STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555923	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temecula Healthcare Center	44280 Campanula Way Temecula, CA 92592

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309 Based on observation, interview, and record review, the facility failed to accommodate the needs for one of three sampled residents (Resident 275), when the call light button was observed on the floor and not within reach. This failure had the potential for Resident 275 not to be able to call staff for assistance which could result in needs of the resident not being met as well as a delay in the provision of care. Findings: Resident 275's record was reviewed. Resident 275 was admitted to the facility on [DATE], with diagnoses which included right below knee amputation (removal of leg). A review of Resident 275's Minimum Data Set (an assessment tool), dated April 9, 2025, indicated, Resident 275 had a Brief Interview of Mental Status (BIMS - a tool to assess cognitive function of an individual) score of 12 (moderate cognitive impairment). A review of Resident 275's Care Plan, initiated on April 2, 2025, indicated, .ADL (Activities of Daily Living) Self-Care Performance Deficit .Encourage the use of call light for assistance - Ensure call light is within reach . On April 13, 2025, at 3:54 p.m., during an observation and concurrent interview with Resident 275, the resident's call light button was on the floor and not within reach. Resident 275 stated, he could not reached it and needed the call light to be closer in order to call the nurse. On April 13, 2025, at 3:57 p.m., an observation in Resident 275's room and concurrent interview were conducted Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 275's call light was on the floor and not within reach. LVN 1 further stated, the call light should not be on the floor and should be within the resident's reach to ensure the resident could call for assistance as needed and have their needs met. On April 13, 2025, at 4:10 p.m., an interview was conducted with Director of Staff Development (DSD). The DSD stated Resident 275's call light should not have been on the floor and should have been within reach. The DSD stated without the call light, he would not be able to get assistance in an emergency and his needs would not be met. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 14, 2025, at 9:25 a.m., an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated it is the facility's practice to ensure resident's call lights are kept within reach. ADON 1 stated the Resident 275's call light should have been within reach and not on the floor. ADON 1 further stated not having the call light within reach could delay the resident's care and result in unmet needs. A review of the facility's policy and procedure titled Answering the Call Light, revised September 2022, indicated .The purpose of this procedure is to ensure timely responses to the resident's request and needs . ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44270 Based on interview and record review, the facility failed to ensure, 11 of 14 residents reviewed for Advance Directive (AD - written statement of a person's wishes regarding medical treatment) (Residents 13, 17, 19, 70, 78, 84, 90, 97, 319, 320, and 322) a copy of the AD was available and the resident or their resident representative (RP) had been provided follow up information regarding the formulation of an AD. These failures had the potential to result in the ADs for Residents 13, 17, 19, 70, 78, 84, 90, 97, 319, 320, and 322 not being readily accessible to staff and physicians, which could lead to the residents' wishes regarding medical treatment being unknown and ultimately not honored. Findings: 1. On April 14, 2025, at 3:58 p.m., an interview was conducted with Resident 70. Resident 70 stated that he was unsure of having an AD and unsure if asked if he would like to formulate one. Resident 70's record was reviewed. Resident 70 was admitted to the facility on [DATE]. A review of the Advance Directive Acknowledgment form, dated March 19, 2025, indicated, .I have not executed any advance directives . A review of Resident 70's Physician Orders for Life-Sustaining Treatment (POLST), dated March 19, 2025, did not indicate Resident 70 had an AD. A review of Resident 70's Minimum Data Set (MDS - an assessment tool), dated March 26, 2025, indicated Resident 70 had Brief Interview of Mental Status (BIMS - a tool to assess cognitive function of an individual) score of 15 (intact cognitive response). A review of the Resident Care Conference dated March 20, 2025, indicated, .Advance Directive/POLST/code status order .(check marked). There was no documented evidence the resident or (RP) was provided information about the right to formulate an AD. On April 17, 2025, at 9:40 a.m., a concurrent interview and record review was conducted with the Social Service Director (SSD) 1. Resident 70's Care Conference dated March 20, 2025, was reviewed with the SSD 1. SSD 1 stated, upon admission, residents in the facility are provided an acknowledgement form indicating whether they have an AD. SSD 1 stated, if a resident has an AD, they would request a copy for facility records; if not, the resident is provided with education on how to create one. SSD 1 further stated a review of the AD should be conducted during the resident care conference. SSD 1 stated that there was no documentation showing Resident 70 or the RP was informed of the right to formulate an AD. SSD 1 stated, it should have been documented and followed up during the resident care conference. SSD 1 stated without an AD on file there was a risk the facility may not be able to honor the resident's care. