26/25 at 9:37 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 9 needed someone to directly supervise and feed Resident 9 during mealtimes. CNA 1 stated Resident 9 had to be offered fluids otherwise, Resident 9 would not have had anything to drink. CNA 1 stated Resident 1 could have had symptoms of dehydration including confusion, blurry vision, dry skin and urinary tract infection (UTI, a bacterial infection in any part of the urinary system). During an interview on 2/26/25 at 11:12 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 9 had history of low meal and fluid intake. LVN 2 stated Resident 9 needed encouragement to eat and drink. LVN 2 stated she did not know if Resident 9 was meeting enough fluid intake because she was not aware on how much hydration Resident 9 should have been receiving in a day. LVN 2 further stated there was also no order from the physician to provide a supplement or nutritional drink to Resident 9. LVN 2 stated without proper hydration and nutrition, Resident could have been fatigued and Resident 9 would have not been able to participate in her physical therapy. During a concurrent record review and interview on 2/26/25 at 12:54 p.m. with the Director of Nursing (DON), the Registered Dietician's (RD) Progress Notes, dated 2/18/24, and Resident 9's record of fluid intake, dated from 2/13/25 to 2/25/25, were reviewed. The DON stated when Resident 9 was admitted to the facility, they were already aware that Resident 9 had very low food and fluid intake because Resident 9 had altered level of consciousness on the week Resident 9 was admitted . The DON stated Resident 9 was treated with intravenous (IV, through the vein) therapy for dehydration. The DON stated she was not aware that Resident 9 had weight loss of 2.4lbs in one week and that RD had a recommendation to maintain Resident's 9 fluid intake between 1240ml-1485ml a day. The DON stated she did not read the RD's progress notes. The DON stated Resident 9's fluid intake recorded by the CNAs were also not meeting and maintaining Resident 9's hydration . The DON stated Resident 9's hydration and nutrition intake should have been maintained and monitored consistently because Resident 9's condition could have gotten worse. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/25 at 10:31 a.m. with the ADON, the ADON stated Resident 9's weights should have been monitored upon admission and every week. The ADON further stated she discontinued the order for Resident 9's weekly weights monitoring by mistake. The ADON stated Resident 9 was last weighed on 2/18/25 that had a weight loss of 2.4 lbs. The ADON stated when a weight loss was identified, the IDT should have created a plan to resolve Resident 9's weight loss. The ADON stated they also did not develop a care plan for Resident 9's weight loss even though they knew Resident 9 was high risk for malnutrition due to very low food and fluid intake. The ADON stated Resident 9 had the risk to have complications such as dehydration and electrolyte imbalances (occurs when the body's minerals were too low or hight that may cause fatigue, headache, dizziness, etc.) because hydration and weight loss were not monitored. During a record review of the facility's policy and procedure (P&P), titled, Resident Hydration and Prevention of Dehydration, dated October 2017, the P&P indicated, This facility will provide adequate hydration and to prevent and treat dehydration .Nurses' aides will provide and encourage intake of bedside snack, meals, and fluids on a daily and routine basis as part daily care .Aides will report intake of less than 1200ml/day to nursing staff . During a record review of the facility's P&P, titled, Weight Assessment and Intervention, dated March 2022, the P&P indicated, Resident weights are monitored for undesirable or unintended weight loss or gain .The physician and the multidisciplinary team identify conditions and medications that maybe causing weight loss or increasing the risk of weight loss .a. cognitive or functional decline .b. chewing or swallowing abnormalities .h. fluid and nutrient loss .

