STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555916	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Connor Hospital D/P Snf	2105 Forest Avenue San Jose, CA 95128

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42819 Based on observation, interview, and record review, the facility failed to provide the call light within resident's reach for one of 12 sampled residents (Resident 22). This failure had the potential to negatively affect the resident's safety and delay the care and services to the residents in the facility. Findings: During a concurrent observation and interview on 5/16/24, at 9:50 a.m., in Resident 22's room. Resident 22 was awake and sitting up in bed without the call light in reach. The call light was attached to a monitor above Resident 22's bed. Resident 22, who was alert and oriented, stated that sometimes the staff forgets to give her the call light after changing her. Resident 22 stated, I just wait for them to come back and remember it. During a concurrent observation and interview on 5/16/24, at 10:00 a.m., with Registered Nurse J (RN J), RN J entered Resident 22's room removed the call light from the monitor above the bed, and placed it in Resident 22's hand. RN J stated Certified Nursing Assistant (CNA) K had been providing care and forgot to give the call light to Resident 22 when CNA K left the room. Review of facility's policy and procedure titled, Safety: Nursing Units & Clinics, dated 8/24/22, indicated, .The call bell is kept within reach of the aged and developmentally appropriate patient .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 42819 Based on observations, interview, and record review, the facility failed to apply the right hand splint (a semi-rigid device to prevent or maintain a body part in a functional position) to one of 12 sampled residents (Resident 7) for contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) management as ordered by the physician. This failure had the potential to worsen contractures in Resident 7's right hand. Findings: During a concurrent observation and interview on 5/13/24, at 09:00 a.m. in Resident 7's room, the surveyor observed Certified Nursing Assistant (CNA) K just finishing care for Resident 7. Resident 7 was lying in bed, non-verbal, with both hands contracted. Rolled hand towels were place in both palms of Resident 7. CNA K stated she always apply hand towels to prevent contractures and that the family would put the splint on the right hand. During a concurrent interview and record review with Registered Nurse (RN) G, on 5/13/24, at 2:08 p.m., Resident 7's Physician's Order was reviewed. The Physician's Order, dated 3/6/24, indicated, Apply right soft hand splint as tolerated. OK for family to place this as well. RN G stated the CNAs should also apply Resident 7's right hand splint in the morning. During a concurrent observation and interview with RN J on 5/16/24, at 11:01 a.m., in Resident 7's room, RN J confirmed the right hand splint was not applied. RN J stated the right hand splint is used for the management of Resident 7's contracture. RN J stated the CNAs should also apply Resident 7's right hand splint and did not have to wait for family members to apply it. RN J stated that Resident 7's family members' visiting hours vary and that Resident 7's right hand splint was not being applied as ordered by the physician. Review of facility's policy and procedure titled, Nursing Care, Restorative & Supportive, reviewed 8/20, indicated, .It is also policy of this facility to provide early detection and intervention when independence declines to prevent complications and maintain the resident at their highest level of functioning.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 42819 Based on observation, interview and record review, the facility failed to ensure that proper care and treatment services for the use of oxygen (O2, colourless, odourless, tasteless gas essential to living organisms; it is not flammable but causes other materials that burn to ignite more easily and to burn far more rapidly, that a fire involving oxygen can appear explosive-like) were provided for 19 of 19 sampled residents (Residents 2, 3, 11, 6, 15, 21, 10, 22, 12, 18, 13, 20, 1, 19, 23, 16, 5, 8, and 9) as there were no Oxygen In Use signs at these 19 residents' doors. This deficient practice had the potential to harm residents receiving O2 therapy. Findings: A review of the facility document titled Sub-Acute Patient List, updated 5/1/24, indicated in the O2 column that Residents 2, 11, 6, 15, 21, 10, 22, 12, 18, 13, 20, 1, 19, 23, 16, 5, 8, and 9 were receiving O2. However, Resident 3 was indicated as being on room air (RA, without supplemental oxygen), but a portable O2 tank was observed at the head of the bed in Resident 3's room. During an observation on 5/14/24 at 12:49 p.m. with another surveyor, it was noted that there were no Oxygen In Use signs posted at the door or side walls of Residents 2, 3, 11, 6, 15, 21, 10, 22, 12, 18, 13, 20, 1, 19, 23, 16, 5, 8, and 9's rooms. During multiple observations from 5/13/24 