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On April 14, 2025, at 4:00 p.m., an interview was conducted with Resident 90. Resident 90 stated that he was unsure of having an AD and unsure if asked if he would like to formulate one and would like to know more about it. Resident 90's record was reviewed. Resident 90 was admitted to the facility on [DATE]. A review of the Advance Directive Acknowledgment form, dated November 27, 2024, indicated, .I have not executed any Advance Directives . A review of Resident 90's POLST, dated October 10, 2024, indicated, .No advance Directive . A review of Resident 90's the MDS, dated [DATE], indicated Resident 90 had a BIMS score of 15. A review of the Resident Care Conference dated November 28, 2024, indicated, .Advance Directive/POLST/code status order .(check marked). There was no documented evidence the resident or (RP) was provided follow up information about the right to formulate an AD. On April 17, 2025, at 9:43 a.m., a concurrent interview and record review was conducted with SSD 1. Resident 90's care conference dated November 28, 2024, was reviewed SSD 1. SSD 1 stated that there was no documentation showing Resident 90's or the RP were informed about their right to formulate an AD and that it should have been documented and followed up during the resident care conference. 3. On April 14, 2025, at 3:50 p.m., an interview was conducted with Resident 97. Resident 97 stated that she was unsure of having an AD and unsure if asked if she would like to formulate one. Resident 97's record was reviewed. Resident 97 was admitted to the facility on [DATE]. A review of the Advance Directive Acknowledgment form, dated March 19, 2025, indicated, .I have not executed any advance directives . A review of Resident 97's POLST, dated March 13, 2025, did not indicate Resident 97 had an AD. A review of Resident 97's MDS, dated [DATE], indicated Resident 97 had BIMS score of 11 (moderate cognitive impairment). A review of the Resident Care Conference dated March 13, 2025, indicated, .Advance Directive/POLST/code status order .(check marked). There was no documented evidence the resident or (RP) was provided follow up information about the right to formulate an AD. On April 17, 2025, at 9:54 a.m., a concurrent interview and record review was conducted with SSD 1. Resident 97's care conference dated March 13, 2025, was reviewed with SSD 1. SSD 1 stated that there was no documentation indicated Resident 97 or the RP were informed about their right to formulate an AD and that it should have been documented and followed up during the resident care conference. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 17, 2025 at 10 a.m., during a concurrent interview and record review of Resident 13's Care Conference dated March 19, 2025, with Social Service Director (SSD) 1, SSD 1 stated upon admission, residents in the facility are provided an acknowledgement form indicating whether they have an AD. SSD 1 stated if a resident had an AD they would request for a copy to have available in the facility or will provide them with education on how to formulate one. SSD 1 further stated a review of the AD should be conducted during the resident care conference. SSD 1 stated that there was no documentation showing Resident 13 or the representative parties were informed about their right to formulate an AD and should have been documented and followed up during the resident care conference. SSD 1 stated if there was no AD on file there was a potential for the facility to not be able to honor their wishes for care. 6. During an interview on April 15, 2025 at 4:30 p.m. with Resident 320, Resident 320 stated she does not have an AD and would like to have one. Resident 320 stated she was unsure if it was offered and if it was followed up. A review of Resident 320's Admission Record indicated Resident 320 was admitted [DATE]. A review of Resident 320's POLST, dated April 4, 2025, did not indicate Resident 320 had an AD. A review of Resident 320's MDS, dated [DATE], indicated Resident 320 had a BIMS score of 14 - (intact cognitive response). There was no documented evidence the resident or (RP) were provided follow up information or education about the right to formulate an AD. A review of the Advance Directive Acknowledgment form, dated April 4, 2025, indicated, .I have not executed any advance directives . A review of the Resident Care Conference dated April 5, 2025, indicated, .Advance Directive/POLST/code status order .(check marked). On April 17, 2025 at 10:03 a.m., during a concurrent interview and record review of Resident 320's Care Conference dated April 5, 2025, with Social Service Director (SSD) 1, SSD 1 stated that there was no documentation showing Resident 320 or the representative parties were informed about their right to formulate an AD and should have been documented and followed up during the resident care conference. 