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	555914	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
We Care Skilled Nursing Facility	21863 Vallejo Street Hayward, CA 94541

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 50474 Based on observation, interview, and record review, the facility failed to ensure that one of one sampled resident (Resident 1) with peripherally inserted central catheter (PICC, a long, thin, flexible tube that is placed into a small vein in the upper arm and moved forward until it is in a larger vein near the heart) received appropriate care and services consistent with professional standards of practice and in accordance with physician orders when Resident 1's PICC line dressing was not changed and monitored for complications. These failures had the potential for Resident 1 to develop complications such as infection and dislodgement (PICC line catheter displacement). Findings: During a record review of Resident 1's Admission Record', printed on 2/27/25, the Admission Record indicated Resident 1 was admitted to the facility in December 2024 with diagnosis of cellulitis (bacterial skin infection) of right and left lower limbs. During a record review of Resident 1's Order Summary, dated 2/27/25, the order summary indicated Resident 1 had an order to change the PICC line dressing every 7 days and as needed with a start date on 12/21/24. During a record review of Resident 1's Medication Administration Record (MAR), dated 2/1/25 to 2/28/25, the MAR indicated that Resident 1's order for PICC line dressing change every 7 days was not provided by a Registered Nurse (RN). During an observation on 02/24/25 at 10:22 a.m. with Resident 1, Resident 1 was lying down in his bed and was observed to have a PICC line on his left upper arm. During an interview on 2/27/25 at 1:58 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was admitted to the facility with PICC line even though Resident 1 was not on intravenous (through the vein) therapy. The DON stated Resident 1 had refused multiple times for his PICC line to be removed. The DON stated Resident 1 did not want the PICC line removed for future use. The DON stated she was responsible in changing the PICC line dressing. The DON stated Resident 1 had also refused PICC line dressing change multiple times. The DON stated the last dressing change she provided for Resident 1 was back in January 2025. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 2/28/25 at 9:29 a.m. with the Assistant Director of Nursing (ADON), Resident 1's progress notes and care plan were reviewed. The ADON stated there were no documentations since admission that Resident 1 had been refusing to have his PICC line removed or have his PICC line dressing changed. The ADON stated there were also no records that the facility had monitored Resident 1 for complications of the PICC line. The ADON further they also did not conduct an Interdisciplinary Team (IDT, a team that includes staff members from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners) meetings that should have discussed the PICC line care for Resident 1.The ADON stated IDT meetings and care plans for PICC line care should have been developed when Resident 1 was admitted to the facility because Resident 1 was at risk for PICC line complications including infection. During a follow up interview on 2/28/25 at 9:32 a.m. with the DON, the DON stated she did not measure Resident 1's PICC line's external catheter length (helps ensure it stays in the correct position) and arm circumference (serves as a reference to determine any arm swelling should it occur due to complications from PICC placement) since Resident 1 was admitted . The DON stated she should have measured and documented Resident 1's external catheter length and arm circumference for monitoring and because it was the standards of practice. During a review of the facility's policy and procedure (P&P), titled Peripheral and Midline IV Dressing Change, dated March 2022, the P&P indicated, The purpose of this procedure is to prevent complications associated with IV therapy, including catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings .Perform site care and dressing change at establisbhed intervals or immediately if the integrity of the peripheral dressing compromised .Change the dressing if it becomes damp, loosened or visibly soiled and .at least every 7 days for TSM (Transparent Semi-Permeable Membrane dressing) .measure arm circumference and compare to baseline when clinically indicated to assess for edema and possible deep vein thrombosis . During a review of the facility's P&P, titled, Charting and Documentation, dated July 2017, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or pyschosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .Documentation of procedures and treatments will include care-specific details, including .whether the resident refused the procedure/treatment .