STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555932	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Heights Health Center	161 S. Reeder Ave Covina, CA 91724

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on interview and record review the facility failed to identify a potential chemical restraint for one of one resident (Resident 204) by having a physician order that indicated to give Ativan (used commonly as a sedative and to relieve anxiety) if Resident 204 attempted to get out of bed unassisted. This deficiency had the potential to restrict Resident 204's movement for staff convenience or discipline. Findings: During a review of Resident 204's Detailed Summary, (DS) undated, the DS indicated Resident 204 was admitted to the facility on [DATE] with multiple diagnoses including generalized muscle weakness (lack of physical or muscle strength) and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). During a review of Resident 204's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated, indicated Resident 204 had moderately impaired cognition (ability to think and reason) and was dependent (helper does all the effort) on staff for bathing and toileting. The MDS also indicated Resident 204 was always incontinent of bowel and bladder. During a concurrent interview and record review on 9/13/2024 at 10:03 AM with the Director of Nursing (DON), Resident 204's Physician's Orders (PO), dated as of 9/12/2024, was reviewed. The PO indicated, May give Ativan if resident tries to get up unassisted, with start date 9/9/2024. The DON stated Resident 204 was a high fall risk and the order indicated to give the medication if resident tried to get out of bed unassisted. The DON further stated the order served to restrict Resident 204's movement and did not indicate a diagnosis or symptom that the medication could relieve. The DON stated the order as written was a chemical restraint and was not an appropriate order for Resident 204 because staff need to find the reason why Resident 204 wants to get out of bed instead of restricting movement. (continued on next page)

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

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Identifying Involuntary Seclusion and Unauthorized Restraint, dated 4/2021, the P&P indicated, Chemical restraint is defined as any drug that is used for discipline or staff convenience and not required to treat medical symptoms. The P&P also indicated residents are free from the use of chemical restraints not required to treat their medical condition. The P&P indicated the risk of falling is not considered a medical symptom or self-injurious behavior that warrants the use of restraints.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40913 Based on observation, interview, and record review, the facility failed to develop a comprehensive plan of care for one of two sampled residents (Resident 153) with a limited Range of Motion (ROM - the degree of movement a joint can make). This deficient practice had the potential for a decline in ROM for Resident 153. Findings: During a review of Resident 153's Face Sheet (FS), the FS indicated the facility admitted Resident 153 on 5/2/2024 with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks). During a review of Resident 153's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 5/8/2024, the MDS indicated the resident rarely/never expressed ideas and wants and rarely/never understood verbal content. The MDS indicated Resident 153 was dependent with all Activities of Daily Living (ADL). The MDS indicated Resident 153 had functional limitation to ROM to both lower extremities. During a concurrent observation and interview on 9/12/2024 at 9 AM, Physical Therapy 1 (PT 1) removed the knee splint (type of brace that supports and stabilizes the knee joint) from Resident 153's knees. During an observation on 9/12/2024 at 10:26 AM, PT 1 assessed Resident 153's joint mobility. Resident 1's both knees would only extend up to 90 degrees, the knees would not extend straight. During a concurrent record review and interview with the facility's Director of Nursing (DON) on 9/12/2024 at 1:04 PM, Resident 153's MDS was reviewed. The DON stated Resident 153 had impaired ROM to bilateral (both) lower extremities. The DON stated there was no care plan developed for Resident 153's impaired ROM. The DON stated if there was a care plan developed for impaired ROM for Resident 153, the interventions to Resident 153 would have included ROM exercises by the RNA after the Physical Therapy (PT) and Occupational Therapy (OT) screening, monitoring the resident for pain, exercise tolerance, skin integrity, and decline in ROM. The DON stated the interventions would help prevent further decline in Resident 153's ROM. The DON stated there was no documented PT/OT evaluation upon Resident 153's admission. The DON stated PT evaluation was completed on 9/11/2024 and ROM exercises for Resident 153 was started on 9/11/2024. During an interview on 9/12/2024 at 1:50 PM, Certified Nursing Assistant 4 (CNA 4) stated Resident 153 had stiffness on both legs since admission. CNA 4 stated PT 1 started training CNAs (in general) on ROM exercises for Resident 153 yesterday (9/11/2024). CNA 4 stated Resident 153 did not receive ROM exercises since admission, until 9/11/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a 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 resident's physical, psychosocial and functional needs is developed and implemented for each resident. During a review of the facility's P&P titled Resident Mobility and Range of Motion dated July 2017, the P&P indicated the care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts.

