STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555933	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chinese Hospital D/P Snf	845 Jackson Street San Francisco, CA 94133

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43913 Based on interview and record review, the facility did not send a copy of the reason for discharge to the office of the local Ombudsman, when one of two residents (Resident 2) was discharged to a lower level of care (board and care home). Findings: Review of Physician Discharge Summary, dated 6/28/24, indicated, .Resident 2 was admitted [DATE] with diagnoses including atrial fibrillation (irregular heartbeat), obesity, was involved in minor MVA (Motor Vehicle Accident) . Patient completed therapy .patient is stable to discharge with home care . During an interview on 8/8/24 at 11:35 AM, with Social Work Manager (SWM), SWM, when patient was admitted , APS (Adult protective Services) was already on the case. Patient was referred to (IOA) Institute on Aging, who helped SW apply for assisted living waiver, so she can go to a board and care. The board and care were able to accept her as Hoyer-lift and ADLs (Activities of daily living) assisted patient. Referred patient to Upward Health for case management if she will need to. This is a facility-initiated discharge. During a concurrent interview and record review on 08/08/24 02:57 PM, with SMW, no notification of Ombudsman in writing was found in the clinical records. SWM said, they were not aware that Ombudsman will have to be notified of discharges. Review of facility policy and procedure titled, Transfer and Discharge Requirements, dated 4/13/23, indicated, .Policy: The D/P SNF Transfer and Discharge Requirements policies and procedures in accordance to federal and state regulations . The policy did not indicate notice to Ombudsman on all discharges, according to federal regulations.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38066 Based on observation, interview and record review, the facility failed to develop a comprehensive care plan (CP) that included measurable objectives and specific interventions for one of eight sampled residents (Residents 159) when there was no individualized person-centered CP for the use of Venlafaxine (medication used to treat depression) for Resident 159. This failure had the potential for not meeting the resident's nursing needs and goals to attain their highest practicable well-being. Findings: Resident 159 was admitted on [DATE] with diagnoses including hypertension (high blood pressure), cocaine abuse, and depression. Review of Resident 159's Order Summary Report, active orders as of 8/8/24, indicated, Resident 159 had an order of Venlafaxine with a start date of 7/19/24. During a concurrent interview and record review on 8/7/24 at 10:39 AM, with Registered Nurse (RN) 3, Resident 159's care plans were reviewed. RN 3 confirmed that Resident 159 had an order for Venlafaxine with a start date of 7/19/24. RN 3 acknowledged that there was no care plan for Resident 159's antidepressant medication, and stated, There should be a plan of care. There's none. Review of facility policy titled, Resident Assessment with approval date of 9/23, indicated, .(d) Use. A facility maintains all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38066 Based on observation, interview, and record review, the facility failed to obtain a physician's (MD) order and develop a comprehensive care plan for the use of female external catheter for two of two sampled residents (Residents 158 and 201). This failure had the potential for residents to not receive appropriate treatment and services. Findings: 1. Resident 158 was admitted on [DATE] with diagnoses including obesity, chronic pain, adult failure to thrive (inability to sustain weight due to poor nutrition), and major depressive disorder. During an observation on 8/5/24 at 10:39 AM, Resident 158 was asleep in bed, with a catheter (a flexible tube used to deliver fluids into or withdraw fluids from the body) draining with yellowish urine to a canister and attached to a wall-mounted suction machine. During an interview on 8/5/24 at 12:38 PM, Resident 158 acknowledged the use of a catheter and stated, The catheter drains my urine. During a concurrent interview and record review on 8/7/24 at 10:15 AM, with Registered Nurse (RN) 3, Resident 158's orders and care plans were reviewed. RN 3 said that Resident 158 was urinary incontinent (loss of urine control), and she had a catheter to prevent skin breakdown, and stated, It's a Purewick catheter. RN 3 said that they ask the MD for an order for the use of the catheter, and stated, Yes, we ask the MD. RN 3 confirmed that there was no MD order for the use of Purewick catheter for Resident 158, and stated, No order. 43913 2. Resident 201 was admitted on [DATE] with diagnoses including pressure ulcer of sacral region stage 4, (bedsore on the tailbone area) hemiplegia (weakness of left side), and chronic respiratory failure with hypoxia (a body part is deprived of oxygen). During an observation on 8/5/24 at 10:00 AM, Resident 201 was in bed with a tubing connected to a canister to a suction machine. Canister had yellowish liquid inside. During an interview on 8/5/24 at 10:20 AM, with Licensed Vocational Nurse (LVN)2 and Interim Director of Nursing (IDON), LVN 2 said that it is a pad for incontinence of urine, so the pressure ulcer will not be wet from urine. The IDON confirmed it was a Purewick. During a concurrent interview and record review on 8/7/24 at 1:30 PM, with RN 1, Resident 201's orders and care plans were reviewed. RN 1 acknowledged there was no MD order for the use of external catheter and the care plan did not indicate the use of female external catheter for incontinence. RN 1 stated, That should be in the care plan, there is incontinence care plan, but no use of Purwick found in the care plan. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility was unable to provide a policy and procedure for the use of female external catheter. The facility provided the Manufacturers Guide for Versette external catheter best practice guide.