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 32717 Based on interview and record review, for two of 15 sampled residents (Resident 3 and Resident 14), the facility failed to ensure; 1. An irregularity in Resident 14's medication regimen was identified by Consultant Pharmacist (CP) when fleet enema (laxative in the relief of occasional constipation, contains high levels of phosphates and sodium) was included in the bowel regimen despite Resident 14's constant refusal of phosphate binder. This failure had the potential to result in adverse events that included kidney injury. 2. Recommendation about Resident 3's medication regimen was not followed-through.This failure had the potential to result in increased risk of medication side effects. Findings: 1. During a review of Resident 14's Admission Record (AR), the AR indicated Resident was initially admitted to the facility in September 2024 with diagnoses that included muscle weakness, difficulty walking and end stage renal disease (ESRD, the final stage of long-term kidney disease when the kidneys are no longer sufficiently able to remove waste products and excess water to support the body's needs). During a review of Resident 14's Order Summary Report dated 2/27/25, the Order Summary Report, indicated the following physician's orders; Milk of Magnesia (also called MOM, a laxative) suspension 400 milligrams (mg) per milliliters (ml) give 30 ml by mouth as needed for constipation if no bowel movement for two days. Fleet enema 7-19 grams (GM)/118 ml (sodium phosphates) insert one application rectally as needed if MOM and Dulcolax (another laxative) is ineffective and no bowel movement in eight hours. During a review of Resident 14's Medication Administration Record (MAR) for January 2025 and February 2025, the MAR indicated an order for Sevelamer HCL (hydrochloride, a medication that binds to phosphate in the digestive tract, preventing its absorption into the bloodstream thereby reducing the phosphate level) oral tablet 800 mg two tablets by mouth three times daily with meals. The January 2025 MAR indicated Resident 14 had repeatedly refused the medication. The February 2025 MAR indicated, on 2/26/25, the medication was discontinued after Resident 14 had refused 74 out of 76 doses of the phosphate binder. During an interview on 2/26/25 at 11:07 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 14's bowel regimen for constipation was milk of magnesia, if that was not effective, to give Dulcolax suppository, and if the suppository still was not effective, to give fleet enema. LVN 1 stated it was safe to give the enema, one that has salt, sodium and phosphates because Resident 14 could just Easily flush it out anyway. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 2/26/25 at 12:38 p.m. with Assistant Director of Nursing (ADON), ADON stated the facility's bowel regimen was a standing order for all residents but should have been changed for residents that were on dialysis (a treatment for kidney failure to remove waste products and excess fluids by external filtration of blood) because these residents should not be getting milk of magnesia and fleet enema. During a telephone interview on 2/26/25 at 1:23 p.m. with Consultant Pharmacist (CP), CP stated fleet enema and milk of magnesia are not medications of choice for Resident 14 because of the increased risk for kidney injury which could be critical for residents with kidney disease, especially that Resident 14 was not getting any phosphate binder. CP stated the medications should be discontinued. CP stated this could have been an irregularity in the medication regimen that was not identified during monthly medication regimen review. During a review of the facility's policy and procedure (P&P) titled Bowel Regimen for Renal Patients, undated, the P&P indicated due to fluid restrictions, dietary limitations and medication side effects, renal patients are at an increased risk for constipation, a bowel regimen to promote regular bowel movements and prevent complications will be implemented. The pharmacologic (the treatment of disease through the application of medications) management included the first line options such as stool softeners and second-line options include lactulose. The P&P indicated to avoid magnesium and phosphate-containing laxatives such as milk of magnesia and phosphate enemas as they increase the risk of electrolyte imbalance. 2. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility in December 2023 with diagnoses that included muscle weakness, seizures, hypertension and osteoporosis, Resident 3 was on palliative care (hospice, specialized care focused on comfort, quality of life, and dignity for individuals with a terminal illness). During a review of Resident 3's Order Summary Report, the Order Summary Report indicated Resident 3 was discontinued from hospice and transitioned to custodial (long-term) care effective 11/11/24. The report also indicated an order for acetaminophen oral tablet 500 milligrams (mg) two tablets by mouth every six hours as needed for severe pain (7-10, total of 4,000 mg or 4 grams per day). During an interview and concurrent record review of Nursing Recommendations by CP on 2/26/25 at 12:29 p.m. with ADON, ADON stated Medication Regimen Review was done on 1/6/25 with recommendation to reduce daily dose of acetaminophen from 4 grams to 3 grams, which has not been communicated to the prescribing physician yet. During a telephone interview on 2/26/25 at 1:23 p.m. with CP, CP stated the facility has to be better responsive to MRR recommendations. CP stated she was still trying to catch up with recommendations that were made in the past months that have not been followed-through. During a review of the P&P titled Medication Regimen Reviews dated 2001, the P&P indicated, the consultant pharmacist provides a written report to the attending physician for each resident identified as having non-life threatening medication irregularity within 24 hours. The attending physician documents in the medical record that the irregularity has been reviewed and what action was taken to address it.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 32717 Based on interview and record review, for one of five sampled residents (Resident 71) reviewed for unnecessary medications, the facility failed to ensure Resident 71 received apixaban (anticoagulant medication that has black box warning) with adequate monitoring for adverse effects. This failure had the potential to result in undetected adverse effects from the medication. Definition: Black Box Warning (BBW) is the strongest warning that the FDA (Food and Drug Administration) requires, and signifies that medical studies indicate that the drug carries a significant risk of serious or even life-threatening adverse effects. Findings: During a review of Resident 71's Admission Record (AR), the AR indicated, Resident 71 was admitted to the facility in January 2025 with diagnoses that included heart failure and atrial fibrillation (common heart rhythm disorder where the upper chambers of the heart [atria] beat irregularly and rapidly) and difficulty walking. During a review of Resident 71's Order Summary Report dated 2/27/25, the Order Summary Report indicated an order for apixaban oral tablet 2.5 milligrams (mg) give one tablet by mouth twice daily. During an interview and concurrent review on 2/26/25 at 12:49 p.m. with Assistant Director of Nursing (ADON), Resident 71's Medication Administration Record (MAR) for January 2025 and February 2025 were reviewed. ADON stated, because apixaban is a prescription medication that comes with a BBW, it should be monitored for adverse effects such as bleeding. ADON stated the MAR indicated monitoring for adverse effects was not done. During a review of the facility's policy and procedure (P&P) titled Policy: Black Box Warning, undated, the P&P indicated patients receiving BBW medications must be closely monitored per the FDA's safety recommendation. A review of the manufacturer's insert for apixaban indicated, premature discontinuation of apixaban increase the risk of thrombotic events (such as stroke) and spinal hematoma (a localized collection of blood outside of blood vessels), patients are monitored frequently for signs and symptoms of neurological impairment, if neurological compromise is noted, urgent treatment is necessary. Other warnings and precautions include bleeding that included intracranial (hemorrhagic stroke) and gastrointestinal (upper gastroinstestinal and lower GI-rectal bleeding). [Reference: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=19a60552-374d-4b8b-a8ce-ceae252ea5ba#LINK_0c9c1e5e-b49a-4bfd-9bda-bfaae5121d81].

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 51692 Based on observation, interview and record review, the facility failed to ensure medication rate was five (5) percent or less when three medication errors were observed out of 25 opportunities (medication error rate was calculated as followed: three divided by 25 then multiplied by 100, which was equal to 12 percent) when: 1.Resident 71 did not receive snack/food with Metformin (an oral medication to control blood glucose in the blood) tablet. 2.Licensed Nurse did not instruct Resident 12 to press inner canthus (inner corner of the eye where the upper and lower eyelids meet) after administering eye drops. 