to 5/16/24 in Resident 3's room, a portable O2 tank was observed at the head of Resident 3's bed, but there was no Oxygen In Use sign posted on the door. During an observation with a Registered Nurse (RN) J on 5/16/24 at 10:20 a.m., Resident 8 was receiving O2 at 2 liters per minute (LPM) via nasal cannula (NC, a plastic device with two protruding prongs for insertion into the nostrils, connected to an oxygen source). RN J stated that Resident 8 receives O2 as needed. During an interview with RN J on 5/16/24, the surveyor inquired about the O2 tank observed at the head of Resident 3's bed. RN J stated that the oxygen is used when Resident 3 goes out to attend activities or appointments. During an interview with Licensed Vocational Nurse (LVN) B on 5/17/24, at 2:54 pm, with another surveyor. LVN B confirmed that there were no Oxygen In Use signs posted on the doors of all residents on Oxygen therapy. LVN B further stated that the facility does not usually put O2 signs on the doors. A review of the facility's policy, titled, Oxygen Therapy, last reviewed 8/2022, indicated, .place 'Oxygen in Use' sign on door . A review of the facility's policy, titled, Safety: Nursing Units & Clinics, dated 8/24/2022, indicated, .Oxygen Cylinders are: a. stored only in safe, properly labeled rooms .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on observation, interview, and record review, the facility failed to ensure proper use of side rails (or bed rails, adjustable rigid bars attached to the side of a bed [examples include safety rails, grab bars, and assist bars]) for 23 of 23 residents (Residents 1, 14, 21, 15, 10, 13, 11, 2, 7, 3, 22, 8, 19, 5, 9, 4, 6, 12, 16, 17, 18, 20, and 23), when 1. For Residents 4 and 23, the Siderail Assessment indicated side rails were not required, though the residents were observed to have side rails. 2. The facility failed to offer/or attempt alternatives prior to the use of side rails and no documentation indicated alternatives were offered and/or attempted prior to using side rails for 23 of 23 residents with side rails (Residents 1, 14, 21, 15, 10, 13, 11, 2, 7, 3, 22, 8, 19, 5, 9, 4, 6, 12, 16, 17, 18, 20, and 23). These failures had the potential to place the residents at risk of entrapment and serious injury. Findings: 1. During an observation in Resident 4's room on 5/13/24 at 11:00 a.m., Resident 4 was lying in bed with both upper side rails in the upright position. During an observation in Resident 23's room on 5/13/24 at 11:35 a.m., Resident 23 was lying in bed with both upper side rails in the upright position. A record review of Resident 4's 'Siderail Assessment' dated 4/2/2024, indicated 8. The Resident has a medical justification for use of siderails? No; Siderail Consent Form obtained? No; Siderail x2 Order Placed? Yes The Assessment has determined the use of siderails is indication reason: Not indicated. A record review of Resident 23's Siderail assessment dated [DATE], indicated 8. The Resident has a medical justification for use of siderails? No, . The assessment has determined the use of siderails is: Not indicated. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) B on 5/16/24 at 11:15 a.m., LVN B reviewed Resident 4's Siderail assessment dated [DATE] and confirmed there was no indication to use the side rails. During a concurrent interview and record review with LVN B on 5/16/2024 at 11:17 a.m., LVN B reviewed Resident 23's Siderail assessment dated on 4/25/2024 and confirmed there was no indication to use the side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Clinical Manager (CM) on 5/20/24 at 11:04 a.m., the CM confirmed that Resident 4 and 23's Siderail Assessment did not require them to have side rails and using side rails might place the residents at risk of entrapment and serious injury. 2. During an observation on 5/13/24 at 8:45 a.m., in the resident's room, Resident 1's bed had four side rails installed with the two upper side rails in the upright position. During an observation on 5/13/24 at 8:56 a.m., in the resident's room, Resident 14's bed had four side rails installed with the two upper side rails in the upright position. During an observation on 5/13/24 at 8:55 a.m., in the resident's room, Resident 21's bed had four side rails installed with the two upper side rails in the upright position. During an observation on 5/13/24 at 8:57 a.m., in the resident's room, Resident 15's bed had four side rails installed with the two upper side rails in the upright position. During an observation on 5/13/24 at 8:59 a.m., in the resident's room, Resident 10's bed had four side rails installed with the two upper side rails in the upright position. During an observation on 5/13/24 at 9:04 a.m., in the resident's room, Resident 13's bed had four side rails installed with the two upper side rails in the upright position. During an observation on 5/13/24 at 9:32 a.m., in the resident's room, Resident 11's bed had four side rails installed with the two upper side rails in the upright position. During an observation on 5/13/24 at 12:22 p.m., in the resident's