7. During an interview on April 15, 2025 at 3:55 p.m. with Resident 322, Resident 322 stated he did not have an AD and was not interested at this time. Resident 322 stated he could not remember if it was offered. A review of Resident 322's Admission Record indicated Resident 322 was admitted [DATE]. A review of Resident 322's POLST, dated January 25, 2025, indicated Resident 322 did not have an AD. A review of Resident 322's MDS, dated [DATE], indicated Resident 322 had a BIMS score of 10 - (moderately impaired cognitive response). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence the resident or (RP) were provided follow up information or education about the right to formulate an AD. A review of the Advance Directive Acknowledgment form, dated January 25, 2025, indicated, .I have not executed any advance directives . A review of the Resident Care Conference dated January 27, 2025, indicated, .Advance Directive/POLST/code status order .(check marked). On April 17, 2025 at 10:06 a.m., during a concurrent interview and record review of Resident 322's Care Conference, dated January 27, 2025, with Social Service Director (SSD) 1, SSD 1 stated that there was no documentation showing Resident 322 or the representative parties were informed about their right to formulate an AD and that it should have been documented and followed up during the resident care conference. SSD 1 stated if there was no AD on file there was a potential for the facility to not be able to honor their wishes for care. 8. During an interview on April 15, 2025 at 4:35 p.m. with Resident 319, Resident 319 stated she did not have an AD but was interested and was unsure if the facility followed up with her. A review of Resident 319's Admission Record indicated Resident 319 was admitted [DATE]. A review of Resident 319's POLST, dated April 9, 2025, did not indicate Resident 319 had an AD. There was no documented evidence the resident or (RP) were provided follow up information or education about the right to formulate an AD. A review of the Advance Directive Acknowledgment form, dated April 9, 2025, indicated, .I have not executed any advance directives . A review of the Resident Care Conference dated April 10, 2025, indicated, .Advance Directive/POLST/code status order .(check marked). On April 17, 2025 at 10:10 a.m., during a concurrent interview and record review of Resident 319's Care Conference, dated April 10, 2025, with the Social Service Director (SSD) 1, SSD 1 stated that there was no documentation showing Resident 319 or the representative parties were informed about their right to formulate an AD and that it should have been documented and followed up during the resident care conference. SSD 1 stated if there was no AD on file there was a potential for the facility to not be able to honor their wishes for care. 9. During an interview on April 16, 2025 with Resident 19, Resident 19 stated he did not have an AD but is interested in formulating one and was unsure if the facility followed up. A review of Resident 19's Admission Record indicated Resident 19 was admitted on [DATE]. A review of Resident 19's POLST, dated February 13, 2025, did not indicate Resident 19 had an AD. A review of Resident 19's MDS, dated [DATE], indicated Resident 19 had a BIMS score of 11 - (moderately impaired cognitive response). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence the resident or (RP) were provided follow up information or education about the right to formulate an AD. A review of the Advance Directive Acknowledgment form, dated April 3, 2024, indicated, .I have not executed any advance directives . A review of the Resident Care Conference dated March 18, 2025, indicated, .Advance Directive/POLST/code status order .(check marked). On April 17, 2025 at 10:14 a.m., during a concurrent interview and record review of Resident 19's Care Conference, dated March 18, 2025, with the Social Service Director (SSD) 1, SSD 1 stated that there was no documentation showing Resident 19 or the representative parties were informed about their right to formulate an AD and that it should have been documented and followed up during the resident care conference. SSD 1 stated if there was no AD on file there was a potential for the facility to not be able to honor their wishes for care. 10. During an interview on April 14, 2025 at 12:45 p.m. with Resident 17, Resident 17 stated she did not have an AD but would like to have one and was unsure if it was offered or followed up. A review of Resident 17's Admission Record indicated Resident 17 was admitted on [DATE]. A review of Resident 17's POLST, dated January 17, 2025, did not indicate Resident 17 had an AD. A review of Resident 17's MDS, dated [DATE], indicated Resident 17 had a BIMS score of 15 - (intact cognitive response). There was no documented evidence the resident or (RP) were provided follow up information or education about the right to formulate an AD. A review of the Advance Directive Acknowledgment form, dated January 17, 2025, indicated, .I have not executed any advance directives . A review of the Resident Care Conference dated April 10, 2025, indicated, .Advance Directive/POLST/code status order .