STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. BUILDING _____ B. WING _____	C 10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS HEALTHCARE CENTER	11300 FAIR OAKS BLVD. FAIR OAKS, CA 95628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. The facility census was 134. The sample size was 28. One (1) facility reported incident #CA00925366 was investigated during the Recertification Survey. The Department was unable to substantiate a violation of the regulations for facility reported incident #CA00925366.	F 000	POC Received 11/7/24 POC Approved 11/11/24 BIC = 11/8/24 - per DB	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have an accurate Minimum Data Set (MDS- an assessment tool used to guide care) assessment for one out of 28 sampled residents (Resident 131) when Resident 131's admission MDS pain management was inaccurate. This failure caused the facility to have inaccurate health status data for Resident 131 and potential for Resident 131 to not achieve his highest practicable well-being. Findings: A review of Resident 131's clinical record	F 641		

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

Administrator 11-7-24

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.

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. The facility census was 134. The sample size was 28. One (1) facility reported incident #CA00925366 was investigated during the Recertification Survey. The Department was unable to substantiate a violation of the regulations for facility reported incident #CA00925366.	F 000	Preparation and/or execution of this response and Plan of Correction (POC) do not constitute an admission by the provider of truth or accuracy of the alleged facts or conclusions set forth in the Statement of Deficiencies. This POC is prepared and/or executed solely for the provisions of Federal and State required regulations. This POC is not an admission of non-compliance with cited regulation(s).	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have an accurate Minimum Data Set (MDS- an assessment tool used to guide care) assessment for one out of 28 sampled residents (Resident 131) when Resident 131's admission MDS pain management was inaccurate. This failure caused the facility to have inaccurate health status data for Resident 131 and potential for Resident 131 to not achieve his highest practicable well-being. Findings: A review of Resident 131's clinical record	F 641	Accuracy of Assessments Resident 131's MDS assessment dated 9/9/24 was corrected immediately to reflect that the resident received both PRN and scheduled pain medication during the 5 days prior. All residents receiving scheduled and PRN pain medication were reviewed to ensure that the most recent MDS assessments were coded accurately. No other residents found to be affected by deficient practice.	10/15/24 11/1/24

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F 641	Continued From page 1 indicated Resident 131 was admitted September of 2024 and had diagnoses that included encounter for other orthopedic aftercare (a care provided after a surgery that involves bones, muscles, and joints), pain in right lower leg, and diabetes mellitus (a chronic condition causing too much sugar in the blood). A review of Resident 131's MDS Cognitive Patterns, dated 9/9/24, indicated Resident 131 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 131 had intact cognition. A review of Resident 131's MDS Health Conditions, dated 9/9/24, indicated Resident 131 did not receive scheduled and PRN (as needed) pain medication regimen in the last 5 days. During an interview on 10/14/24 at 9:35 a.m. with Resident 131, Resident 131 stated he has pain and has been receiving pain medication since he was admitted. A review of Resident 131's active physician's order with start date of 9/4/24 indicated, "Norco [a medication for pain which contains a combination of Hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever that increases the effects of hydrocodone] Oral Tablet 5-325 MG [milligrams- unit of measurement] ...Give 1 tablet by mouth every 4 hours as needed for AS NEEDED FOR [sic] MODERATE TO SEVERE PAIN." A review of Resident 131's Medication Administration Record (MAR, a legal document used to record medications given to the residents) for the month of September 2024 indicated Resident 131 received Norco on 9/6/24, 9/8/24, and 9/9/24.	F 641	The MDS coordinators were all in-serviced about reviewing medication administration records to check if pain medication was administered routine and/or PRN during the MDS 5-day look back period and to code administration of pain medications as indicated. Two MDS coordinators will review the MDS assessment for accuracy; the MDS nurse completing the assessment and another MDS coordinator. Any discrepancies will be corrected immediately. MDS accuracy reviews will be brought to the QA committee on a quarterly basis to evaluate compliance. The Facility is in compliance with F641 on 11/8/24	11/5/24 Ongoing

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F 641	Continued From page 2	F 641		

A review of Resident 131's physician's order with start date of 9/4/24 and discontinued on 9/5/24 indicated, "Tylenol [a pain medication] Oral Tablet 325 MG... Give 2 tablet by mouth every 6 hours as needed for MILD PAIN..." A review of Resident 131's MAR for the month of September 2024 indicated Resident 131 received Tylenol on 9/4/24.

A review of Resident 131's active physician's order with start date of 9/5/24 indicated, "Tylenol Extra Strength Oral Tablet 500 MG... Give 1 tablet by mouth three times a day for PAIN MANAGEMENT." A review of Resident 131's MAR for the month of September 2024 indicated Resident 131 received Tylenol 2 times on 9/5/24, 3 times on 9/7/24, 3 times on 9/8/24, and 3 times on 9/9/24.

During a concurrent interview and record review on 10/15/24 at 1:30 p.m. with the MDS Coordinator (MDSC), Resident 131's clinical records were reviewed. The MDSC confirmed that Resident 131's admission MDS pain management assessment was inaccurate and stated, "I might have missed it [pain management questions]." The MDSC also stated she would expect the MDS assessment to be accurate. The MDSC further stated, "...It's [MDS assessment] patient [residents] information and about the patient's [resident's] health so we [facility staff] can meet their [residents] needs."

During an interview on 10/16/24 at 2:45 p.m. with the Director of Nursing (DON), the DON stated she would expect the MDS assessment to be accurate so the facility would have an accurate resident health status.