room, Resident 2's bed had four side rails installed with the two upper side rails in the upright position. During an observation on 5/13/24 at 08:45 a.m. in Resident 7's room, Resident 7 was lying in bed with both upper siderails in upright position. During an observation on 5/13/24 at 9:00 a.m. in Resident 3's room, Resident 3 had both upper siderails in upright position. During an observation on 5/13/24 at 10:40 a.m. in Resident 22's room, Resident 22 was awake, seated up in bed with both upper siderails in upright position. During an observation on 5/13/24 at 12:46 p.m. in Resident 8's room, Resident 8 was lying in bed with both upper siderails in upright position. During an observation on 5/13/24 at 12:48 p.m. in Resident 19's room, Resident 19 was lying in bed with both upper siderails in upright position. During an observation on 5/13/24 at 12:54 p.m. in Resident 5's room, Resident 5 was lying in bed with both upper siderails in upright position. During an observation on 5/13/24 at 12:56 p.m. in Resident 9's room, Resident 9 was lying in bed with both upper siderails in upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation in Resident 4's room on 5/13/24 at 11:00 a.m., Resident 4 was lying in bed with both upper side rails in the upright position. During an observation in Resident 6 's room on 5/13/24 at 11:10 a.m., Resident 6 was lying in bed with both upper side rails in the upright position. During an observation in Resident 12 's room on 5/13/24 at 11:15 a.m., Resident 12 was lying in bed with both upper side rails in the upright position. During an observation in Resident 16 's room on 5/13/24 at 11:20 a.m., Resident 16 was lying in bed with both upper side rails in the upright position. During an observation in Resident 17 's room on 5/13/24 t 11:23 a.m., Resident 17 was lying in bed with both upper side rails in the upright position. During an observation in Resident 18 's room on 5/13/24 at 11:25 a.m., Resident 18 was lying in bed with both upper side rails in the upright position. During an observation in Resident 20 's room on 5/13/24 at 11:30 a.m., Resident 20 was lying in bed with both upper side rails in the upright position. During an observation in Resident 23 's room on 5/13/24 at 11:35 a.m., Resident 23 was lying in bed with both upper side rails in the upright position. During an interview with Registered Nurse (RN) C on 5/15/2024 at 10:08 a.m., RN C confirmed that 23 residents (Residents 1, 14, 21, 15, 10, 13, 11, 2, 7, 3, 22, 8, 19, 5, 9, 4, 6, 12, 16, 17, 18, 20, and 23) were using bilateral upper-side rails and stated all the upper-side rails were installed before admission, and further stated no alternatives were provided to the residents prior to using them. During an interview review with the Director of Operations (DO) on 5/15/24 at 4:00 p.m., the DO stated that they did not offer alternatives to use before installing the siderails. During an interview with the CM on 5/20/2024 at 11:04 a.m., the CM confirmed that 23 residents (Residents 1, 14, 21, 15, 10, 13, 11, 2, 7, 3, 22, 8, 19, 5, 9, 4, 6, 12, 16, 17, 18, 20, and 23) were using bilateral upper-side rails, no alternatives were provided or attempted prior to installing the side rails and no documentation indicated that the alternatives were provided. During a review of the facility's policy and procedure (P&P) titled Side Rails, the P&P indicated To provide a resident with safety devices for medical conditions, or as a restraining devise to prevent injuries for those residents who have been assessed for the use of restraints and for whom the use of side rails has been determined to be the appropriate, least restrictive type of restraint and informed consent from the physician has been obtained for their use .upon admission to the facility, all residents will be assessed to determine if the use of side rails is justified, in accordance with the Side Rail Assessment Policy and Procedure . 48590 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor: [NAME], [NAME]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48590 Based on interview and record review, the facility failed to ensure accurate accountability of controlled medication (medication with high potential for abuse and addiction) when random controlled medication use audit for one of two residents (Resident 2) did not reconcile. The medication was signed out of the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medications) but not documented on the Medication Administration Record (MAR, used to document medications taken by each individual) to indicate they were administered to the resident. The failure resulted in inaccurate accountability and had the potential for misuse or diversion of controlled medications. Findings: The Controlled Drug Record (CDR) for two residents receiving PRN (Pro Re Nata, meaning as needed) controlled medications were requested for review during the survey. A review of Resident 2's clinical record indicated he had a Physician order for Tramadol (Ultram, a controlled medication for pain) 50 milligrams (mg, unit of measurement) 