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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. 40913 During an observation, interview, and record review, the facility failed to provide services to prevent a further decrease in range of motion (ROM, full movement potential of a joint) that included performing an assessment of joint mobility for one of two sampled residents (Resident 153) as a baseline for monitoring decline or improvement in ROM for Resident 153 as indicated in the facility's Policy and Procedure (P&P) titled Resident Mobility and Range of Motion. This deficient practice had the potential to result in a decline to Resident 153's ROM. Findings: During a review of Resident 153's Face Sheet (FS, admission record), the FS indicated the facility admitted Resident 153 on 5/2/2024, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning,) Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks.) During a review of Resident 153's Minimum data Set (MDS - a standardized assessment and care planning tool) dated 5/8/2024, the MDS indicated Resident 153 rarely/never expressed ideas or wants and rarely/never understood verbal content. The MDS indicated Resident 153 was dependent with all activities of daily living (ADL, term used in healthcare that refers to self-care activities). The MDS indicated Resident 153 had functional limitations to range of motion on both lower extremities. During a concurrent observation and interview on 9/12/2024 at 9 AM, Physical Therapist 1 (PT 1) removed Resident 153's knee splints. During a concurrent record review and interview on 9/12/2024 9:07 AM with PT 1. Resident 153's Joint Mobility Screening dated 8/2/2024 for PT and Occupational Therapy (OT, profession aimed to increase or maintain a person's capability of participating in everyday life activities) dated 8/7/2024 were reviewed. The screenings indicated 26-50% loss of ROM to bilateral (both) knees. PT 1 stated 26-50% loss meant the knees could only extend a maximum of 90 degrees; the knees could not extend straight. Resident 153's PT Evaluation & Plan of Treatment dated 9/11/2024 were reviewed. PT 1 stated there was a gap between the Joint Mobility Screening to when the PT evaluation was done because Resident 153 was under hospice care and the facility was communicating with the hospice agency to get the order for therapy and , It took hospice a while. PT 1 stated the order for PT evaluation was ordered on 9/6/2024. During an observation and concurrent interview on 9/12/2024 at 10:26 AM, with PT 1, PT 1 assessed Resident 153's joint mobility, both knees extended up to 90 degrees, the knees could not extend straight. PT 1 stated, a 90-degree extension caused Resident 153 discomfort. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 9/12/2024 at 1:04 PM, with the DON, Resident 153's chart (medical record) was reviewed. The DON stated the DON could not find the assessment for joint mobility. The DON stated the facility needed to have an assessment for joint mobility upon admission to have a baseline on joint mobility and be able to monitor any decline or improvement in joint mobility. The DON stated Resident 153 was admitted under hospice care and the facility did not ask the hospice agency to provide their own rehabilitation to perform Resident 153's joint mobility assessment. The DON stated there was no documented evidence the facility communicated with the hospice agency since Resident 153's admission to request an evaluation for PT/OT. The DON stated contractures (limited range of motion of a joint due to stiffness in the muscles, tendons, or skin) could develop from lack of exercise and could lead to changes in skin condition, pain ,and/or discomfort. During an interview on 9/12/2024 at 1:50 PM, with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated Resident 153 had stiffness on both legs since Resident 153's admission. CNA 4 stated PT 1 started to train CNA 4 on ROM exercises for Resident 153 yesterday on 9/11/2024. CNA 4 stated when there was an order for ROM exercises, exercises were provided to each extremity (arms or legs) 10 to 15 times going up and down, lateral, circles, and bending exercises. CNA 4 stated CNA 4 did not provide ROM exercises to Resident 153 until 9/11/2024. During a review of the facility's P&P titled, Resident Mobility and Range of Motion dated July 2017, the P&P indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in range of motion. The P&P indicated as part of the resident's comprehensive assessment, the nurse will identify the resident's current range of motions of his or her joints.