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F 641	Continued From page 3 A review of the facility's policies and procedures titled, "Certifying Accuracy of the Resident Assessment", revised 11/2019, indicated, "Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment."	F 641		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one out of 28 sampled residents (Resident 396) was provided with appropriate care and services with enteral	F 693	Tube Feeding Mgt/Restore Eating Skills Resident 396 was in the hospital during the NOC shift on 10/10/24 so the nurse could not document intake and output due to the resident not being in the building. The nurse that cared for resident on 10/13/24 AM shift was contacted to notify them of the missed intake and output documentation for the shift they cared for the resident. The nurse recorded the Intake and output on the electronic medical record as a late entry for 10/13/24. No evidence of dehydration noted due to the late entry documentation. All other residents with Intake and Output monitoring orders were reviewed for complete documentation and no other residents found to be affected by deficient practice.	10/16/24 11/1/24

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F 693	Continued From page 4 feeding (also referred to as "tube feeding/ feeding tube"- the delivery of food and nutrients through a feeding tube directly into the stomach or part of the intestines) when Resident 396's physician's order for intake and output monitoring for tube feeding was not consistently followed. This failure increased the potential for inadequate monitoring of Resident 396 intake and output, failure to recognize early signs of fluid imbalance, and for Resident 396 to not achieve the highest practicable well-being. Findings: A review of Resident 396's clinical record indicated Resident 396 was admitted October of 2024 and had diagnoses that included cerebral infarction (damage to a part in the brain due to a disrupted blood flow), muscle weakness, and aphasia (a language disorder that affects a person's ability to understand and express written and spoken language). A review of Resident 396's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 10/14/24, indicated Resident 396 was rarely or never understood, and had short-term and long-term memory impairment. A review of Resident 396's MDS Swallowing/Nutritional Status, dated 10/14/24, indicated Resident 396 has feeding tube while a resident in the facility. During an observation on 10/14/24 at 12:31 p.m. of Resident 396, in Resident 396's room, Resident 396 was observed to have an NG tube (Nasogastric tube- a tube that is inserted through the nose and into the stomach to deliver food,	F 693	Licensed nurses were in-serviced about requirement to complete all Intake and Output monitoring at the end of their shifts. The were instructed to check the electronic medication administration record prior to ending their shift to ensure they do not miss any monitoring orders. The Medical Records department will audit Intake and Output monitoring on a weekly basis to ensure complete documentation. The results of Intake and Output monitoring audits will be brought to the quarterly QA committee meetings to evaluate compliance with documentation. The Facility is in compliance with F693 as of 11/8/24	11/6/24 11/7/24 Ongoing

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F 693	Continued From page 5	F 693		

liquid, or medication, or to remove substances from the stomach) on her left nostril.

A review of Resident 396's active physician's order, dated 10/10/24, indicated, "Intake and Output monitoring for Enteral Nutrition...every shift."

A review of Resident 396's Medication Administration Record (MAR, a legal document used to record medications given to the residents and to monitor intake and output) for the month of October 2024 indicated the intake and output monitoring was not done on the night shift of 10/10/24, and day shift of 10/13/24.

During a concurrent interview and record review on 10/16/24 at 9:16 a.m. with Licensed Nurse (LN) 1, Resident 396's clinical records were reviewed. LN 1 confirmed that Resident 396 had an order of intake and output monitoring every shift but it was not done on the night shift 10/10/24 and day shift of 10/13/24. LN 1 stated Resident 396's intake and output monitoring should be done every shift. LN 1 further stated that staff monitor Resident 396's fluids so they would know Resident 396's current fluid balance status.

During an interview on 10/16/24 at 2:45 p.m. with the Director of Nursing (DON), the DON stated it is important to always follow the physician's order for intake and output monitoring every shift to measure if the intake is adequate for the resident.

A review of the facility's policies and procedures titled, "Enteral Nutrition", revised 11/2018, indicated, "...9. The nursing staff and provider monitor the resident for signs and symptoms of

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F 693	Continued From page 6 inadequate nutrition, altered hydration...and altered electrolytes [minerals in the blood and other body fluids] ..."	F 693		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one out of 28 sampled residents (Resident 69) received appropriate pain management services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's order when Resident 69's physician's order of pain medication was not followed. This failure had the potential for Resident 69 to not achieve relief from pain and not attain her highest practicable well-being. Findings: A review of Resident 69's clinical record indicated Resident 69 was admitted August of 2024 and had diagnoses that included cerebral infarction (damage to a part in the brain due to a disrupted blood flow), muscle weakness, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and osteoarthritis (a disease that	F 697	Pain Management Resident 69 was interviewed and stated that Acetaminophen 325mg 2 tabs is effective for managing pain levels of 1 to 6. Resident 69's Physician was contacted, and PRN Acetaminophen order was updated by the Physician with instructions to give PRN for pain level of Mild to Moderate pain. All other residents with PRN pain medication with instructions to give based on mild, moderate or severe pain levels were audited to ensure that medication administration was given per MD orders. No other residents were found to be affected by deficient practice. Licensed nurses were in-serviced about following instructions specified in physician orders, especially paying close attention for instructions regarding pain level intensity. Licensed nurses were educated on contacting the physician if the resident is requesting pain medication that does not follow the instructions regarding pain intensity and ask if the instructions can be updated based on what is effective for the resident.	11/1/24 11/2/24 11/6/24 11/7/24

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F 697	Continued From page 7 causes the cartilage and bone in joints to break down over time causing pain). A review of Resident 69's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 8/15/24, indicated Resident 69 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 69 had intact cognition. A review of Resident 69's MDS Mood Status, dated 8/15/24, indicated Resident 69 experienced feeling down, depressed, or hopeless for several days. During an interview on 10/14/24 at 1:35 p.m. of Resident 69, Resident 69 stated she sometimes would experience pain and takes pain medications for it. A review of Resident 69's active physician's order, dated 8/9/24, indicated, "Acetaminophen [pain medication] Oral Tablet 325 MG [milligrams- unit of measurement] ...Give 2 tablets via G-Tube [gastrostomy tube- a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) every 6 hours as needed for Pain - Mild..." A review of Resident 69's active physician's order, dated 8/9/24, indicated, "Acetaminophen-Codeine [a medication for pain which contains a combination of Acetaminophen; a potent pain reliever, and Codeine; a controlled pain medication] Oral Tablet 300-30 MG [mg, milligram, a unit of measurement]... Give 1 tablet via G-Tube every 12 hours as needed for Pain - Moderate; Pain - Severe..."	F 697	During the Monthly Recap of orders done by the ADON/Unit supervisor, the PRN pain medication administration record will also be reviewed to audit if PRN pain medication is being administered per physician order instructions. The results of the PRN pain medication administration audit will be brought to the quarterly QA committee meeting to monitor compliance with follow physician orders. The Facility is in compliance with F697 as of 11/8/24	ongoing ongoing

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F 697	Continued From page 8	F 697		

A review of Resident 69's Medication Administration Record (MAR, a legal document used to record medications given to the residents) for the month of September 2024 indicated Resident 69 was given Acetaminophen on 9/1/24 when her pain was at 5 out of 10 (a numeric pain scale where 1 being the lowest and 10 being the highest), and on 9/16/24 when her pain was at 5 out of 10.