1 tablet via gastrostomy tube (G-tube, a feeding tube used to deliver nourishment, liquid, and medication into the stomach) every 8 hours as needed, dated 4/15/24, and Butalbital-Acetaminophen-Caffeine (Fioricet, used to treat tension headaches) 50-325-40 mg per tablet every 4 hours as needed via G-tube, dated 3/25/24. During a concurrent interview and record review on 5/13/24 at 1:15 p.m., with Registered Nurse (RN) G, RN G reviewed Resident 2's CDR for Tramadol and the 4/2024 MAR, which indicated the nursing staff removed this Tramadol medication from the locked controlled medication compartment in the medication cart and signed it out of the CDR on 4/28/24 at 4:00 a.m., but did not document the respective administration on the MAR. RN G acknowledged that the controlled substance medication was not accounted for in the MAR. During a concurrent interview and record review on 5/13/24 at 2:58 p.m., with RN G, RN G reviewed Resident 2's CDR for Butalbital-Acetaminophen-Caffeine and the 12/2023 MAR which indicated the nursing staff removed this medication from the locked controlled medication compartment in the medication cart and signed it out of the CDR on 12/27/23 at 6:45 a.m., but did not document the respective administration on the MAR. RN G acknowledged that the controlled substance medication was not accounted for in the MAR. During an interview on 5/16/24 at 7:38 a.m., with RN H, RN H stated that on 4/28/24 at 4:00 a.m., she removed the controlled substance (Tramadol) medication and administered it to the resident. RN H acknowledged that the administration of the controlled substance medication was not documented in the MAR. RN H stated she forgot to sign the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/24 at 7:50 a.m., with Licensed Vocational Nurse (LVN) I, LVN I stated she removed the controlled substance medication (Butalbital -Acetaminophen-Caffeine [Fiorecit]) on 12/27/23 at 6:45 a.m. and administered it to the resident. LVN I acknowledged that the administration of the controlled substance medication was not documented in the MAR. LVN I stated she takes the responsibility of forgetting to sign the MAR. During an interview on 5/17/24 at 11:01 a.m., with the Clinical Manager (CM), the CM acknowledged the the two controlled substance medications were not accounted for in the MAR. The CM stated the nursing staff should sign the MAR after the administration of the medications. During a review of the facility's policy and procedure titled, Medication Administration, revised 7/2018, indicated Medications shall be charted immediately after being administered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42819 Based on interview and record review, the facility failed to monitor side effects of anticoagulant (medicines that help prevent blood clots) medication for two of 12 sampled residents (Residents 7 and 1) reviewed. This failure had the potential to put the residents at risk for complications and adverse effects from the medication. Findings: 1. Review of Resident 7's clinical record indicated Resident 7 was admitted on [DATE] and had diagnosis of Anoxic Brain Injury (lack of oxygen to the brain). Review of Resident 7's Physician Orders, indicated Resident 7 had an order dated 8/16/19 for Rivaroxaban (Xarelto, used to treat and prevent blood clots) 20 milligrams (mg, unit of measurement), gastrostomy tube (G-tube, a tube inserted into the stomach and can be used to give medication and liquids) daily. Indication for this medication: Deep vein thrombosis (DVT, a blood clot that forms within the deep veins)/Pulmonary Embolism (PE, a blood clot that forms and travels to the lungs). Review of Resident 7's Physician Orders, dated 6/17/21, indicated, Monitor for signs and symptoms of bleeding every shift and notify prescriber if resident experiences: dark/discolored urine, black tarry stools, nose bleeds, vomiting and/or coughing up blood. Monitor signs and symptoms of thrombocytopenia every shift and notify prescriber if resident experiences any of the following: unexpected bruising, bleeding from the nose or gums, black or bloody bowel movements, red or pink colored urine, bloody vomit and/or severe headache. Review of Resident 7's Medication Administration Record (MAR) for month of May 2024, indicated that while there was monitoring for the anticoagulant Xarelto, there was no documentation initialed by the nursing staff to confirm that this monitoring was performed every shift. During a concurrent interview and record review with Registered Nurse (RN) C on 5/16/24, at 11:10 a.m., RN C was made aware of the concern. RN C confirmed that there was no adequate evidence in the MAR that anticoagualant monitoring for side-effects was performed every shift. 48590 2. Review of Resident 1's clinical record indicated he was admitted on [DATE] and had the diagnosis of atrial fibrillation (irregular heartbeat). Review of Resident 1's Physician Medication Orders, indicated Resident 1 had an order dated 4/29/24 for Apixaban (Eliquis, an anticoagulant medication used to treat and prevent blood clots and to prevent stroke) 5 mg 1 tablet by mouth twice daily. During a review of the Consultant Pharmacist's Medication Regimen Review, dated 1/31/23, indicated recommendations were made to monitor Resident 1 for signs/symptoms of bleeding/bruising and monitor for signs/symptoms of thromboembolism (blood clot in the blood vessel). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/16/24 at 11:00 a.m., with Registered Nurse (RN) C, RN C acknowledged that the monitoring of side effects was not documented in the Medication Administration Record (MAR, used to document medications or treatments). RN C stated the monitoring was not being done. During a concurrent interview and record review on 5/17/24 at 11:01 a.m., with the Clinical Manager (CM), the CM verified that the monitoring of side effects was not done. During a review of the facility's policy and procedure titled, Medication Regimen Review and Reporting, dated 1/24, indicated Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48590 Based on observation, interview, and record review, the facility had a medication error rate of 8% when two medication errors occurred out of 25 opportunities during the medication administration for two of eight residents (Residents 14 and 12). The failure resulted in medications not given as per accepted professional standards of practice and had the potential for residents not receiving the full therapeutic effects of medications which may negatively affect the residents' health. Findings: During a concurrent observation and interview on 5/14/24 at 12:49 p.m., at Resident 14's bedside, Licensed Vocational Nurse (LVN) A administered Genteal Tears (artificial tear to treat dry eyes or irritation) 0.1-0.3-0. 2% ophthalmic solution 2 drops on both eyes to Resident 14. LVN A did not wait between administering the same eye drop medication. LVN A stated he did not wait one minute in between drops. During a review of the facility's policy and procedure titled, Medication Administration Eye Drops, dated 01/23, indicated If another drop of the same or different medication is prescribed for administration in the same eye at the same time, wait 3 to 5 minutes for optimal absorption. During a concurrent observation and interview on 5/16/24 at 8:34 a.m., at Resident 12's bedside, LVN B did not flush with water the gastrostomy tube (G-tube, a feeding tube used to provide nutrition to people who cannot obtain nutrition by mouth, unable to swallow safely, or need nutritional supplementation) before the administration of medications. LVN B stated he should flush first before giving the medications. During an interview on 5/16/24 at 10:03 a.m., with Registered Nurse (RN) C, RN C stated flush the G-tube with 15 milliliters (ml, unit of measurement) of water before giving the medications. During an interview on 5/16/24 at 4:24 p.m., with RN D, RN D stated the G-tube needed to be flushed before and after medications. During an interview on 5/17/24 at 11:01 a.m., with the Clinical Manager (CM), CM stated flush the feeding tube before starting the medications. During a review of the facility's policy and procedure titled, Medication Administration Through a Feeding Tube, dated 7/18, indicated 10. Insert syringe and flush resident's feeding tube with 50 cc water (use warm water as needed to adequately flush the tube ensuring patency). 11. Administer medications via gentle instillation or gravity via syringe into the resident's feeding tube .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555916	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Connor Hospital D/P Snf	2105 Forest Avenue San Jose, CA 95128

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48590 Based on observation, interview, and record review, the facility failed to implement infection control and prevention practices when: 1. Licensed vocational nurse (LVN) E did not remove gloves, sanitize (to reduce or remove pathogenic agents) hands and put on new gloves after touching and removing the electrical fan on top of the bedside table before administering the medications using the gastrostomy tube (G-tube, a feeding tube used to deliver nourishment, liquid, and medication into the stomach) for Resident 11. 2. Licensed vocational nurse (LVN) F did not remove gloves, sanitize (to reduce or remove pathogenic agents) hands and put on new gloves after moving the bedside table to the side of the bed before administering the medications using the gastrostomy tube for Resident 9. These failures had the potential to compromise the health and well-being of the residents in the facility. Findings: During a concurrent observation and interview on 5/14/24 at 8:41 a.m., with LVN E, in the Resident 11's room, LVN E donned personal protective equipment (PPE, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses, includes gloves and gown). LVN E removed the electrical fan that was on top of the resident's bedside table. LVN E then placed her medication tray on the bedside table and without changing her gloves & doing hand hygiene (HH, reducing or inhibiting growth of microorganism by applying an