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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** 38066 Based on observation, interview, and record review, the facility failed to obtain a physician's (MD) order and develop a comprehensive care plan for oral suctioning for two of two sampled residents (Residents 151 and 205). This failure had the potential for residents to not receive appropriate treatment and services. Findings: 1. Resident 151 was admitted on [DATE] with diagnoses including transient ischemic attack (TIA-a brief episode when blood flow to the brain is temporarily cut off), dysphagia (difficulty swallowing), and depression. Mental status assessment indicated Resident 151 was moderately impaired. During an observation on 8/5/24 at 9:58 AM, Resident 151 was asleep in bed, oral suctioning equipment was at resident's bedside table. The canister was filled with light yellowish secretions. During an interview on 8/5/24 at 10:07 AM, Registered Nurse (RN) 2 said that the oral suction equipment was used as needed to suction secretions of Resident 151. Review of Resident 151's clinical record, the Order Summary Report (OSR), active orders as of 8/8/24, the OSR did not indicate an order for oral suctioning. Review of Resident 151's care plans indicated no care plan was developed for suctioning of oral secretions. 43913 2. Resident was admitted on [DATE], with diagnoses including encephalopathy (a disturbance in the brain function causing confusion, memory loss), and dysphagia. During an observation on 8/5/24 at 11:00 AM, Resident 205, was in bed, had a tubing attached to a suction catheter, and a canister filled with whitish fluid connected to the suction machine. During an interview on 8/5/24 at 11:15 AM, with LVN 1, LVN 1 confirmed Resident 205 required suctioning on as needed (PRN) basis and stated, I did not suction him yet on my shift. During an interview on 8/7/24 at 10:20 AM, with RN 2, per RN2 suctioning is on PRN basis, the canister and suction tip should be changed every 2-3 days, will check the policy, date is important to know when to change the set. Review of Resident 205's clinical records, the OSR, there was no MD order for suctioning. Review of Resident 205's care plans indicated no care plan for suctioning of oral secretions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/7/24 at 2:00 PM, with RN 1, Residents 151 and 205's orders and care plans were reviewed. RN1 acknowledged that there was no MD order and no care plan found in the clinical records for oral suctioning.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38066 Based on observation, interview, and record review, the facility failed to ensure residents were assessed for risk of entrapment, risk and benefits for the use of bed rails were reviewed and bed rail assessment reflect the use of bed rails for three of eight sampled residents (Residents 151, 159, and 207). These deficient practices had the potential to put the residents at risk for entrapment, accidents, or injuries due to the use of bed rails. Findings: 1. Resident 151 was admitted on [DATE] with diagnoses including transient ischemic attack (TIA-a brief episode when blood flow to the brain is temporarily cut off), prostate cancer, and depression. Mental status assessment indicated Resident 151 was moderately impaired. During an observation on 8/5/24 at 9:58 AM, Resident 151 was asleep in bed, with both upper bed rails up. During a subsequent observation on 8/7/24 at 9:54 AM, Resident 151 was asleep in bed, with both upper bed rails up. On concurrent interview with Hospital Aide (HA) 1, HA 1 said that Resident 151 grabs the bed rails when turning, and stated, It is used for mobility. Review of Resident 151's clinical record, the Bed Rail Assessment (BRA) with effective date of 3/27/24, indicated, .Side Rails/Assist Bar are not indicated at this time . The BRA did not indicate Resident 151 was assessed for risk of entrapment and risks and benefits of bed rails were not reviewed with the resident. There was no care plan for the use of bed rails. 2. Resident 159 was admitted on [DATE] with diagnoses including hypertension (high blood pressure), heart failure (condition in which the heart doesn't pump blood as well as it should), intracerebral hemorrhage (a type of stroke caused by bleeding within the brain tissue itself), and muscle weakness. During an observation on 8/5/24 at 10:47 AM, Resident 159 was in bed, pleasant, alert, and oriented. Resident 159's both bed rails were up and grabbed it to turn to her side. During an interview on 8/7/24 at 10:00 AM, Registered Nurse (RN) 3 said that Resident 159 had right side weakness. RN 3 confirmed that Resident 159 had both bed rails up and was used for movement. RN 3 stated, It is used as an enabler, for mobility. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 159's clinical record, the BRA with effective date of 7/19/24, indicated, Resident 159 expressed a desire to have side rails/assist bar for safety and/or comfort and side rails/assist bar are not indicated at this time. The BRA did not indicate Resident 159 was assessed for risk of entrapment and risks and benefits of bed rails were not reviewed with the resident. There was no care plan for the use of bed rails. 43913 3. Resident 207 was admitted on [DATE], with diagnoses including bacterial infection, enterocolitis due to Clostridium Difficile (a highly contagious bacterial infection of the colon), and osteoarthritis of knees (knees hurting, stiff or swollen due to knee cartilages broken down). During a concurrent observation and interview on 8/5/24 at 11:30 AM, with Licensed Vocational Nurse (LVN) 2, Resident 207 was in bed, awake, alert, and oriented, on tube feeding. Both bed rails were up, and resident was able to reach and hold on to it. Resident 207 said he has been in the facility for several months now, and stays in bed most of the time. LVN 2 confirmed Resident 207 has both bed rails up to help him reposition in bed. Resident 207 stated, I like this, when touching the bed rails to position himself. Resident 207 did not know if he was asked about the use of bed rails. During a concurrent interview and record review on 8/7/24 at 1:30 PM, with RN1, Resident 207's orders and care plans were reviewed. RN 1 confirmed that there was no physician's order and care plan for the use of bed rails. Review of Resident 207's BRA with effective date of 2/13/24, consent for the use of bed rails was done on 2/13/24. The BRA indicated, .Siderails/Assist bar are not indicated at this time . During an interview on 8/6/24 at 2:00 PM, with the Interim Director of Nursing (IDON), IDON said that bed rails need physician's order, assessment, consent, and care plan. Review of facility Policy and Procedure, Restraint Reduction Program, with approval date of 9/2023, indicated, .Policy: The least restrictive alternative measures will be used according to the resident's assessment and care plan .

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43913 Based on observation, interviews and record review, the facility did not provide daily, the nurse staffing information, when on 8/5/24, 8/6/24, and 8/7/24, there was no staffing data information posted. Findings: During an interview on 8/5/24 at 10:22 AM, with Interim Director of Nursing (IDON), per IDON, the staffing information should be posted. Facility provided daily nursing assignments and monthly staff schedule. Not the staffing data required. On 8/7/24, asking the IDON for the staffing posting, the Census and Direct Care service Hours Per Patient Day (DHPPD) was posted in the nursing station. Review of facility policy and procedure titled, Posted Nurse Staffing Information, dated 4/20/23, indicated, .It is the policy of the facility to make staffing information readily available in a readable format to residents and visitors at any given time .1. The facility will post the following on a daily basis . 2. The facility will post the nurse staffing data daily at the beginning of each shift.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38066 Based on interview and record review, the facility failed to ensure two of four sampled residents (Residents 158 and 159) were free from unnecessary psychotropic medication (drug that affect brain activities associated with mental processes and behavior) when there was no specific target behavior monitoring for the use of Venlafaxine (medication used to treat depression). This failure had the potential for residents to receive unnecessary psychotropic medication, be exposed to adverse health consequences from the medication, which could negatively impact the residents' mental, physical, and psychosocial well-being. Findings: 1. Resident 158 was admitted on [DATE] with diagnoses including obesity, chronic pain, adult failure to thrive (inability to sustain weight due to poor nutrition), and major depressive disorder. During a review of Resident 158's clinical record, the Order Summary Report (OSR), active orders as of 8/8/24, indicated, .Venlafaxine HCl ER Oral Tablet Extended Release 24-hour 75 milligram (mg) Give 1 tablet by mouth one time a day related to major depressive disorder .Start Date 5/21/24 . During a review of Resident 158's clinical record, the Medication Administration Record (MAR), dated 7/1/24 to 7/31/24 indicated, .Venlafaxine HCl ER Oral Tablet Extended Release 24-hour 75 mg Give 1 tablet by mouth one time a day related to major depressive disorder . was administered daily at 9:00AM from 7/1/24 to 7/31/24. During a review of Resident 158's clinical record, the MAR dated 8/1/24 to 8/31/24 indicated, .Venlafaxine HCl . was administered daily at 9:00 AM from 8/1/24 to 8/7/24. During a concurrent interview and record review on 8/7/24 at 10:15 AM with Registered Nurse (RN) 3, Resident 158's OSR and MAR were reviewed. RN 3 confirmed that Resident 158 had a diagnosis of depression and acknowledged that the clinical records did not indicate the specific target behavior symptom to be monitored for depression and the use of Venlafaxine, and stated, No behavior monitoring for depression. None. 2. Resident 159 was admitted on [DATE] with diagnoses including hypertension (high blood pressure), cocaine abuse, heart failure (condition in which the heart doesn't pump blood as well as it should), and depression. During a review of Resident 159's clinical record, the OSR, active orders as of 8/8/24, indicated, .Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour 75 mg Give 75 mg by mouth at bedtime for depression . Start Date 7/19/24 . (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 review of Resident 159's clinical record, the MAR dated 7/1/24 to 7/31/24 indicated, .Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour 75 mg Give 75 mg by mouth at bedtime for depression . was administered at 9:00 PM from 7/19/24 to 7/31/24. During a review of Resident 159's clinical record, the MAR indicated, .Venlafaxine HCl . was administered at 9:00 PM from 8/1/24 to 8/6/24. During a concurrent interview and record review on 8/7/24 at 10:39 AM with RN 3, Resident 159's OSR and MAR were reviewed. RN 3 confirmed that Resident 159 had a diagnosis of depression and acknowledged that the clinical records did not indicate the specific target behavior symptom to be monitored for depression and the use of Venlafaxine, and stated, No behavior monitoring for the use of antidepressant. None. During an interview on 8/7/24 at 1:22 PM, with the Pharmacist (PHM), for psychotropic medications, PHM confirmed that there was no specific target behavior monitoring for the use of Venlafaxine for Residents 158 and 159. PHM acknowledged that behavior monitoring is performed to check if the use of medication is effective. During an interview on 8/8/24 at 10:23 AM, with the Interim Director of Nursing (IDON), for psychotropic medications specific target behavior monitoring, the IDON said that monitoring is done to see if medication is effective, or dose needs to be changed. IDON further stated that behavior monitoring is done every shift. Review of facility policy titled, Drug Regimen Review/Pharmaceutical Care Monitoring - SNF last reviewed on 3/2024, indicated, .Upon conducting the DRR, the pharmacist may identify and report irregularities in one or more of the following categories .f. The use of a medication without evidence of adequate monitoring .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27194 Based on observation, interview, and record review the facility failed to ensure safe medication storage practice in one of three medication carts (Med Cart, a locked mobile cart used to store medications and supplies) when several prescription medications were kept on top of a med cart and available for taking. This failed practice could contribute to unsafe medication storage and the potential for drug diversion. Findings: During a concurrent observation and interview on 8/6/24 at 8:33 AM, with Interim Director of Nursing (IDON), a medication cart was found on the hallway outside of a Resident's room (room [ROOM NUMBER]). On top of the med cart were bottles of prescription medications (metoprolol 50 mg - medication for treatment of high blood pressure, oxcarbazepine 300 mg - a medication used in the treatment of partial seizures, lisinopril 40 mg - medication for treatment of high blood pressure, and tamsulosin 0.4 mg - medication used in reducing the symptoms of an enlarged prostate gland) belonging to Resident 202. These medications were left there unattended on the hallway while the Licensed Vocational Nurse (LVN 2) stayed in a Resident room. During a concurrent interview with the IDON on 8/6/2024 at 8:33 AM, she confirmed the medications should not be left unattended on the med cart when LVN 2 left to provide nursing care to a Resident. Review of the facility's policy titled Drug Storage, dated April 2023, indicated All drugs are stored in designated area in SNF medication carts or lockable cabinets .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 34975 Based on observation, interview, and facility document review, the facility failed to have a system in place to ensure the safe storage of residents' personal perishable food. This failure had the potential to result in foodborne illness for 18 residents who took food by mouth out of a facility census of 19. Findings: Review of the Policy and Procedure (P&P) titled Bringing In Outside Food for Residents in Skilled Nursing Unit revised January 2024, showed Resident's nurse will store the perishable food in the resident refrigerator and freezer located in Dining Room on the SNF (Skilled Nursing Facility). The temperature will be systematically monitored, and a temperature log will be maintained in collaboration with the Facilities department. Review of the P&P titled Food Handling revised March 2024, showed temperatures of refrigerators and freezers will be monitored daily and documented. Refrigerators should