A review of Resident 69's MAR for the month of October 2024 indicated Resident 69 was given Acetaminophen on 10/7/24 when her pain was at 4 out of 10, and on 10/8/24 when her pain was at 5 out of 10.

During a concurrent interview and record review on 10/16/24 at 9:16 a.m. with Licensed Nurse (LN) 1, Resident 69's clinical records was reviewed. LN 1 confirmed that the physician's order of pain medication was not followed on 9/1/24, 9/16/24, and 10/8/24. LN 1 stated the facility staff would consider 4 out of 10 as mild pain. LN 1 further stated, "For moderate pain...I would give the other one [Acetaminophen-Codeine] ...We [facility staff] have to verify pain scale and follow the doctor's order."

During an interview on 10/16/24 at 2:45 p.m. with the Director of Nursing (DON), the DON stated it is important to always follow the physician's order for pain management to control the resident's pain.

A review of Resident 69's care plan intervention for pain, initiated 8/9/24, indicated, "Administer medication as ordered and observe for side effects and effectiveness of medication..."

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F 697	Continued From page 9 A review of the facility's P&P titled, "Pain - Clinical Protocol", revised 03/2018, indicated, "...b. Pain level intensity will be assessed based on a numeric scale 1- 10 (1-3=Mild pain, 4-6=Moderate pain, 7-10=Severe pain) ..." A review of the facility's P&P titled, "Administering Medications", revised 04/2019, indicated, "4. Medications are administered in accordance with prescriber orders..."	F 697		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755	Pharmacy Srvcs/ Procedures/Pharmacist/Records The loose pills were removed immediately from the medication carts. Packaged medication that was stuck in the back of the med cart was removed and placed in the appropriate section of the cart for use. The nurse that administered medication as indicated on the controlled drug record (CDR) was contacted to inquire why the electronic Medical Administration Record (eMAR) was not signed and they said "they forgot". The nurse documented on the eMAR the administration of Norco 5/325 1 tablet on10/4/24 at 8:28 p.m., and 1 tablet on 10/8/24 at 8:50 p.m as a late entry.	10/14/24 10/15/24 10/16/24

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F 755	Continued From page 10 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure pharmacy services were maintained to ensure a system that will account for and maintain accurate reconciliation (count of pills matches documentation for administration of medication) of all pharmaceutical products for a census of 134 residents when: 1. Loose medication found in the bottom of the medication drawer. 2. Packaged medication with a resident label found in the back of medication drawer. 3. The controlled medication (drug that is regulated by the government for its manufacture, possession, and use) audit for Resident 131 did not reconcile. The medications were signed out of the Controlled Drug Record (CDR, an inventory sheet in the narcotic book that keeps record of the usage of controlled medications) but was not documented on the Medication Administration Record (MAR, a legal document used to record medications given to the residents) on two occasions to indicate it was given to Resident 131. These failures resulted in the potential risk for diversion of the loose medication (use of medication for purposes not intended by prescriber/physician) and the facility failing to	F 755	All other medication carts were checked for loose pills and stuck packaged medication and none were found. All residents receiving controlled drugs were audited to compare the controlled drug record to the eMAR to ensure documentation times matched. No other residents found to be affected by deficient practice. Licensed nurses were in serviced on facility policy for medication storage and to ensure that loose pills are removed from the medication cart, as well as checking the medication carts for medication packages that could be stuck in the back of the medication cart. The Licensed nurses were also in serviced about signing both the controlled drug record and the eMar at the time of controlled drug administration. The licensed nurses will be assigned to check the medication carts weekly to ensure proper medication storage per policy. Medical Records Department will audit CDR and eMAR weekly to check that both records are documented as appropriate.	10/15/24 11/1/24 11/6/24 11/7/24

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F 755	Continued From page 11 ensure non-controlled (medication that the use and possession of are not controlled by the federal government) and controlled drugs were accounted for accurate medication administration and medication reconciliation for a total of four medication carts and two treatment carts managed by the facility staff of which 2 medication carts and 2 treatment carts were inspected alongside Licensed Nurse (LN) staff members during survey. Findings: 1. During a concurrent observation and interview of medication cart 1 in D-wing on 10/14/24, with LN 4 at 4:02 p.m., there was 1 loose white pill found in the back of the controlled medication drawer and 1 loose white pill found in the back of the non-controlled medication drawer. LN 4 verified these findings. LN 4 stated, these loose pills should not be there. LN 4 took the 2 loose tablets, placed them in a plastic bag, crushed them, and stated she would take the crushed medications to the Director of Nursing (DON) for destruction and disposal. During concurrent observation and interview of medication cart 1 in A-wing on 10/15/24, at 9:42 a.m., there was 1 loose white pill found in the back of the non-controlled medication drawer. LN 5 verified this finding. LN 5 stated the loose pill should not be there. LN 5 stated she would take it to the bin (medication collection container for medication destruction and disposal) for disposal, which was in the A-wing locked medication storage room. During concurrent observation and interview in the DON's office, on 10/16/2024 at 4:08 p.m., the DON demonstrated and described the medication	F 755	Results of the medication cart audits and CDR/eMAR audits will be brough to the QA committee meetings on a quarterly basis to evaluate compliance with facility policies. The Facility is in compliance with F755 as of 11/8/24	Ongoing

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F 755	Continued From page 12	F 755		

retrieval and destruction process. The DON stated the staff should have removed the loose pills from the storage medication cart to prevent medication errors.