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40913 During an observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 153) was assessed for the use of Buspirone (medication used to treat anxiety [a feeling of fear, dread, and uneasiness]) and Clonazepam (medication used to treat seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), panic disorders [reoccurring unexpected panic attacks: persistent worry, intense fear, sweating, shaking, and shortness of breath], and anxiety) to treat a behavior of persistent blowing. Additionally, the facility failed to ensure Buspirone was not increased unless the behavior was clinically significant. This deficient practice had the potential to result in Resident 153 to develop an adverse reaction (unwanted, uncomfortable, or dangerous effects that a resident may have due to a medication) to the medications and could affect Resident 153's well-being. Findings: During a review of Resident 153's Face Sheet (FS, admission record), the FS indicated the facility admitted Resident 153 on 5/2/2024, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning,) Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks.) During a review of Resident 153's Minimum data Set (MDS - a standardized assessment and care planning tool) dated 5/8/2024, the MDS indicated Resident 153 rarely/never expressed ideas or wants and rarely/never understood verbal content. The MDS indicated Resident 153 was dependent with all activities of daily living (ADL, term used in healthcare that refers to self-care activities). The MDS indicated Resident 153 had functional limitations to range of motion on both lower extremities. During a review of Resident 153's written physician orders dated 5/17/2024, the order indicated to start Buspirone 5 milligrams (mg, unit of measurement) twice a day for anxiety. A clarification physician order dated 5/20/2024 indicated Buspirone 5 mg twice a day for anxiety manifested by persistent blowing. During a review of Resident 153's Physician's Orders (PO, summary report), the PO indicated the following medications, - Buspirone 10 milligrams (mg) two times a day for anxiety manifested by persistent blowing, ordered on 6/13/2024. - Clonazepam, 0.25 mg two times a day for anxiety manifested by persistent blowing, ordered on 9/6/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 9/12/2024 at 3:40 PM, with the Director of Nursing (DON) Resident 153's admission orders were reviewed, the DON stated Resident 153 was not on Buspirone and Clonazepam upon admission. The DON stated Buspirone 5 mg was started on 5/17/2024 and the medication was increased to Buspirone 10 mg on 6/13/2024 for anxiety manifested by persistent blowing. The DON stated Resident 153 got restless and exhibited non-stop blowing behavior. During a concurrent record review and interview on 9/12/24 at 3:52 PM, with the DON. Resident 153's Nurse Practitioner (NP, unidentified) Progress Notes dated 5/15/2024 were reviewed. The DON was asked to provide documentation that indicated the blowing behavior caused Resident 153 discomfort or harm to the resident. The DON stated the notes found regarding resident's behavior from the NP indicated Resident 153 had screaming episodes. The DON provided NP Progress Notes dated 8/11/2024, the notes indicated Resident 153 exhibited continuous puffing, probably habits. The notes indicated no discomfort observed. During an interview on 9/12/2024 at 4 PM, with the Social Services Director (SSD), the SSD stated psychotropic medications for all residents were reviewed by the in-house psychiatrist. The SSD stated during the monthly medication review, the SSD referred to the Medication Administration Record (MAR) and the marked behavior to report to the in-house psychiatrist, the in-house psychiatrist made a recommendation to continue the prescribed medication when symptoms persisted. The SSD stated Resident 153 was not assessed by the in-house psychiatrist because Resident 153 was not following Resident 153 as his patient. The SSD stated due to persistent blowing through the mouth, the behavior could appear as anxiety. During an observation on 9/13/2024 at 8:15 AM, Resident 153 was in Resident 153's room with eyes closed and lying in bed, Resident 153 was not blowing through the mouth. During an interview on 9/13/2024 at 8:17 AM with Licensed Vocational Nurse 2 (LVN 2). LVN 2 stated Resident 153 had been having the blowing behavior since Resident 153's admission. LVN 2 stated there were days when Resident 153 had a lot of blowing behaviors and some days with no behavior. LVN 2 stated Resident 153 stopped blowing when Resident 153 ate, drank, and when Resident 153 was asleep. During a concurrent record review and interview on 9/13/2024 at 10:11 AM with the Director of Staff Development (DSD). Resident 153's MAR was reviewed with the DSD. Resident 153's Medication Administration Record (MAR, a log initialed and/or signed by the nurse with the date and time each time a medication is administered to a resident) was reviewed and indicated Resident 153 was not on Buspirone and Clonazepam upon admission. The MAR indicated an order for lorazepam (medication used to treat anxiety disorders) 0.5 mg every 4 hours as needed for shortness of breath, anxiety manifested by persistent blowing and administration of lorazepam since Resident 153's admission. The MAR indicated the following behavior monitoring: May 2024 - monitoring was not completed. June 2024 - a total of 182 episodes marked for the month. July 2024 - a total of 238 episodes marked for the month. August 2024 - a total of 679 episodes marked for the month. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	September 2024 - 260 episodes marked from September 1 to the 13th. During an observation on 9/13/2024 at 11:03 AM, Resident 153 was sitting on a wheelchair in the living area, Resident 153 was awake, watching TV, and smiling. Resident 153 was not blowing through the mouth. During an interview on 9/13/2024 at 1:53 PM, with the DON, the DON stated the best way to determine if Resident 153's blowing behavior was a result of anxiety was through a psychiatric consultation. The psychiatrist assessed the resident (in general) and made a clinical recommendation for Buspirone and Clonazepam for Resident 153'blowing behavior. The DON stated there was no documentation of an assessment to determine whether the behavior of blowing through the mouth was a habit or a manifestation of anxiety. During a review of the facility's undated Policy and Procedure (P&P) titled 'Clinical Care Psychoactive/Psychotropic Medications the P&P indicated the information material to a decision concerning the administration of a psychotherapeutic drug that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following: The reason for the treatment and the nature and seriousness of the patient's illness, the probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment, the reasonable alternative treatment and risks, and why the health professional is recommending this particular treatment. The P&P indicated if the resident does not improve on the medication ordered, the physician may request a psychiatrist and/or psychologist. When indicated, a psychiatrist may be consulted for review of diagnosis, medications and additional interventions. The P&P indicated the resident's interdisciplinary team in consultation with the facility pharmacist shall have notes to include reasons for the drug, manifestations for the drug, an analysis of the resident's response to the drug and response to psychiatric consult or recommendations for psychiatric consult if appropriate.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on observation, interview, and record review, the facility failed to ensure it was free of medication error rates of 5 percent or greater for one of three sampled residents. There were 4 medication errors out of 25 medications observed during Medication Administration Observation on 9/10/24 and on 9/12/24. The facility's medication error rate was 16 percent. 1. Licensed Vocational Nurse 1 (LVN 1) did not check Resident 152's blood pressure (BP, pressure inside the blood vessels) and heart rate (HR, the number of times the heart beats in a minute, also known as the pulse rate) immediately before LVN 1 administered (gave) amlodipine (medication used to treat high blood pressure and/or chest pain) 10 milligrams (mg, unit of measure) to Resident 152. 2. LVN 1 did not check Resident 152's BP and HR immediately before LVN 1 administered metoprolol (medication used to treat high blood pressure and/or chest pain) 25 mg to Resident 152. 3. LVN 1 did not administer metoprolol 25 mg with food to Resident 152 as ordered by the physician. 4. LVN 1 did not administer hydroxychloroquine (medication used to treat rheumatoid arthritis [disorder that causes pain and inflammation of the joints]) 200 mg with food to Resident 152 as ordered by the physician. These failures placed Resident 152 at risk for medication side effects (unwanted effects of a drug/medication or medical treatment) and had the potential to place all residents in the facility at risk for harm that caused by a medication errors. Findings: During a review of Resident 152's Face Sheet (FS, document that contains a patient's personal and contact information, diagnoses, and medical history), the FS indicated Resident 152 was admitted to the facility on [DATE] with diagnoses which included hypertension (HTN, high blood pressure, when pressure in the blood vessels is always high) and rheumatoid arthritis (RA, disorder that causes pain and inflammation of the joints). During a review of Resident 152's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 5/3/24, the H&P indicated Resident 152 had the capacity to understand and make decisions. During a review of Resident 152's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/6/24, the MDS indicated Resident 152 communicated verbally and ate independently. The MDS indicated Resident 152 required substantial/maximal assistance (helper does more than half of the effort) from staff for upper body dressing and personal hygiene, and was dependent (helper does all of the effort) on staff for toileting hygiene, showering/bathing, lower body dressing, putting on/taking off footwear, transferring to and from a bed to a chair/wheelchair, and getting on and off a toilet or commode. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 152's Physician's Orders (PO) on 9/12/24, the PO indicated the following: a. A PO, dated 4/30/24, indicated to administer amlodipine 10 mg to Resident 152 once a day for HTN. The PO indicated to hold amlodipine when Resident 152's systolic blood pressure (SBP, the pressure in the blood vessels when the heart pumps blood out of the heart; the top number in a BP reading) was less than 110 or HR less than 60. b. A PO, dated 5/2/24, indicated to administer hydroxychloroquine 200 mg with food to Resident 152 twice a day for RA. c. A PO, dated 5/30/24, indicated to administer metoprolol 25 mg with food to Resident 152 twice a day for HTN. The PO indicated to hold metoprolol when Resident 152's SBP was less than 110 or HR less than 60. During a concurrent observation and interview on 9/12/24 from 8:49 am to 9:07 am with LVN 1, LVN 1 prepared and administered Resident 152's medications. LVN 1 prepared all of Resident 152's medications scheduled to be administered at 9 am, which included amlodipine 10 mg, hydroxychloroquine 200 mg, and metoprolol 25 mg. LVN 1 stated LVN 1 checked BP and HR after breakfast for all residents who needed BP and HR measurements with their medications. LVN 1 administered Resident 152's medications at 9 am. LVN 1 did not check Resident 152's BP and HR before giving medications to Resident 152 and did not give Resident 152 food with Resident 152's medications. LVN 1 stated LVN 1 checked Resident 152's BP and HR when Resident 152 went back to bed at 8 am, an hour before LVN 1 administered Resident 152's medications. LVN 1 stated LVN 1 must check Resident 152's BP and HR immediately before LVN 1 administered medications to Resident 152 because Resident 152's BP and/or HR could change in an hour. LVN 1 stated Resident 152's physician ordered for metoprolol 25 mg and hydroxychloroquine 200 mg to be given with food because they (metoprolol 25 mg and hydroxychloroquine 200 mg) could cause stomach issues (nausea, vomiting, diarrhea, stomach pain, and cramps). During an interview on 9/12/24 at 10:18 am with the Director of Nursing (DON), the DON stated the resident's BP and HR must be checked immediately before administration of medication which required BP and/or HR measurements. The DON stated when a medication was ordered by the physician to be given with food, the licensed nurse must offer the resident food when they give the medication to the resident. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, medications are administered in accordance with prescriber orders . The P&P indicated, the following information is checked/verified for each resident prior to administering medications: allergies to medications and vital signs (measurements of the body's basic functions, such as heart rate, breathing rate, blood pressure, and temperature), if necessary .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555932	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Heights Health Center	161 S. Reeder Ave Covina, CA 91724

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 40913 Based on observation, interview, and record review, the facility failed to ensure two of four garbage dumpster's lids were not left open as indicated in the facility's Policy and Procedure (P&P) titled, Non-medical Waste Disposal. This deficient practice had the potential to result in pests and the spread of infectious diseases throughout the facility. Findings: During an observation on 9/10/2024 at 10:15 AM, facility staff (unidentified) were walking toward a shed carrying garbage trash bags and placed the bags in the shed. During a concurrent observation and interview on 9/10/2024 at 11:04 AM, there was a black insect flying around the kitchen. The Director of Dietary Services (DDS) stated it was a fly that could have entered the facility during food delivery. The DDS showed the location of the delivery door, the delivery door led to the outside of the facility and the door was close in proximity to the kitchen door. During a concurrent observation and interview on 9/11/2024 at 3:45 PM, with the DDS, there was a fly flying around in the kitchen. The DDS stated the staff had already killed a fly yesterday and this fly could have entered through the delivery door. During a concurrent observation and interview on 9/11/2024 at 4:05 PM, with the DDS, a shed located a few meters from the skilled nursing facility had 4 dumpsters inside. Two dumpsters had lids that were left open, there were garbage trash bags inside