3.Licensed Nurse did not check Resident 5's Vital Signs (measurements of the body's most basic functions, including heart rate, pulse, temperature, respirations) before, during, and/or after nebulizer treatment. These failures placed Resident 71, Resident 12, and Resident 5 at risk for ineffective/compromised effects of above-mentioned medications. Findings: 1. A review of Resident 71's physician order dated 1/21/25, indicated to give one tablet of Metformin HCl) 850 milligrams (mg) by mouth two times a day for Diabetes Mellitus Type II (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). During an observation on 2/25/25 at 9:48 a.m. Licensed Vocational Nurse (LVN) 1 did not provide a snack or meal with administration of Metformin 850 mg oral tablet to Resident 71. During an interview on 2/25/25 at 01:59 p.m. with LVN 1, LVN 1 stated she gave Metformin without food because breakfast was at 0730 and lunch was at 1130-1200. LVN 1 stated it was important to give snacks/food with Metformin tablets to Resident 71 because, it could upset Resident 71's stomach. A review of manufacturer's guidelines for Metformin hydrochloride; and Metformin Extended- Release tablets dated 04/2017 indicated, it should be given once daily with the evening meal. 2. During a record review of Resident 12's Physician order dated 9/3/22, indicated to administer one drop of Artificial tears solution 1% (Carboxymethylcellulose Sodium; eye drop protectant against further irritation or to relieve dryness of the eye) in both eyes two times a day for eye dryness. During an observation on 2/25/25 at 9:38 a.m. Licensed Vocational Nurse (LVN) 2 instructed Resident 12 to rapidly blink eyes after administration of Artificial tears eye drops. During an interview on 2/25/25 at 02:11 p.m. with LVN2, LVN 2 stated, I should have followed the standard nursing practice to instruct Resident 12 to slowly close eyes and press inner canthus (inner corner of the eye where the upper and lower eyelids meet) for absorption of eye medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of facility's undated Policy and Procedure (P&P) titled 'Instillation of Eye Drops' the P&P indicated instruct the resident to slowly close his/her eyelid to allow for even distribution of the drops. Instruct the resident not to blink or squeeze the eyelids shut, which forces the medication out of the eye. 3. During a record review of Resident 5's Physician order dated 3/7/24, the order indicated to administer Ipratropium-Albuterol (inhaled solution used to help control the symptoms of lung disease) Inhalation Solution 0.5-2.5 3 milligrams/3 milliliters (mg/ml) (Ipratropium-Albuterol; s) During an observation on 2/25/25 at 01:41 p.m. with LVN2, LVN 2 did not check Resident 5's vital signs (measurements of the body's most basic functions, including heart rate, pulse, temperature, respirations) before, during or after inhalation treatment. During an interview on 2/26/25 at 09:26 a.m. with LVN2, LVN 2 stated it was important to check Resident 5's vital signs routinely during treatment to see if medication was working. During a record review of facility's undated P&P titled 'Administering Medications through a Small Volume (Handheld) Nebulizer the P&P indicated, obtain baseline pulse, respiratory rate, and lung sounds . approximately five minutes after treatment begins obtain the residents pulse .obtain post-treatment pulse, respiratory rate and lung sounds .

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 50474 Based on observation, interview, and record review, the facility failed to follow the food preference and therapeutic diet as ordered by the physician for one out of 20 sampled residents (Resident 10). These failures had the potential to result in Resident 10 feeling disrespected and placed Resident 10 at risk for choking. Findings: During a review of Resident 10's Admission Record, printed 2/27/25, the record indicated Resident 10 was admitted to the facility in November 2023 with a diagnoses of low back pain and chronic obstructive pulmonary disease (COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis.) During a record review of Resident 10's undated Breakfast Meal Ticket, the meal ticket indicated Resident 10's diet was controlled carbohydrates (a diet that is designed to manage blood sugar levels) diet with mechanical soft texture (consist of soft, easily chewed and swallowed foods). The meal ticket also indicated Dislikes: Cereal, ravioli, cranberry juice, sausage . and Beverages: 2 milks. During a concurrent observation and interview on 2/26/25 at 9:25 a.m. with Resident 10, Resident 10 was having breakfast in her bed. Resident 10 was served hash browns, cream of wheat, a bowl of dry corn flakes cereal, and 2 small glasses of milk. Resident 10 stated she did not like the corn flakes because it was hard for her to chew, and she could have choked if she ate it. Resident 10 stated she was on a mechanical soft diet because her dentures could not bite and chew hard foods. Resident 10 stated she felt disregarded because her food preferences and therapeutic diet were not being followed by the facility. During an interview on 2/26/25 at 9:31 a.m. with the Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 10 notified her that she was given a bowl of dry cornflakes that she did not like to eat it. CNA 1 stated Resident 10 was also not provided a carton 1of milk for cereal CNA 1 stated the kitchen staff made a mistake and gave Resident 10 the wrong cereal. CNA 1 stated Resident 10 should have been given the correct therapeutic diet to prevent choking. During an interview on 2/26/25 at 10:33 a.m. with Dietary Manager (DM), DM stated the dry corn flakes cereal was provided to Resident 10 even though in the meal ticket indicated she was on mechanical soft diet and disliked cereal because Resident 10 had so many food preferences and it changed every now and then. DM stated the kitchen staff provided the dry corn flakes to Resident 10 because CNA 1 requested it. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 1:22 p.m. with the Director of Nursing, the DON stated the meal tickets should have been checked before serving the breakfast to Resident 10. The DON stated kitchen staff and CNA 1 should have respected and followed Resident 10's therapeutic diet and food preference. The DON stated no matter how long CNA 1 have known Resident 10; CNA 1 should have should have verified with a licensed nurse if Resident 10 was allowed to have dry corn flakes cereal to prevent issues like feeling upset and disrespected. During a record review of the facility's policy and procedure (P&P), titled, Therapeutic Diets, dated 2001, the P&P indicated, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences .Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32717 Based on observation, interview and record review, the facility failed to prepare food in accordance with professional standards of food service safety when: -Frozen meats inside the refrigerator were thawed on top of ready-to-drink fresh milk. -Multiple kitchen staff used the wrong test strip to check sanitizer concentration for the three-compartment sink and dishwasher. -Frozen chicken was thawed on the food preparation counter before cooking. -Two kitchen staff did not wear hair cover during food preparation. These failures had the potential to result in cross-contamination and food-borne illnesses. Findings: During an observation and concurrent interview on 2/24/25 at 10:22 a.m. with Dietary Manager (DM), inside the reach-in refrigerator, the following were observed: a) A pan overflowing with chicken and turkey, thawing on top of multiple gallons of fresh milk. DM stated there was not enough space in the refrigerator, so the staff had to somehow squeeze the meats in. b) DM tested the three-compartment sink sanitizer concentration by submerging two inches of the test strip in the solution and obtained a reading of 50 ppm (parts per million, unit used to describe very small concentrations of a substance in a larger solution). An instruction on how to check for quaternary (quat, a group of chemicals used in many products, including disinfectants, sanitizers, and detergents) sanitizer was posted on the wall above the three-compartment sink. DM stated the facility has stopped using quat sanitizer for a while now but forgot to remove the signage. Review of the poster titled Quat Sanitizer Testing Procedures indicated the following: sanitizer solution must be clean and between 200-400 ppm concentration, solution must be at room temperature, submerge test paper in solution and hold still for 10 seconds, and compared to chart on the test paper immediately, reading should be between 200-400 ppm concentration. c)DM stated the dishwasher sanitizer concentration was checked with Spartan pH test strip with a pH (a measure of how acidic/basic water is) of 10. During a follow-up observation and concurrent interviews with multiple kitchen staff on 2/27/25 between 9:36 a.m. and 9:50 a.m., [NAME] 2 prepared pureed turkey at the food preparation area. [NAME] 2 wore a hat that did not completely cover his hair from above the ears to the nape area. There were pieces of frozen chicken thighs submerged in clear liquid inside a plastic bowl placed on the food preparation counter. Kitchen Staff (KS) stated the frozen chicken were pulled from the freezer at 9:30 a.m. and was thawed for lunch service. (continued on next page)

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We Care Skilled Nursing Facility	21863 Vallejo 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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interviews on 2/27/25 at 9:54 a.m. with KS and [NAME] 1, KS used Spartan pH test strip by submerging the strip in a pool of rinse water in the dishwasher for three seconds. KS stated the test strip came back with a pH 9 reading. KS stated the pH level should be 102, then proceeded to write 100 under breakfast test strip for 2/25/25 in the Dish Machine Temperature Log. KS stated 100 meant 100% but unable to explain further. KS did not answer why there were missing temperature logs for 2/25/25 and 2/26/25, or why he recorded the day's sanitizer and temperature level under 2/25/25. [NAME] 1 stated 100 meant 100 ppm but failed to show how he came up with 100 ppm since the chart on the test strip only showed 1-14 pH. Both KS and [NAME] 1 stated they had only used the pH strip to check dishwasher sanitizer level. During review of the Dish Machine Temperature Log (Low Temp Machine) for February 2025, for 2/1/25 to 2/25/25, test strip readings were all 100 for breakfast, lunch and dinner. During