A review of the facility's policy and procedure titled, "Medication Labeling and Storage," dated 2/23, indicated, "Medications are stored in an orderly manner in cabinets, drawers, cart ..." and "Each resident's medications are assigned ... area to prevent the possibility of mixing medication of several residents."

2. During concurrent observation and interview of medication cart 1 in D-wing on 10/14/24, at 4:02 p.m., with LN 4, LN 4 verified there was a medication blister pack (a form of tamper -evident packaging where an individual pushes individually sealed tablets through the foil in order to take the medication) that had slipped to the back and bottom of the non-controlled medication cart drawer. LN 4 stated the blister pack should not be kept at the back of the medication drawer.

During an interview with the DON on 10/16/2024 at 4:08 p.m., the DON stated she removed the medication blister pack from cart 1 in D-wing and stated the non-controlled medication should not have been stored in this manner per policy and procedure. The DON said, "The medication blister pack in the back of the drawer was [brand name of medication used to treat or prevent blood clots] and belonged to a patient." They couldn't find it, so they had to order another blister pack." The DON further stated the pharmacist said it was too early to order more medication, however the staff explained location of the blister pack could not be found." The DON

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F 755	Continued From page 13	F 755		

stated, "another order for medication was processed."

A review of the facility's policy and procedure titled, "Medication Labeling and Storage," dated 2/23, indicated, "Medications are stored in an orderly manner in cabinets, drawers, cart ..." and "Each resident's medications are assigned ... area to prevent the possibility of mixing medication of several residents."

3. A review of Resident 131's clinical record indicated Resident 131 was admitted September of 2024 and had diagnoses that included encounter for other orthopedic aftercare (a care provided after a surgery that involves bones, muscles, and joints), pain in right lower leg, and diabetes mellitus (a chronic condition causing too much sugar in the blood).

A review of Resident 131's MDS Cognitive Patterns, dated 9/9/24, indicated Resident 131 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 131 had an intact cognition.

During an interview on 10/14/24 at 9:35 a.m. with Resident 131, Resident 131 stated he has pain and has been receiving pain medication since he was admitted.

A review of Resident 131's active physician's order with start date of 9/4/24 indicated, "Norco [a medication for pain which contains a combination of Hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever that increases the effects of hydrocodone] Oral Tablet 5-325 MG [milligrams- unit of measurement] ...Give 1 tablet by mouth every 4 hours as needed

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F 755	Continued From page 14 for AS NEEDED FOR [sic] MODERATE TO SEVERE PAIN." A controlled medication uses audit of Resident 131's MAR and the CDR for Norco, for the month of October 2024, indicated nursing staff did not document Norco administration on the MAR when signed out from CDR as follows: 1 tablet on 10/4/24 at 8:28 p.m., and 1 tablet on 10/8/24 at 8:50 p.m. During a concurrent interview and record review on 10/16/24 at 10:13 a.m. with LN 2, Resident 131's CDR and MAR were reviewed. LN 2 confirmed the finding of Norco being signed out of the CDR but was not accurately documented on the MAR on two separate occasions. The LN stated, "For narcotics [controlled pain medications such as Norco], as soon as I sign the MAR, I would sign the sheet [CDR] too...both [CDR and the MAR] should be matching, if its given, it should be signed here [MAR] ...It's [signing both CDR and MAR] being accountable for the narcotics." During an interview on 10/16/24 at 2:45 p.m. with the DON, the DON stated both CDR and the MAR should reconcile as part of the controlled medication accountability. The DON agreed that it would be a risk of controlled medication diversion when the CDR and MAR do not reconcile. During an interview on 10/17/24 at 10:33 a.m. with the Nurse Consultant (NC) 2, the NC 2 stated the facility's policy required the documentation of the quantity of the remaining medication which is only found in the CDR. The NC 2 further stated that it is implied in the facility's policy that both the CDR and MAR should be	F 755		

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F 755	Continued From page 15 signed upon administration of the controlled medication. A review of the facility's policies and procedures (P&P) titled, "Controlled Substances", revised 04/2019, indicated, "...9. Upon Administration: a. The nurse administering the medication is responsible for recording: (1) name of the resident receiving the medication; (2) name, strength and dose of the medication; (3) time of administration; (4) method of administration; (5) quantity of the medication remaining; and (6) signature of nurse administering medication." A review of the facility's P&P titled, Administering Medications", revised 04/2019, indicated, "...22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones."	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761	Label/Store Drugs and Biologicals The expired medication was removed from the treatment cart and disposed of per facility policy The emergency drug without a resident specific label was removed from the medication cart and disposed of per facility policy. The glucometer testing strips were removed from the cart and disposed. All other treatment and medication carts were checked to ensure proper medication storage per facility policy and no other issues were identified.	10/14/24 10/15/24 10/15/24

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F 761	Continued From page 16 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accurate labeling and storage of drugs for a census of 134 residents when: 1. An expired medication was stored in a treatment cart with all active medications. 2. An emergency medication did not have a label with resident's name affixed to medication. 3. An "open date" label (a label that captures the date a new bottle was opened) was not affixed to an open bottle of glucose test strips (small, disposable plastic strips that collect a blood sample to measure blood sugar levels). These failures increased the risk to administer medication that had lost its potency due to being expired or give medication to the wrong resident and to have inaccurate readings of glucose. Findings: 1. During a concurrent observation and interview of medication cart 1 in D-wing on 10/14/2024, at 4:02 p.m., with Licensed Nurse (LN) 4, 1 glucagon emergency kit (a medication kit used to treat severe low blood sugar containing one vial	F 761	Licensed nurses were in serviced on facility policy for medication storage and to ensure that expired medications are removed, open dates are placed on items that have shortened expiration after first use, and all prescription medications have resident specific labels. The licensed nurses will be assigned to check the medication/treatment carts weekly to ensure proper medication storage per policy. The results of the medication storage audits will be brought to the QA committee meeting on a quarterly basis to reviewing compliance with medication storage policy. The Facility is in substantial compliance with F 761 as of 11/8/24	11/6/24 11/7/24 Ongoing

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F 761	Continued From page 17	F 761		

with dry glucagon powder and a prefilled syringe with liquid to mix with the powder) was found in the medication drawer without a resident specific pharmacy label. LN 4 stated the glucagon pen should have the resident's name label affixed to medication.