alcohol-based hand rub to surface of hands or hand washing with soap and wate) proceeded to check the placement, residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding), and patency (state of the tube being open or unblocked) of the G-tube. After checking the G-tube was patent, LVN E then proceeded to administer the medications using the G-tube. LVN E stated he should have changed the gloves and perform hand hygiene after touching the fan and before giving the medications. During a concurrent observation and interview on 5/14/24 at 12:37 p.m., with LVN F, in the Resident 9's room, LVN F donned personal protective equipment (PPE, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses, includes gloves and gown). LVN F placed the medication tray on top of the bedside table and moved the table to the side of the bed. Without changing her gloves and doing HH, LVN F then checked the placement, residual, and patency of the G-tube. After checking that the G-tube was patent, LVN F then proceeded to administer the medications using the G-tube. LVN F stated she should have changed gloves and sanitize hands before giving the medications. During an interview on 5/17/24 at 11:01 a.m., with the Clinical Manager (CM), the CM stated the nurses should have changed the gloves after touching the bedside table and removing the fan on top of the bedside table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Infection Control Hand Hygiene, revised 6/18, indicated 2. Hand sanitization with an alcohol-based product .in the following circumstances: d. after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. 3. Gloves are not a substitute for handwashing or hand sanitizing.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48590 Based on interview and record review, the facility failed to ensure one of five residents (Residents 19) were offered and/or received pneumococcal (common bacteria that can affect different parts of the body) vaccinations. This failure increased the potential for residents to have inadequate immunity to pneumococcal infections (also known as pneumonia, an infection of one or both lungs). Findings: During a concurrent interview and record review on 5/15/2024 at 11:04 a.m., the Minimum Data Set Coordinator (MDS) reviewed Resident 19's admission and immunization records. MDS confirmed Resident 19 was admitted on [DATE] and that he had a history of getting the pneumococcal polysaccharide vaccine (PPSV23, a vaccine that can prevent pneumococcal disease) on 2/11/2011 and pneumococcal pneumonia vaccine (PCV 13, a vaccine that protects against 13 types of pneumococcal bacteria that cause common pneumococcal infections) on 11/24/2014. MDS stated she did not give the pneumococcal conjugate vaccine 20 (PCV20, one of the three pneumococcal conjugate that helps protect against bacteria that cause pneumococcal disease) to Resident 19 when she reviewed Resident 19's immunization record. Review of Resident 19's Immunization Consent Authorization Form, dated 12/13/23, indicated Resident 19's responsible party (grandchild) authorized the facility to administer the pneumococcal vaccine. Review of the facility's policy and procedure titled, Standardized Procedure for Adult Pneumococcal Vaccine Screening and Administration in the Acute Care Setting, indicated Use the vaccine history and algorithm to determine if the patient is eligible for a PCV-20 or PPSV-23 . During a review of CDC's recommendations titled, Pneumococcal Vaccine Timing for Adults, dated 3/15/2023, indicated, For adults [AGE] years or older who have received PCV13 at any age and PPSV23 at or after age [AGE] years, CDC recommends you give 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 46001 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the facility is free from flies and spiders. These failures could potentially lead to the transmission of diseases carried by pests to residents, their family members, staff and visitors who come to the activity room. Findings: On 5/14/24 at 9:00 a.m. and 4:40 p.m., a fly was observed in the activity room. On 5/17/24 at 8:30 a.m. and 2:24 p.m., a fly was observed in the activity room. During an observation with Licensed Vocational Nurse (LVN) B on 5/16/2024 at 9:45 a.m., LVN B caught a spider crawling on a tablet keyboard in the activity room. During a concurrent observation and interview with the Deputy Director(DD) on 5/17/2024 at 2:24 p.m., the DD confirmed that a fly was in the activity room and called the pest control service company. The DD stated that flies and spiders were not supposed to be in the activity room. During an interview with LVN B on 5/17/2024 at 2:54 p.m., LVN B confirmed that he caught a spider crawling on a tablet keyboard on 5/16/2024 in the activity room and stated that flies and spiders were not supposed to be in the activity room. During an interview with the Clinical Manager (CM) on 5/20/24 at 11:16 a.m., the CM stated that flies and spiders were not supposed to be in the activity room because they could spread germs and place residents and family members at risk for infection.