STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055866	A. Building B. Wing	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plum Tree Care Center	2580 Samaritan Drive San Jose, CA 95124

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 46001 Based on interview and record review, the facility failed to inform the resident the items and services included in the nursing facility for one of four sampled residents (Resident 45) when Resident 45's Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN, notice that transfers potential financial liability) was not provided. This failure had the potential in Resident 45 not being informed of his payment responsibilities to the facility after Medicare Part A services ended. Findings: A review of Resident 45's medical record indicated he was admitted to the facility under Medicare Part A on 4/27/2023. The medical record further indicated Resident 45 came off Medicare Part A services on 6/7/2023 but continued living in the facility. A review of Resident 45's SNF Beneficiary Protection Notification Review, filled out by the facility on 11/29/2023, indicated the facility initiated Resident 45's discharge from Medicare Part A services when benefit days were not exhausted (the resident still had Medicare Part A days remaining). The SNF Beneficiary Protection Notification Review further indicated the facility did not provide a SNF ABN to Resident 45. During an interview with the business office manager (BOM) on 11/30/2023 at 4:20 p.m., she acknowledged the facility should have been completed and provided a SNF ABN to Resident 45. The Department of Health and Human Services and Centers for Medicare & Medicaid Services Form CMS-20052, dated 2/2017, indicated the facility must provide a SNF ABN when the resident has skilled benefit days remaining, discharged from Part A services and would continue living in the facility. During a review of the facility's policy and procedure(P&P) titled Beneficiary Protection Notification, effective date: 7/01/20, the P&P indicated .A SNF ABN must be provided to the beneficiary when the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care before it terminates such extended care or services .

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44185 Based on observation, interview, and record review, the facility failed to ensure services were provided to meet the professional standard of practice for two of 15 sampled residents when: 1. Resident 57 refused her medications and the doctor was not notified and; 2. Resident 111 refused her medication and the doctor was not notified. These failures had the potential to jeopardize the residents' health. 1. During the medication administration observation of Resident 57 with licensed vocational nurse B (LVN B), on 11/29/23 at 8:45 a.m., Resident 57 refused two of his medication the juven packet (therapeutic nutrition drink), to give one packet by mouth, once a day for supplement, mix in four to eight ounce (oz, a unit of weight) fluids, and prostat (ready-to-drink concentrated liquid protein medical food), 30 milliliter (ml, unit used to measure capacity) by mouth two times a day for supplement. Review of Resident 57's physician orders, indicated, Resident 57 had an order of juven packet, one packet by mouth, once time a day for supplement, mix in four to eight oz fluids, ordered on 10/24/23. Review of Resident 57's medication administration record (MAR, a report detailing the medications administered to a resident by a healthcare professional at a treatment facility), indicated, Resident 57 refused the juven packet 11/26/23. Review of Resident 57's clinical record indicated, there was no nurse's notes that the doctor was notified about his refusal on 11/26/23. During an interview with LVN B, on 11/29/23 at 3:15 p.m., LVN B verified that Resident 57's doctor was not notified and Resident 57 refused juven packet on 11/26/23 and there were no nurses' notes whether the doctor was notified about the refusal on 11/26/23. 1b. Review of Resident 57's physician orders, indicated, Resident 57 had an order of prostat, 30 ml by mouth two times a day for supplement, start date on 10/24/23. Review of Resident 57's MAR, indicated, Resident 57 refused the prostat supplement on 10/29/23. Review of Resident 57's clinical record indicated, there was no documented evidence the doctor was notified about his refusal on 10/29/23. During an interview with licensed vocational nurse B (LVN B), on 11/29/23 at 3:18 p.m., LVN B verified that Resident 57's doctor was not notified for his refusal of prostat on 10/29/23. There were no nurses' notes the doctor was notified about the refusal on 10/29/23. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the director of nursing (DON) on 12/01/23 at 1:10 p.m., DON verified the licensed nurse should have informed the doctor about Resident 57 refusal of juven packet on 11/26/23 and his prostat supplement. There were no nurses' notes the doctor was notified about the refusal of Resident 57 of his juven packet on 11/26/23 and prostat supplement, on 10/29/23. 2. During the concurrent medication administration observation of Resident 111 and interview with licensed vocational nurse B (LVN B), on 11/29/23 at 9:23 a.m., Resident 111 refused one of her medication, calcium with vitamin D (essential for healthy bones and other bodily functions). LVN B confirmed Resident 111 refused her calcium with vitamin D on 11/29/23. Review of Resident 111's physician orders, indicated, Resident 111 had an order of calcium with vitamin D, and to give once a day at 9 a.m. Review of Resident 111's clinical record indicated, there was no documented evidence the doctor was notified about her refusal of medication on 11/29/23. During an interview with the director of nursing (DON) on 12/01/23 at 1:10 p.m., DON verified the licensed nurse should have informed the doctor of Resident 111. She also stated Resident 111 refused her calcium with vitamin D on 11/29/23 and there was no nurse's notes the doctor was notified about her refusal. Review of the facility's policy and procedure titled, Medication Refusal and/or Missed Doses, effective date 