During an interview on 10/16/24 at 4:08 p.m., with the Director of Nursing (DON), the DON stated all prescribed medications should have applicable resident name labels affixed to the medications.

A review of the facility's policy and procedure titled, "Medication Labeling and Storage," dated 2/23, indicated, "The medication label includes, at a minimum, medication name, prescribed dose ...resident's name ...appropriate instructions ..."

2. During a concurrent observation and interview of treatment cart 1 in D-wing on 10/14/24, at 4:14 p.m., with Licensed Nurse (LN) 4, a 75 ml (milliliters, unit of measure) multi-dose bottle of liquid lidocaine (medication used to treat pain) medication found in a treatment drawer with an expiration date of 1/24. LN 4 verified the medication had an expiration date of 1/24 and stated the medication should have been discarded and not kept in the treatment cart.

During an interview on 10/16/24 at 4:08 p.m. with the DON, the DON stated expired medications should not have been found in medication treatment carts and expired medications should have been disposed of per policy and procedure.

A review of the facility's policy and procedure titled, "Medication Labeling and Storage," dated 2/23, indicated, "Multi-dose vials that have been opened or accessed ...are dated and discarded

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F 761	Continued From page 18 within 28-days unless the manufacturer specifies a shorter or longer date for the open vial." 3. During a concurrent observation and interview of medication cart 1 in A-wing on 10/15/24, at 9:42 a.m., with LN 5 an open bottle of glucose test strips did not have an "open date" label affixed to the bottle. LN 5 verified the bottle of glucose test strips was opened and there was no "open date" label affixed to the bottle. LN 5 stated the bottle should be labeled with the "opened date" and verified that the glucose test strip bottle did not have and open date label. During an interview on 10/16/24 at 4:08 p.m. with the DON, the DON stated an opened bottle of glucose test strips should have an "open date" label affixed to the bottle to ensure expired strips are not used on residents requiring blood glucose level checks. A review of the bottle of test strip manufacture label, located on the bottle of test strip, stated, glucose stirps should be, "used within six months after first opening or before the given expiration date." A review of the facility's policy and procedure titled, "Administering Medications," dated 4/19, indicated, "The expiration/beyond use date on the medication label is checked ...When opening a multi-dose container, the date opened is recorded on the container."	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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F 812	Continued From page 19 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to properly store raw meat and dry foods in accordance with safe food practices and failure to wear hair restraints in the kitchen for a census of 134 residents when: 1. raw ground beef was found stored above the vegetables; 2. uncooked lasagna pasta, polenta powder and chocolate chips stored unsealed; 3. Restorative Nursing Assistant (RNA) did not wash his hands, wear a hair and facial hair restraint before entering the kitchen; and 4. Dietary Aide's (DA) facial hair was not covered with hair restraints. This deficient practice had the potential to cause	F 812	The ground beef and vegetables were separated on both sides of the walk-in freezer. The unsealed food was thrown out. The dietary aid was instructed to wear the hair restraints properly. All food being stored were audited to ensure they were being stored properly, both in the dry storage and walk in freezer. There were no other findings. Dietary staff were provided an Inservice on how to store food properly. Staff were also provided an Inservice on the proper use of hair restraints. The CDM will conduct weekly audits to ensure food is stored properly and staff are using proper hair restraints for the next 6 weeks. Facility is in compliance with F 812 as of 11/7/24	10/16/24 10/16/24 ongoing

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F 812	Continued From page 20	F 812		

cross contamination of harmful bacteria; attract pests or rodents to unsealed dry foods; and transfer harmful germs onto food.

Findings:

1. During a concurrent observation and interview with the Dietary Manager (DM), in the kitchen's walk-in freezer on 10/14/24 at 9:10 a.m., raw ground beef was observed on a shelf, stored above the vegetables. The DM acknowledged and stated, the raw meat should be stored with other meats below the vegetables to avoid contamination from the drips from the raw meat.

2. During a concurrent observation and interview with the DM, in the dry pantry on 10/14/24 at 9:35 a.m., it was observed that there were open and unsealed boxes of uncooked lasagna pasta, polenta powder and chocolate chips [brand name]. The DM acknowledged and stated, once staff open a box or package, the dietary staff must use the food grade plastic bags to seal and store the food to avoid bugs or pests.

3. During a concurrent observation and interview in the kitchen on 10/15/24 at 1:40 p.m., with a RNA and the DM, the RNA was observed to have entered the kitchen, without washing his hands, or put on a hair net and facial hair restraint. The RNA then walked towards the stainless counter near the steam table to pick up a meal tray. The RNA confirmed and stated, I did not wash my hands and wear hair restraints before entering the kitchen which I should have done to promote infection control. The RNA acknowledge he should have rung the doorbell to alert the kitchen staff that he was outside waiting for his meal tray. The DM stated, the RNA staff should not enter