(check marked). On April 17, 2025 at 10:16 a.m., during a concurrent interview and record review of Resident 17's Care Conference dated April 10, 2025, with the Social Service Director (SSD) 1, SSD 1 stated that there was no documentation showing Resident 17 or the representative parties were informed about their right to formulate an AD and that it should have been documented and followed up during the resident care conference. SSD 1 stated if there was no AD on file there was a potential for the facility to not be able to honor their wishes for care. 50309 11. On April 15, 2025, at 10:36 a.m. an interview was conducted with Resident 78. Resident 78 stated initially he did not execute an AD but would like to complete one now. Resident 78 further stated, he could not recall being asked about it again and would like more information. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 78's Admission Record indicated Resident 78 was admitted to the facility on [DATE]. A review of Resident 78's Physician Orders for Life-Sustaining Treatment (POLST), dated February 6, 2025, indicated resident did not have an AD. A review of Resident 78's MDS dated [DATE], indicated Resident 78 had a BIMS score of 15 (cognitively intact). A review of the Advance Directive Acknowledgment form, dated August 1, 2024, indicated, .I have not executed any advance directives . A review of the Resident Care Conference dated March 27, 2025, indicated, .Advance Directive/POLST/Code Status Order (check marked) . There was no documented evidence Resident 78 or RP were provided follow up information or education about the right to formulate an AD. On April 17, 2025, at 10:22 a.m. a concurrent interview and record review of Resident 78's Care Conference was conducted with the Social Service Director (SSD) 1. SSD 1 stated residents in the facility are provided an acknowledgement form upon admission and if they had an AD, they would request a copy to be available in the facility. SSD 1 stated if they did not have one, they would provide a handout with information and provide education on how to formulate one. SSD 1 further stated during a resident's Care Conference, which was done quarterly, a follow up with the resident or RP about AD would be conducted. She stated there was no documentation which indicated Resident 78 and/or RP were provided follow up information during the care conference. The SSD stated if there was no AD on file there was a potential for the facility to not be able to honor their wishes for care. A review of the facility's policy and procedure titled, Advance Directives, revised September 2022, indicated, . the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment .advance directives are honored in accordance with state law and facility policy .Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his legal representative, about the existence of any written advance directives .The resident or representative is provided with written information concerning the right to refuse .and to formulate an advance directive if he or she chooses to do so .If the resident does not have an advanced directive .the facility staff will offer assistance in establishing advance directive .staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance .Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retreivable by any staff .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038 Based on interview and record review the facility failed to ensure one of three residents reviewed for accidents (Resident 40) was free from exposure to chemical hazards when a housekeeper (HK) left a toilet bowl cleaning solution within the resident's reach. This failure had the potential for Resident 40 to be exposed to chemical poisoning or chemical burn if the substance was ingested or mistakenly taken. Findings: On April 16, 2025, at 12:57 p.m., during an interview with Resident 40's Family Member (FM), she stated, on April 15, 2025, at 11 a.m., she found a white cup containing a pink solution with a brush inside, placed on the bedside table near Resident 40's drinking cup. The FM stated, the nurse told her that the brush was a toilet brush and the pink solution was a toilet cleaner. A review of Resident 40's Admission record, indicated, Resident 40 was admitted to the facility on [DATE], with diagnoses which included dementia (forgetfulness). A review of Resident 40's History and Physical Examination dated February 6, 2025, indicated, Resident 40 can not make medical decisions . On April 16, 2025, at 1:12 p.m., during an interview with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she found the toilet cleaning solution near Resident 40's water bottle. LVN 2 stated, there was a potential risk the resident could have accidentally ingested the cleaning solution, which could have caused poisoning. She further stated, this situation was unsanitary, and the cleaning solution should not have been near the resident. LVN 2 stated, it should have been properly secured away from Resident 40's room. On April 16, 2025, at 2:57 p.m., during an interview with Housekeeping Supervisor (HS), the HS stated, residents should not have access to chemical cleaning agents. The HS stated, housekeeping staff are expected to secure all cleaning solutions safely and away from resident areas. On April 17, 2025, at 10:31 a.m., during an interview with the Housekeeper (HK), she stated, she left the cleaning solution inside Resident 40's room. The HS stated, there was a potential for Resident 40 to access the cleaning solution and be harmed. The HK further stated, she should have stored the cleaning solution in the proper storage area before leaving the room. A review of the facility policy and procedure titled, Storage Area-Environmental Service, dated July 1, 2020, indicated .cleaning supplies .maintained in safe manner .