the two dumpsters, the dumpsters were more than halfway full of garbage. The DDS stated garbage from the kitchen was thrown into the dumpsters. The DDS stated the dumpster needed to remain closed at all times and when the dumpsters were left open, the garbage inside could attract rats and flies. During a concurrent record review and interview on 9/12/2024 at 5:35 PM, with the Director of Facility Engineering (DFE) the facility's Pest Management Service Report was reviewed. The DFE stated the DFE had in-serviced (training) staff regarding keeping the dumpster lids closed at all times after the surveyor's observation conducted on 9/11/24. During a review of the facility's P&P titled, Non-medical Waste Disposal dated 4/10/2024, the P&P indicated the facility shall safeguard the health and safety of its employees and patients by maintaining a system of internal control over the waste management process to ensure compliance with requirements under federal and state laws and regulations concerning waste containment, storage, and disposal. The P&P indicated all trash receptacles/bins that have covers should be covered after trash is placed inside to prevent odor, reduce transmission of communicable disease, and prevent serving as vector for insect or rodent infestation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview, and record review, Certified Nursing Assistant 3 (CNA 3) and Director of Nursing (DON) failed to wear the needed personal protective equipment (PPE) for one of one resident (Resident 203) at indicated by Resident 203's physician orders, the signage posted outside of Resident 203's room and the facility's policy for Enhanced Barrier Precaution. This failure put Resident 203's risk of acquiring an infection through the indwelling foley catheter (device that drains urine from the bladder into a collection bag outside one's body). Findings: During a review of Resident 203's Detailed Summary, (DS) undated, the DS indicated Resident 203 was admitted to the facility on [DATE] with multiple diagnoses including spinal stenosis (narrowing of the space inside the spine causing pressure on the nerves that travel through the spine) and neuromuscular dysfunction of the bladder (when a problem in the brain, spinal cord or nerves makes one lose control of their bladder). During a review of Resident 203's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 5/7/2024, the MDS indicated Resident 203 had intact cognition (ability to think and reason) and was dependent (helper does all the effort) on staff for eating, toileting, and hygiene. The MDS also indicated Resident 203 had an indwelling foley catheter. During a review of review of Resident 203's Physician's Order (PO) dated as of 9/13/2024, the PO indicated, enhanced barrier precautions due to presence of urinary catheter - hand hygiene, gown and gloves to be used during high-contact care activities, with start date of 5/23/2024. During an observation on 9/10/2024 at 12:47 PM in Resident 203's room, CNA 3 was observed brushing 203's teeth and wore a surgical mask and gloves without a gown. During an observation on 9/10/2024 at 1:02 PM in Resident 203's room, CNA 3 and the DON were observed transferring Resident 203 from a wheelchair to the bed. CNA 3 and the DON each handled Resident 203's indwelling foley catheter during the transfer without wearing a gown and wore only gloves and surgical mask. During an interview on 9/11/2024 at 1:36 PM with Infection Preventionist Nurse (IPN), IPN stated under enhanced barrier precaution, staff are supposed to perform hand hygiene and wear full gown and gloves when performing any type of direct touch care with Resident 203 including repositioning. The IPN stated it is important to protect Resident 203 because the indwelling foley catheter is a source of entry for potential infection. The IPN stated if PPE are not worn, it is possible for Resident 203 to obtain an infection. (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 concurrent interview and record review on 9/10/2024 at 1:49 PM with CNA 3, the signage posted outside Resident 203's room was reviewed. The signage titled Enhanced Barrier Precaution from U.S. Department of Health and Human Services, undated, the signage indicated providers and staff needed to wear a gown and gloves for high-contact resident activities. CNA 3 stated that the signage meant anyone who entered Resident 203's room needed to wear a gown and gloves. CNA 3 further stated CNA 3 would ideally wear a gown when handling Resident 203's catheter to help prevent the resident from potential infection but did not. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions dated 8/2022, the P&P indicated enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. Examples of high contact resident care activities requiring the use of gown and gloves include transferring and providing hygiene.