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F 812	Continued From page 21 the kitchen, only the kitchen staff are allowed inside the kitchen. The RNA should have rung the doorbell and wait for the kitchen staff to give him his meal tray. 4. During a concurrent observation and interview on 10/16/24 at 10:30 a.m., the DA was observed with a long mustache and beard not wearing a facial hair restraint while working in the kitchen. The DA confirmed and stated, "Yes, my mustache and beard are long, and I'm not wearing a hair net. I should be wearing it." The DM acknowledge the DA must wear facial hair restraints at all times when working in the kitchen. During a review of the facility's policy and procedure titled, "Food Receiving and Storage," revised 10/2022, indicated, " ... Foods shall be received and stored in a manner that complies with safe food handling practices ..., 9. Uncooked and raw animal product and fish are stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat food to prevent meat juices from dripping onto these foods." During a review of the facility's policy and procedure titled, "Food Preparation and Service," revised 10/2022, indicated, " ... 5. Food and nutrition services staff, including nursing services personnel, wash their hands ..., 8. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food ..."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		

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F 880	Continued From page 22 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	Infection Prevention and Control Staff that removed their N95 masks inside the resident's room were immediately educated on removing the N95 masks after exiting the room. Visitors were educated on wearing proper PPE while visiting a resident with an infectious condition. Facility Infection Preventionist initiated N95 fit testing for staff that did not have documentation of fit testing. Resident 395's Oxygen tubing was removed from the floor and a new Oxygen tubing was provided and placed in a bag when not in use. Resident 120's urinary bag was pick up off the floor and placed on the bed frame so that it did not touch the ground. Facility staff were educated on adhering to EBP while caring for residents with wounds or invasive devices. All other residents who are on isolation precaution room and/ or on Enhanced Barrier Precaution (EBP) were audited to ensure that there are appropriate sign for all required PPE are posted .	10/14/24 10/14/24 10/14/24 10/14/24 11/01/24

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F 880	Continued From page 23 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 134 residents when: 1. Two facility staff removed their N95 mask respirators (a type of mask that filters up to 95% of particles in the air) inside a droplet isolation precaution room (an isolation precaution implemented when a patient infected with a pathogen which is transmittable through air droplets by coughing, sneezing, talking, and close contact with an infected patient's breathing)	F 880	All other residents who have urinary catheter were reviewed to ensure that the urinary bags were not touching the floor and have fig leaf or placed in privacy bag. All other residents with oxygen tubing were audited to make sure that the are in the bag when not in use. No other resident found to be affected by the defcient practice. The facility Infection Preventionist conducted an audit for staff that did not have documentation of N95 Fit Test. Staff found to have no documentation of N95 Fit Testing were Fit tested for N95 Staff were in service on following Policies and Procedures: 1) Isolation-Categories of Transmission 2) Enhanced Barrier Precaution 3)Personal Protective Equipment 4) Visitation, Infection Control During 5) Catheter care, Urinary with emphasis on making sure that the urinary drainage bag has fig leaf or in the privacy bag 6) Oxygen Administration, with highlights on ensuring that the tubing is in the bag when not in use, if or when the oxygen tubing is found on the floor, to let the nurse know for replacement new tube.	11/01/24 11/05/24 11/05/24 11/06/24 11/07/24

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F 880	Continued From page 24 before exiting the room; 2. Two resident visitors entered a COVID (an infectious disease) isolation precaution room without using all the required personal protective equipment (PPE); 3. Four out of five sampled facility staff did not have a current N95 mask fit test (a test protocol conducted to verify that the specific type and model of N95 mask is both comfortable and provides the wearer with the expected protection) done. 4. Resident 395's nasal cannula (a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils) was observed on the floor and not covered. 5.Resident 120's urinary bag (a bag attached to a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time), was observed laid on the floor on two separate instances. 6. A facility staff provided care to Resident 42 who was on Enhanced Barrier Precaution (EBP) without wearing all the required PPE. These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure of Resident 395, Resident 120, and Resident 42 to germs, and may cause infection among residents, staff, and visitors. Findings:	F 880	the facility Infrction Preventionist will conduct a random skill check of 10 staff a month for Donning PPE and Removing PPE The facility Infection Preventionist will continue to perforn N95 Fit Testing for new employees and as needed it there is change in the brand of N95 supply The facility Infection Preventionis will be responsible to conduct Infection Rounds monthly. Findings will be brought to Quallity Assurance Committee qaurterly. The facility in in compliance with F800 as of 11/08/2024	on-going on-going on-going on-going

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F 880	Continued From page 25 1. During a concurrent observation and interview on 10/14/24 at 9:51 a.m. with Licensed Nurse (LN) 2, LN 2 was observed coming out of Unit C Room 3 not wearing an N95 mask. LN 2 confirmed the observation. LN 2 stated a resident in the room tested positive for COVID, so the room is on COVID-isolation precaution. During an observation on 10/14/24 at 9:52 a.m., Unit C Room 3 had a "RED ZONE" sign posted on the wall on the left side of the door which indicated, "N95 mask required to care staff working on this area...Googles or face shield must be worn when providing care to all residents...Gowns required when providing care too residents on isolation precaution...N95 AND EYE PROTECTION REQUIRED!". Next to the "RED ZONE" sign was a signage from The Centers for Disease Control and Prevention (CDC- the national public health agency of the United State) which indicated, "HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)...Remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence: 1. GOWN AND GLOVES...2. GOGGLES OR FACE SHIELD...3. MASK OR RESPIRATOR...4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE..." During an interview on 10/14/24 at 1:06 p.m. with LN 2, LN 2 stated, "We [facility staff] remove everything [all PPE] inside the [COVID- isolation] room." During a concurrent observation and interview on	F 880		

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F 880	Continued From page 26 10/14/24 at 1:27 p.m. with Certified Nurse Assistant (CNA) 3, CNA 3 was observed coming out of Unit C Room 5 without wearing an N95 mask. CNA 3 confirmed the observation. CNA 3 stated a resident in the room tested positive for COVID. CNA 3 further stated he removed all his PPE inside the room including his N95 mask. During an interview on 10/16/24 at 12:21 p.m. with the Infection Preventionist (IP), the IP stated their practice in the facility is to remove all the PPE, including the N95 mask, inside the resident's room before going out. During an interview on 10/16/24 at 2:45 p.m. with the Director of Nursing (DON), the DON stated the N95 mask should be removed after going out of the room and closing the door of a COVID isolation room. The DON stated they have to follow the CDC guidelines. The facility's guidelines for properly removing PPE after entering an isolation room was requested from the DON. A review of the guidelines provided titled, "SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)", undated, indicated, "Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing the door...." 2. During an observation on 10/14/24 at 9:58 a.m. in Unit C Room 5, two resident visitors entered the room only using surgical masks (a type of mask that protects the mouth and nose from splashes, sprays, and large droplets that may include microorganisms). During an observation on 10/14/24 at 9:59 a.m.,	F 880		