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44270 Based on observation, interview, and record review, the facility failed to follow the policy and procedures for oxygen use for two of two sampled residents (Resident 17 and 70) when: 1. Resident 70 was observed receiving continuous oxygen at an incorrect flow rate, without proper documentation or assessment; and 2. Resident 17 had an unlabeled nasal cannula (oxygen tubing - a device that delivers oxygen). These failures had the potential to result in unnecessary or unsafe oxygen administration and increased risk of infection for Residents 17 and 70. Findings: 1. On April 14, 2025, at 2:21 p.m., a concurrent observation and interview was conducted for Resident 70. Resident 70 was alert, oriented and able to verbalize his needs. Resident 70 was observed with oxygen on at six liters per minute (a unit of measure) via nasal cannula. Resident 70 stated he had been on oxygen since the early morning. On April 14, 2025, Resident 70's record was reviewed. Resident 70 was admitted to the facility on [DATE], with diagnosis which included Chronic Obstructive Pulmonary Disease (COPD -a lung disease that makes it difficult to breathe). A review of Resident 70's physicians order dated April 1, 2025, indicated, .Oxygen: at 2-4 L/Min (liters per minute) via NC (nasal cannula) PRN (as needed) to keep O2 sats (oxygen saturation) greater then 90% as needed . A review of Resident 70's Care Plan initiated on March 19, 2025, indicated, .resident has a medical diagnosis of COPD .Goal .the resident will display optimal breathing patterns daily .Approaches .administer oxygen therapy as ordered by physician . On April 14, 2025, at 2:44 p.m., during a concurrent interview and record review, Licensed Vocational Nurse (LVN) 3 stated, Resident 70's oxygen was set at six liters. LVN 3 stated, Resident 70 should not be on six liters. LVN 3 stated, the resident's oxygen use that early morning had not been assessed or documented, and the nurses had not reported the higher oxygen level. LVN 3 stated she should have checked on Resident 3. On April 15, 2025, at 3:51 p.m., during an interview with Registered Nurse Supervisor (RN) 1, RN 1 stated she was not informed that Resident 70 had shortness of breath or any change in condition. RN 1 stated, if there is a physician's order for oxygen, the correct amount should be monitored and maintained. RN 1 stated, staff should report any changes in a resident's condition. RN 1 stated, giving more oxygen than ordered could lead to adverse effects, such as over-oxygenation. (continued on next page)

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	555923	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temecula Healthcare Center	44280 Campanula Way Temecula, CA 92592

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 17, 2025, at 9:20 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated, all nurses are responsible for proper resident assessments, which included monitoring of vitals signs, identifying changes in condition, and following physicians orders. The DON stated, if a resident is not in respiratory distress and has a as needed oxygen order, nurses must follow the physician's specified rate and frequency. The DON stated, Resident 70 should not have been on six liters of oxygen and should have been receiving oxygen at the rate between two and four liters as needed. The DON further stated, providing too much oxygen could worsen the resident's breathing. A review of the facility policy and procedure titled, Oxygen Administration, dated 2001, indicated, .Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following .signs or symptoms of oxygen toxicity .tracheal irritation, difficulty breathing, or slow, shallow rate of breathing .adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered .observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated .documentation .the rate of oxygen flow, route, and rationale .the frequency and duration of the treatment . 