another observation and concurrent interviews on 2/27/25 at 10:10 a.m. with KS and [NAME] 1 to check the three-compartment sink sanitizer concentration, KS stated using the Hydrion Chlorine test strip but failed to explain how it was done. [NAME] 1 stated to submerge the test strip in a bucket of the sanitizer solution for 30 seconds and compare the color of the test strip with the color chart on the box. The test strip came back white (unchanged) but [NAME] 1 stated the reading was 50 ppm. [NAME] 1 submerged another strip which turned into mottled purplish gray, which he stated was 100 ppm. During a telephone interview on 2/27/25 at 10:15 a.m. with Vendor 1, Vendor 1 stated, for the dishwasher, the pH test strip was to check the detergent concentration while the chlorine test strip would check for the sanitizer concentration. Vendor 1 also stated, for the three-compartment sink, quat sanitizer was used so a quat test strip, not the chlorine test strip, should be used by staff to check for sanitizer level. During a review of the Quaternary Ammonium Log for February 2025, that had been scratched off with multiple lines across and was replaced by Sanitizer. The instructions included to test the ammonium concentration in the quaternary sanitizer per policy using the proper strips, Ammonium reading should be at least 200 ppm or manufacturer's recommendation, crossed out with a line across and replaced with 50-100 ppm. Record reading once in the morning and once in the afternoon. The log indicated one test strip reading daily. During an observation and concurrent interview on 2/27/25 at 10:37 a.m. with DM, DM stated staff should use the chorine test strip to check sanitizer concentration for the three-compartment sink. [NAME] 2 was observed cooking the previously frozen chicken thighs that were thawing on the counter for an hour. DM stated, frozen food, when thawed as part of the cooking process, As long as it is cooked right away, it is okay. During a review of the facility's policy and procedure (P&P) titled Thawing of Meats dated 2023, the P&P indicated thawing meat can be done; in a refrigerator on the bottom shelf below prepared, ready-to-eat foods, submerge under running, potable water with a pressure sufficient to flush away loose particles, and as part of the cooking process, works well with frozen vegetables and ground meat. During an observation on 2/28/25 at 9:23 a.m., DM was at the food preparation counter preparing salads for lunch service, not wearing hair cover. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Dress Code dated 2023, the P&P indicated for kitchen staff to wear hat for short hair, the hat should completely cover the hair, or hair net when hair is over the ear or longer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51692 Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices when following was noted: 1. Seven (7) out of seven expired Intravenous Administration sets (IV kit, a medical device used to deliver nutrients and medications in a fluid form directly into patient's bloodstream) were kept in the medication storage room. 2. One (1) out of one expired Peripherally Inserted Central Catheter (PICC, a long, flexible thin tube, also known as catheter, put into a vein in upper arm for extended use) stabilizing device (a device to stabilize the wings of PICC line) were kept with ready to use medication administration supplies. This failure placed facility residents at risk for receiving medications via expired and with compromised sterility IV/ PICC line devices. Findings: During an observation and concurrent interview on [DATE] at 10:00 a.m. with Licensed Vocational Nurse (LVN 1), in facility's medication storage room, seven IV Kits with expiration date of [DATE], and one PICC line stabilizing device with expiration date of [DATE], were kept in the room along with other ready to use supplies. LVN 1 stated there were no unexpired IV kits and/or PICC line stabilizing device available at the facility. LVN 1 stated facility had one active resident in the facility at that time, who could have required above supplies. During an interview on [DATE] at 10:20 a.m. with the Director of Nursing (DON), DON stated it was important to discard expired medication administration supplies to maintain sterility. The DON stated night shift licensed nurses, and the DON were responsible to complete monthly audit to check entire medication storage room to ensure expired items were not kept. During an interview and record review on [DATE] at 10:25 a.m. with DON in medication storage room, a notice was posted in the medication room. The DON stated the notice indicated Night Shift Nurse's Responsibilities, which included change PICC Line/Central lines/IV dressing .change all tubings with date . check audit binder everyday. The DON stated, however, she was unable to find the documentation if facility was completing the medication room audits to ensure the integrity of all medication administration supplies.