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F 880	Continued From page 27 Unit C Room 5 had a "RED ZONE" sign posted on the wall on the left side of the door which indicated, "N95 mask required to care staff working on this area...Googles or face shield must be worn when providing care to all residents...Gowns required when providing care to residents on isolation precaution...N95 AND EYE PROTECTION REQUIRED!". Next to the "RED ZONE" sign was a signage from CDC which indicated, "SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)...1. GOWN...2. MASK OR RESPIRATOR...3. GOGGLES OR FACE SHIELD...4. GLOVES..." During an interview on 10/14/24 at 9:51 a.m. with LN 2, LN 2 stated resident visitors entering a COVID isolation room should also wear everything the staff wears before entering the room including an N95 mask and gown. During a concurrent observation and interview on 10/14/24 at 10:12 a.m. with Certified Occupational Therapist Assistant (COTA), COTA confirmed that two resident visitors entered unit C room 5 only using surgical mask. COTA stated a resident in room 5 tested positive with COVID. COTA further stated, "...As far as I know, they're [visitors] encourage to wear mask...Both of them [Room 5's visitors] are wearing regular mask..." During an interview on 10/14/24 at 10:50 a.m. with the IP, the IP stated everybody going inside Unit C Room 5- including visitors, should wear PPE. The IP further stated, "...They [resident's visitors] have to cross the threshold [starting point of isolation precaution], they should wear PPE..." During an interview on 10/16/24 at 12:21 p.m.	F 880		

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with the IP, the IP stated she cannot force visitors to wear the proper PPE. The IP further stated visitors going inside a COVID isolation room should follow the proper use of PPE.

During an interview on 10/16/24 at 2:45 p.m. with the DON, the DON stated her expectation is that staff should inform the visitors on the use of required PPE when going inside a COVID isolation room. The DON further stated that not wearing the proper PPE could spread infection to the visitors, staff, or other residents in the facility.

A review of the facility's policy and procedure (P&P) titled, "Visitation, Infection Control During", revised 08/2019, indicated, "Visiting a resident who is under transmission-based precautions is permitted. a. Family members and visitors who are providing care or have very close contact with the resident are trained regarding the appropriate use of infection control barriers such as personal protective equipment. b. Adherence to transmission-based precautions by visitors is required."

3. During a concurrent observation and interview on 10/14/24 at 9:51 a.m. with LN 2, LN 2 was observed wearing a white 3M N95 mask and entered a COVID isolation room. LN 2 confirmed the observation. LN 2 stated she started working in the facility 03/2024 and was not fit tested with N95 mask in the facility prior to her start date.

During a concurrent observation and interview on 10/14/24 at 10:12 a.m. with COTA, COTA was observed wearing a white N95 mask and entered a COVID isolation room. COTA confirmed the observation. COTA stated she started working in the facility 01/2024.

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F 880	Continued From page 29 During an interview on 10/14/24 at 10:50 a.m. with the IP, the IP stated that N95 mask fit testing is done upon hiring of the staff and then annually. During a concurrent observation and interview on 10/14/24 at 12:24 p.m. with Unit Secretary (US), US was observed wearing a white N95 mask and was working at Unit C. US confirmed the observation. During a concurrent observation and interview on 10/14/24 at 1:27 p.m. with CNA 3, CNA 3 was observed wearing a white N95 mask and entered a COVID isolation room. CNA 3 confirmed the observation. CNA 3 stated he has been working in the facility for 5 months already. During a concurrent interview and record review on 10/16/24 at 12:21 p.m. with the IP, the employee files of LN 2, COTA, US, and CNA 3 were reviewed. The IP confirmed that the N95 fit testing upon hire for LN 2, COTA, US, and CNA 3 was not done. The IP stated N95 fit testing should be done upon hire of the staff. During an interview on 10/16/24 at 2:45 p.m. with the DON, the DON stated facility staff should have a current N95 fit test. The DON also stated that N95 fit testing is done upon hiring of the staff. The DON further stated N95 fit testing is done to make sure the N95 fits properly to that staff and to make sure the staff wearing the N95 is protected. A review of Centers for Disease Control and Prevention document titled, "Fit test FAQs [Frequently Asked Questions]", dated 9/3/21, indicated, "Are fit tests required? Yes. The	F 880		

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F 880	Continued From page 30 Occupational Safety and Health Administration (OSHA) (29 CFR 1910.134) requires respirator users to be fit tested to confirm the fit of any respirator that forms a tight seal on your face before using it in the workplace. Fit testing is important to ensure the expected level of protection is provided by minimizing the total amount of contaminant leakage into the facepiece through the face seal..." https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/respsource3fittest.html 4. A review of Resident 395's clinical record indicated Resident 395 was admitted October of 2024 and had diagnoses that included intracerebral hemorrhage (a type of stroke that occurs when a blood vessel in the brain ruptures and bleeds into the brain tissue), moyamoya disease (a disease in which blood vessels in the brain are constricted which blocks blood flow into the brain), and diabetes mellitus (a chronic condition causing too much sugar in the blood that can affect lung function and breathing). A review of Resident 395's active physician's order, dated 10/11/24, indicated, "Resident...does not...have the capacity to understand choices &make [sic] health care decisions." A review of Resident 395's active physician's order, with start date of 10/12/24, indicated, "O2 [oxygen] 2L/min [liters per minute- unit of measurement for oxygen administration flow rate] when she sleeps at bedtime for Sleep apnea [a sleep disorder that causes people to stop breathing or breathe shallowly while they sleep]." During an observation on 10/14/24 at 12:21 p.m., in Resident 395's room, Resident 395 was	F 880		

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observed lying on her bed, awake, and was not currently using oxygen. Resident 395's nasal cannula was observed on the floor, on the bottom of her bed, and was not covered.