be below 40 degrees Fahrenheit (F) and freezers at or below 0 degrees F. An observation on 8/5/24 at 12:10 p.m., showed a compact refrigerator and a compact freezer located in the resident dining room. The freezer was very full of unopened resident food. The freezer had a layer of ice build-up on the inside walls and ceiling. There was also ice build-up on the freezer door. Located on top of the freezer was untitled print-out of a calendar page dated July 2024. By each date, from June 30 to July 31, there was an initial and a checkmark. During a consecutive interview with Licensed Vocational Nurse (LVN) 1 and the Interim Director of Nursing (IDON) on 8/5/24 at 12:15 p.m., LVN 1 stated nursing was responsible for checking the freezer to ensure resident's frozen food was not stored over three days. LVN 1 confirmed the untitled calendar page with initials and checkmarks was documentation for checking the freezer. LVN 1 also confirmed there was no documentation for August 2024. IDON stated it was the P.M. (night) staff who monitored the freezer and were initialing the calendar page, and she did not know the meaning of the checkmarks but would follow-up. During an interview on 8/6/24 at 10 a.m., IDON stated the nursing staff were only checking for expiration dates on food for the food stored in the resident refrigerator. During an interview on 8/6/24 at 10:04 a.m., the Food and Nutrition Services Manager (FNSM) stated Food and Nutrition Staff did not have oversight of the resident refrigerator and freezer in the resident dining room. FNSM also said the resident refrigerator and freezer temperatures were not monitored by Facilities. FNSM stated if a frozen food package was not opened, it did not need to be discarded within three days, and the manufacturer's use-by/expiration date could be followed. FNSM stated she did not provide training to nursing staff regarding monitoring the resident food refrigerator/freezer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555933	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chinese Hospital D/P Snf	845 Jackson Street San Francisco, CA 94133

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/6/24 at 10:22 a.m., the Director of Staff Development (DSD) stated temperatures of the resident refrigerator and freezer should be recorded daily but she did not know what the appropriate refrigerator and freezer temperatures. DSD stated she did not have training regarding appropriate monitoring of the refrigerator and freezer. The DSD also stated she was not aware maintenance needs such as ice build-up was reported by nursing to Facilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38066 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one of two sampled residents (Resident 151) when the tip of the oral suction (involves inserting a small plastic tube attached to a suction machine into the mouth to remove saliva or mucus) tubing was touching the floor. This deficient practice had the potential to transmit microorganisms and increase the risk of infection for Resident 151. Findings: Resident 151 was admitted on [DATE] with diagnoses including transient ischemic attack (TIA-a brief episode when blood flow to the brain is temporarily cut off), dysphagia (difficulty swallowing), and depression. Mental status assessment indicated Resident 151 was moderately impaired. During an observation on 8/5/24 at 9:58 AM, Resident 151 was asleep in bed, oral suctioning equipment was at resident's bedside table. The canister was filled with light yellowish secretions. The tip of the suction tubing was touching the floor. During an interview on 8/5/24 at 10:07 AM, Registered Nurse (RN) 2 said that the oral suction equipment was used as needed to suction secretions of Resident 151. RN 2 acknowledged that the tip of the suction tubing was touching the floor, and stated, It should not be touching the floor. It's considered contaminated. That's for infection control. During an interview on 8/7/24 at 10:30 AM, with the Interim Director of Nursing (IDON), the IDON said the tip of the suction tubing should not be touching the floor to prevent cross contamination. The IDON stated, For infection control and safety, and best practice. During an interview on 8/8/24 at 2:30 PM, with the Infection Preventionist (IP), the IP said that the suction tubing is attached to a Yankuer catheter (small plastic tube). The IP acknowledged that the suction tubing was touching the floor, and stated, That is contaminated because it's touching the floor. It may cause spread of infection. Review of facility policy titled, Cleaning and Disinfection/Non-critical care and shared equipment, last revised on 3/2024, indicated, Policy: It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to provide a safe, sanitary, and comfortable environment to prevent the spread on infection in accordance with State and Federal Regulations, and national guidelines. The policy did not indicate care for oral suction equipment.