8/1/20, indicated, . Steps will be taken to avoid missed or refused doses of medications and related adverse reactions. Missed/refused medications are documented in the resident's medication record and the prescribing physician should have been notified or according to physician parameters. Physician parameters must be retained in writing and kept on file. Physician instructions regarding missed dose are followed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on observation, interview, and record review, the facility failed to ensure services were provided to meet the professional standard of practice for four out of five sampled residents (Resident 24, 34, 4, and 3) who had a pacemaker (implanted device for a heart condition, a battery-powered device implanted inside the heart to restore a normal heartbeat) when: 1. Resident 24 had no documentation of apical pulse checks and no pacemaker malfunction monitoring, no pacemaker-related information in the medical records, no medical identification card regarding pacemaker, and no care plan regarding the pacemaker management, 2. Resident 34 had no care plan to manage the pacemaker care; 3. Resident 4 had no medical identification card regarding pacemaker; and 4. Resident 3 had no documentation of pacemaker information. These failures had the potential to compromise those residents' health and safety. Findings: 1. A review of Resident 24's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including acute on chronic diastolic (congestive) heart failure (a chronic condition in which the heart didn't pump blood as well as it should), stage 5 chronic kidney disease (end-stage renal disease), dependence on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally), unspecified pneumonia, acute respiratory failure with hypoxia (a state in which oxygen was not available in sufficient amounts at the tissue level to maintain adequate homeostasis), presence of cardiac pacemaker, and dependence on supplemental oxygen. During an interview with Licensed Vocational Nurse (LVN) B on 11/30/23 at 10:15 a.m., LVN B acknowledged that she did not check Resident 24's apical pulse to monitor pacemaker malfunction. During a concurrent interview and record review with Registered Nurse (RN) E on 11/30/2023 at 10:22 a.m., RN E reviewed Resident 24's medical record and confirmed there were no documentation of apical pulse checks and pacemaker malfunction monitoring, no care plan to manage the pacemaker care, no pacemaker related information in medical record. RN E stated the licensed nurses should have checked Resident 24's apical pulse daily, monitored for signs and symptoms of pacemaker malfunction every shift, kept pacemaker information in the medical records, provided a medical indetification card with pacemaker information, and developed a care plan to manage pacemaker care. During an interview with Registered Nurse (RN) C on 11/30/2023 at 2:18 p.m., RN C acknowledged she did not know the paced rate and did not check Resident 24's apical pulse. RN C further stated she should have known the paced rate and checked the apical pulse to monitor pacemaker malfunction. RN C also confirmed there was no medical identification card with Resident 24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 11/30/2023 at 3:20 p.m., the DON stated licensed nurses should have develop a care plan to manage pacemaker care, check apical pulse, and monitor the signs and symptoms of the pacemaker malfunction. The DON further stated Resident 24 was a dialysis resident who went out for dialysis three times a week and the facility should have provided a medical identification card with pacemaker information. 2. A review of Resident 34's clinical record indicated she was admitted to the facility on [DATE] with diagnoses including the presence of a cardiac pacemaker. During a concurrent interview and record review with the DON on 11/30/2023 at 3:22 p.m., the DON reviewed Resident 34's care plan and confirmed there was no care plan to address the pacemaker care. The DON further stated the licensed nurses should have developed a care plan to address the pacemaker management. 3. A review of Resident 4's clinical record indicated she was admitted to the facility on [DATE] with diagnoses including the presence of a cardiac pacemaker. During an observation and concurrent interview with Resident 4 in her room on 11/30/2023 at 1:47 p.m., Resident 4 had a pacemaker on her left upper chest and she stated that she had no medical identification card with pacemaker information. During an interview with the DON on 11/30/2023 at 3:24 p.m., the DON confirmed the above observation and stated the facility should have provided a medical identification card with pacemaker information to Resident 4 for emergency purposes. 4. A review of Resident 3's clinical record indicated she was admitted to the facility on [DATE] with diagnoses including the presence of a cardiac pacemaker. During a concurrent interview and record review with the DON on 11/30/2023 at 3:26 p.m., the DON reviewed Resident 3's medical record and confirmed there was no documentation of Resident 3's pacemaker information in her medical record. The DON stated staff should have documented the pacemaker information in Resident 3's medical record and medical identification card upon admission. During a review of the facility's undated policy and procedure (P&P) titled Pacemaker, Care of a Resident with, the P&P indicated, .monitor the resident for pacemaker failure by monitoring for signs and symptoms of bradyarrhythmia .make sure the resident has a medical identification card that indicates he or she has a pacemaker. The medical record must contain this information as well .for each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: name, address, and telephone number of the cardiologist, type of pacemaker, manufacturer, and model, serial number, date of implant and paced rate. During a review of the facility's policy and procedure (P&P) titled Baseline Care Plan effective date:7/01/2023, the P&P indicated . to assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed with forty-eight hours of the resident's admission .