During a concurrent observation and interview on 10/14/24 at 12:23 p.m. with CNA 1, in Resident 395's room, CNA 1 confirmed that Resident 395's nasal cannula was on the floor, on the bottom of her bed, and was not covered. CNA 1 acknowledged that the nasal cannula should not be on the floor.

During an interview on 10/16/24 at 12:21 p.m. with the IP, the IP stated, "...That's [nasal cannula on the floor and not covered] gross." The IP further stated the nasal cannula should be kept inside a black bag when not being used by the resident.

During an interview on 10/16/24 at 2:45 p.m. with the DON, the DON stated, "That [nasal cannula on the floor and not covered] needs to be discarded...That [nasal cannula on the floor and not covered] would be contaminated." The DON further stated that a nasal cannula should be clean.

A review of the facility's P&P titled, "Departmental (Respiratory Therapy) - Prevention of Infection", revised 11/2011, indicated, "The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment...among residents and staff...Infection Control Considerations Related to Oxygen Administration...6. Keep the oxygen cannula and tubing used PRN [as needed] in a plastic bag when not in use."

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5. A review of Resident 120's clinical record indicated Resident 120 was admitted August of 2024 and had diagnoses that included hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body) following cerebral infarction (damage to a part in the brain due to a disrupted blood flow) affecting left non-dominant side, retention of urine, and neuromuscular dysfunction of bladder (the nerves and muscles in the urinary bladder don't work together properly).

A review of Resident 120's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 8/29/24, indicated Resident 120 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 9 out of 15 which indicated Resident 120 had a moderately impaired cognition. A review of Resident 120's MDS Mood Status, dated 8/29/24, indicated Resident 120 experienced feeling down, depressed, or hopeless nearly every day. A review of Resident 120's MDS Bladder and Bowel Status, dated 8/29/24, indicated Resident 120 had indwelling catheter (a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time).

A review of Resident 120's active physician's order, dated 10/11/24, indicated, "Indwelling (FOLEY...catheter [a type of indwelling catheter] Fr [French- unit of catheter seize measurement] 16...10_CC [cubic centimeter- unit of volume] (Gravity drainage bag or leg bag) duet to Dx [diagnosis] of...NEUROMUSCULAR DYSFUNCTION OF BLADDER CHECK PLACEMENT AND FUNCTION...every shift."

During an observation on 10/14/24 at 11:33 a.m.,

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in Resident 120's room, Resident 120 was observed lying on his bed, awake, and half of his urinary drainage bag was laid on the floor.

During a concurrent observation and interview on 10/14/24 at 11:36 a.m. with LN 2, in Resident 120's room, LN 2 confirmed that Resident 120's urinary drainage bag was laid on the floor. LN 2 stated the urinary drainage bag should be hanging and off the floor for infection control. LN 2 further stated a urinary drainage bag laid on the floor could cause the urine to back flow.

During an observation on 10/15/24 at 9:35 a.m., in Resident 120's room, Resident 120 was observed lying on his bed, awake, and his urinary drainage bag was laid on the floor.

During a concurrent observation and interview on 10/15/24 at 9:37 a.m. with CNA 2, in Resident 120's room, CNA 2 confirmed that Resident 120's urinary drainage bag was laid on the floor. CNA 2 stated the urinary drainage bag should be hanging for infection control.

During an interview on 10/16/24 at 12:21 p.m. with the IP, the IP stated, "...No, they [urinary catheter bag] should be hanging and never be on the floor."

During an interview on 10/16/24 at 2:45 p.m. with the DON, the DON stated, "Ideally, it [urinary catheter bag] should not be touching the floor." The DON further stated that a urinary catheter bag touching the floor poses infection control issues.

A review of the facility's P&P titled, "Catheter Care, Urinary", revised 08/2022, indicated,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 "Infection Control...2. Be sure the catheter tubing and drainage bag are kept off the floor." 6. Resident 42 was admitted to the facility in 2023 with a diagnoses that included open wounds to the right hip and sacrum (a large triangular bone at the base of the spine). A review of Resident 42's, "Plan of Care" dated 10/17/24, indicated Resident 42 required, "Enhanced Barrier Precautions (EBP)" related to the presence of wounds. The Plan of Care further indicated, to wear a gown and gloves when providing direct resident care. During an observation on 10/17/24 at 10:57 a.m., CNA 4 was observed going into Resident 42's room without a gown or gloves and provided care to Resident 42. Next to the entrance to Resident 42's room, signage was posted for EBPs. The sign indicated, to wear a gown and gloves for high contact resident care activities prior to entering the room. During an interview with CNA 4 on 10/17/24 at 11:06 a.m., CNA 4 verified she did not wear a gown or gloves to provide care for Resident 42. CNA 4 stated, she should have put on a gown and gloves to provide care for Resident 42. During an interview with LN 6 on 10/17/24 at 11:11 a.m., LN 6 verified, Resident 42 is on EBPs for wounds. LN 6 stated, "If staff go into a EBP room and are providing direct resident care they need to wear gloves and gown." During a concurrent interview and record review with the Nurse Consultant (NC 1) on 10/17/24 at 11:27 a.m., the NC 1 verified Resident 42 is on EBP for wounds. The NC 1 stated, a resident	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. BUILDING _____ B. WING _____	C 10/18/2024

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F 880	Continued From page 35 can be placed on EBPs based on nursing judgement and does not require an order, only a plan of care. The NC further stated, "If a staff member goes into the room to provide direct patient care and the resident is on EBPs, the staff must wear a gown and gloves." A review of the facility policy titled, "Enhanced Barrier Precautions" dated June 2024 indicated, "Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity. EBPs are indicated for residents with wounds..."	F 880		