51063 2. During an observation on April 13, 2025 at 9:45 a.m., Resident 17 was observed in bed using oxygen via nasal cannula at two liters per minute. The nasal cannula tubing was unlabeled. On April 13, 2025 at 9:45 a.m. during a concurrent observation and interview with RN Supervisor (RN) 2, RN 2 acknowledged and stated Resident 17's nasal cannula tubing was not labeled with the date and it should have been. RN 2 further stated there is a risk of infection if oxygen tubing was unlabeled. A review of Resident 17's Admission Record indicated Resident 17 was admitted [DATE], with the diagnoses which included acute respiratory failure (a sudden condition when there is not enough oxygen or too much carbon dioxide in the body) and pleural effusion (collection of fluid around the lungs). A review of the Physician Orders dated January 18, 2025, the orders indicated, .Oxygen: Change Oxygen tubing to include NC and/or Mask and Storage Bag every week and prn .every night shift every Sun. During an interview on April 16, 2025 at 10:05 a.m. with the Assistant Director of Nursing (ADON 1), ADON 1 stated staff are expected to label all oxygen tubing with the date to prevent infection. The ADON 1 stated the tubing must be changed every Sunday on the night shift and as needed. A review of the facility's policy and procedure titled, Oxygen Administration, dated October 2010, indicated, . Oxygen tubing and humidifier (if in use) will be changed and labeled every 7 days and as needed.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 36038 Based on observation, interview, and record review, the facility failed to ensure the dietary staff were adequately trained to carry out duties in a sanitary and safe manner when one dietary staff did not follow the manufacturer's instructions for the testing of Quaternary (Quaternary ammonium compounds [quats]are a group of chemicals used for disinfectants) sanitizer. This failure had the potential to result in inaccurate readings of the sanitizing solution, which could lead to cross-contamination. Findings: On April 15, 2025, at 10:23 a.m., during an observation of a Dietary Aide (DA) testing the sanitizing solution in the three-compartment sink, the DA was observed dipping the Quat strip into the sanitizing solution for four seconds before comparing the strip to the color comparator chart. A review of the Directions for use Quat-10 Testing Paper indicated .Dip paper for 10 seconds then compare to colors on test strip package . During a concurrent interview with the DA, he stated he should have waited for 10 seconds before comparing the test strip to the color chart. The DA stated, failing to follow the correct procedure could result in inaccurate readings, leading to ineffective sanitization, and increasing the risk for food borne illness (stomach illness acquired from ingesting contaminated food) as well as compromised cleanliness of kitchen surfaces and utensils. On April 15, 2025, at 1:30 p.m., during an interview with Registered Dietician (RD) 1, the RD 1 stated the DA should have followed the manufacturer's instructions when testing the sanitizing solution. A review of the facility policy and procedure titled, Policy & Procedure Manual Resource-Sanitation of Dishes/Manual Washing - Quaternary Ammonium Compound Solutions - Concentration as indicated by manufacturer .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices when: 1. One sandwich snack was observed to be expired; 2. One dispensing scoop was left inside the container and not stored outside or on top of the mashed potato powder; 3. The kitchen door located near the garbage container area was left open for 20 minutes; and 4. Three garbage containers did not have covers. These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) among a vulnerable population of 112 out of 115 residents who received food prepared in the facility's kitchen. Findings: 1. On [DATE], at 9:20 a.m., during an initial kitchen observation, with the Assistant Dietary Supervisor (ADS), one peanut butter and jelly sandwich was found in the snacks refrigerator with a label that read Expired on [DATE], readily available. During a concurrent interview with the ADS, the ADS stated the sandwich was prepared on [DATE], and should have been discarded on [DATE]. The ADS stated, the sandwich should not have been found in the refrigerator. The ADS further stated, if the sandwich had been served to a resident, it could have caused illness. On [DATE], at 1:25 p.m., during an interview with the Registered Dietician (RD) 1, the RD 1 stated the sandwich was past its expiration date, should have been discarded, and was not safe to serve to residents. A review of the facility policy and procedure titled, Food Safety Product Labeling and Dating Guide, dated [DATE], indicated, .clearly marked with use by date (day or date product must be discarded) . 2. On [DATE], at 9:27 a.m., a dispensing scoop was observed stored inside a container, in direct contact with mashed potato powder. During a concurrent interview with the ADS , the ADS stated the scoop should not be in contact with the powder and should be stored in its designated place. On [DATE], at 1:25 p.m., during an interview with Registered Dietician (RD) 1, RD 1 stated a dispensing scoop should be hanging and not touching the product, to prevent cross-contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the professional reference U.S. FDA (Food and Drug Administration) Food Code 2022, Section , d+[DATE].12 In-Use Utensils, Between-Use Storage. indicated, .During pauses in FOOD preparation or dispensing. FOOD preparation and dispensing UTENSILS shall be stored: .in the food with their handles above the top of the food . 3. On [DATE], at 9:47 a.m., the kitchen door leading to the garbage area was observed to be open. During a concurrent interview with the ADS, he stated, the door was propped open for approximately 20 minutes. The ADS stated, the door should not have been left open due to risk of insects and dust entering the kitchen, which could lead to cross-contamination. A review of the professional reference U.S. FDA Food Code 2022, Section ,d+[DATE].14 Outer Openings, Protected. indicated, .The outer openings of a FOOD ESTABLISHMENT shall be protected against the entry of insects and rodents by Solid, Self-closing, tight fitting doors . 4. On [DATE], at 9:51 a.m., three large dumpsters were observed without a tight fitting covers. During a concurrent interview with the ADS, the ADS stated the dumpsters should be covered to prevent insects and rodents infestation. A review of the facility policy titled, .Dispose of Garbage and Refuse, dated [DATE], indicated .Garbage and refuse containers are maintained in good condition .and waste is properly contained in dumpsters .with lids covered .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 50309 Based on interview and record review, the facility failed to effectively utilize its Quality Assessment and Performance Improvement (QAPI) program to address an ongoing issue involving missing covers on all three dumpsters. This failure resulted in the facility to not implement timely preventative measures and increased potential risk of cross-contamination. Findings: A review of facility document titled Food & Nutrition Services: Daily Supervisor Rounds Checklist, dated March 2, 2025, to April 17, 2025, indicated that the task Trash Lids closed and clean . was not checked off on any day. On April 17, 2025, at 8:37 a.m., during a concurrent interview and record review with the Administrator (ADM), the ADM stated, one of the current QAPI projects was replacing the covers for the three dumpster bins. The ADM stated, they have not been able to check off the task because the dumpster bins remained uncovered. The ADM stated, the facility made multiple attempts to contact the waste management company to replace or repair the bins, but appointments were repeatedly canceled. The ADM stated, while they considered temporary measures such as placing metal mesh over the openings, no interim solutions were implemented. The ADM stated, they should have taken action to prevent animal access and potential contamination while awaiting a resolution. The facility's policy and procedure titled, Quality Assurance and Performance Improvement (APIA) Plan, revised April 16, 2021, indicated, .This facility shall develop, implement and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) Plan designed to monitor and evaluate the quality of resident care, pursue methods to improve quality of care and resolve identified problems .

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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. 51063 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when a licensed nurse did not clean and disinfect a shared blood pressure (BP-pressure of blood in blood vessels) cuff according to the manufacturer's recommended contact time (the required duration the equipment must remain wet with the disinfectant to effectively kill microorganisms [germs]). This failure had the potential to expose vulnerable residents to cross-contamination and increase the risk of infections. Findings: On April 15, 2025 at 9:30 a.m., during a medication pass observation, LVN 3 was observed wiping a shared manual blood pressure cuff with a (brand name) disposable wipe after removing it from Resident 223's right upper arm. LVN 3 was not observed leaving the blood pressure cuff surface visibly wet for at least one minute. LVN 3 stated, she should have allowed the cuff to air dry for three minutes. LVN 3 reviewed the manufacturer's instructions and stated the required contact time was one minute. On April 15, 2025 at 10:31 a.m., during an interview with the Infection Preventionist (IP), the IP stated the facility's expectation was for nursing staff to clean shared resident equipment, such as blood pressure cuffs and stethoscopes, before and after each use. The IP stated nursing staff should read and follow the manufacturer's instructions printed on the (brand name) disposable wipe container to ensure the item remains wet for the full recommended contact time. The IP stated, following these instructions is critical to prevent the spread of organisms and infections. On April 17, 2025 at 9:10 a.m., during an interview with Assistant Director of Nursing (ADON) 2, ADON 2 stated the expectation was for nursing staff to disinfect shared resident equipment according to the (brand name) disposable wipe manufacturer's instructions. The ADON 2 stated nursing staff should have followed the manufacturer's instructions to ensure the effectiveness of the product and prevent cross contamination and infection. A review of the facility's policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated March 2021, the P&P indicated, .reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions. A review of the manufacturer's instructions for contact time for the (brand name) disposable wipes provided by the facility, the manufacturer's instructions indicated, .Contact time .Allow surface to remain wet for 1 full minute .