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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** 45853 Based on observation, interview, and record review, the facility failed to ensure one out of 19 sampled residents (Resident 44) was free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behaviors) when: Resident 44 received Seroquel (an antipsychotic medication) without adequate indication and evaluation for its use. The failure resulted in unnecessary medications for the resident, which had the potential for increased risks associated with psychotropic medication use that include, but not limited to, sedation, respiratory depression, falls, constipation, anxiety, agitation, abnormal involuntary movements, and memory loss. Findings: Resident 44 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and adjustment disorder with depressed mood (an emotional or behavioral reaction to a stressful event or change in a person's life). During a review of Resident 44's Minimum Data Set (MDS, a resident clinical assessment tool) dated 8/29/23, the MDS indicated, Resident 44 had a BIMS score of 8 (Brief Interview for Mental Status, a mandatory tool used to screen and identify the cognitive condition of residents. A score of 8-12 suggests moderately impaired), indicating his cognition was moderately impaired. During a review of Resident 44's progress notes dated 11/11/23, the note indicated, AM [morning] shift endorsed that resident was yelling and screaming since this morning, resident was non-stop screaming. LN [licensed nurse] checked on him every 30 minutes. Resident just keep screaming. denies any pain. [.] pt [patient] stated he wants to go home. [.] MD [medical doctor] notified about behavior. During a review of Resident 44's physician order dated 11/11/23, it was indicated a new order for Seroquel 12.5mg every 8 hours as needed for yelling and screaming. This order did not have a stop date and was discontinued on 11/16/23. During a review of Resident 44's physician order dated 11/16/23, it indicated the Seroquel order was restarted with a 14-day duration. During a review of Resident 44's physician order dated 12/1/23, it indicated the Seroquel order was renewed for another 14 days. (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 44's physician progress note dated 11/29/23, the note indicated, agitation noted started on Seroquel. There was no documented evidence indicated the physician performed an onsite evaluation of Resident 44's behaviors on 11/11/23 and 11/16/23. The physician progress note dated 11/29/23 did not indicate an adequate evaluation of Resident 44's behaviors and documentation of the benefits and risks of the antipsychotic medication use. During a concurrent observation and interview on 11/27/23 at 8:05 a.m., Resident 44 was lying in bed quietly. He responded to questions but was confused. No behaviors or distress was observed. During an observation on 11/28/23 at 11:50 a.m., Resident 44 was lying in bed and chatting with his son, the resident was dozing off during conversations. No behaviors or distress was observed. During a concurrent interview and record review on 12/1/23 at 12:11 p.m. with Licensed Vocational Nurse (LVN) D, Resident 44's Medication Administration Record (MAR) date 11/2023 was reviewed. The MAR indicated the resident had yelling and screaming episodes eight times during day shifts, and one time during night shift. The resident received 16 doses of Seroquel during day shifts, and seven doses during evening shift in November. LVN D stated Resident 44 was yelling and screaming a lot during the day but had not showed anything that was harmful to others or to himself. During a review of Resident 44's psychiatry diagnostic interview dated 11/29/23, the interview indicated there was no evidence for self-harm risk or risk to others. The psychiatric nurse practitioner also recommended to discontinue as needed Seroquel and re-evaluate the resident in 30 days. During an interview on 12/1/23 at 1:11 p.m. with the consultant pharmacist (CP), the CP stated an in-person physician evaluation was required before renewing antipsychotic medications for Resident 44. During a review the facility's policy and procedure (P&P) titled Antipsychotic Medication Use revised 7/1/20, the P&P indicated,1. Residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and the risk to the resident and others. Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications would generally only be considered if the following conditions are also met: a. the behavioral symptoms present a danger to the resident or others. PRN order for antipsychotic medications would now be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. The physician should respond appropriately by changing or stopping problematic doses or medications, we're clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility had a medication error rate of 6.45% when two medication errors occurred out of thirty-one opportunities during the medication administration, for one out of eight residents, (Resident 115). These deficient practices resulted in medications not given in accordance with the prescriber's orders, which resulted in the resident, not receiving the full therapeutic effects of the medications and may cause preventable side effects for the resident. Findings: During the medication pass observation on 11/29/23 at 9:54 a.m., with licensed vocational nurse B (LVN B), LVN B was not able to administer two of Resident 115's medications which was the calcium with vitamin D (essential to building strong, dense bones), 600 milligrams (mg, a unit of measurement of mass)-200 units (mesures the biological effects of a substance), 1 tablet daily at 9 a.m., and the latanoprostene bunod (used to lower the pressure inside the eye) 0.024%, 1 drop to both eyes daily at 9 a.m. The medications were not available during the medication pass. During an interview with LVN B on 11/29/23 at 10:00 a.m., LVN B verified Resident 115's calcium with vitamin D, 600 mg-200 units, and latanoprostene bunod 0.024%, were not available. LVN B stated Resident 115's medication were missed. Review of Resident 115's physician orders indicated, Resident 115 was admitted to the facility on [DATE] with following medication orders to give calcium with vitamin D, 600 mg-200 units, 1 tablet daily at and latanoprostene bunod 0.024%, 1 drop to both eyes daily. During an interview with the director of nursing (DON) on 11/30/23 at 4:25 p.m., DON verified Resident 115's medications should have been available and should have been given to Resident 115. DON further verified that the availability of Resident 115's medications should have been verified during her admission. During an interview with the consultant pharmacist (CP) on 12/01/23 at 1:59 p.m., CP verified Resident 115's medications should have been clarified with the doctor and to ensure the availability. Review of the facility's policy and procedures titled, Administering Medications, revision date 7/1/2020, indicated, It was the policy of this facility that medications should have been administered in a safe and timely manner as prescribed by the healthcare provider. Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one (1) hour before and/or after their prescribed time, unless otherwise specified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44185 Based on observation, interview and record review, the facility failed to ensure proper medication storage and labeling of medications when: 1. three personal water bottles were kept in the medication room; 2. unlabeled used medication in the refrigerator; 3. discontinued medications were not discarded. These deficient practices had the potential for unsafe, ineffective and risk the misuse of medications. Findings: During the inspection and observation of the facility's Medication Storage room [ROOM NUMBER] on 11/27/23 at 8:00 a.m., the following were identified: 1. three personal water bottles, one opened and two unopened personal water bottles, were kept in the medication storage room, 2. one used medication in the medication refrigerator, Admelog Solostar (insulin lispro, fast-acting insulin, used to control blood sugar spikes), 100 unit (the concentration of insulin)/milliliter (ml, unit of volume), inject 5 units subcutaneously (beneath or under, all layers of the skin), 3 times daily with meals, discard 28 days after opening, not labeled with open and discard date and 3. discontinued medications were still not discarded. During an interview with the director of nursing (DON) on 12/01/23 at 1:10 p.m., DON verified the three personal water bottles should have not be kept in the medication storage room, the used medication in the medication refrigerator, Admelog Solostar, 100 unit/ml, inject 5 unit should have been labeled with open and discard date, and discontinued medications must be discarded right away. Review of the facility's policy and procedure titled, Storage of Medications, revision date 11/28/23 indicated, It was the policy of this facility that all drugs and biologicals are stored in a safe, secure and orderly manner. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. The facility should not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure titled, Labeling of Medication Containers, revision date 11/28/23 indicated, It was the policy of this facility that all medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. Labels for individual drug containers shall include all necessary information, such as: . the date that the medication was dispensed, . the expiration date when applicable . Review of the facility's policy and procedure titled, Discontinued Medications, revision date 11/28/23 indicated, It is the policy of this facility that staff shall destroy discontinued medications or shall return them to the dispensing pharmacy in accordance with facility policy. Discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46553 Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained in the kitchen when: 1. Undated and unrefrigerated bottle of sauce in the dry storage area; 2. Dented can in the dry storage area; 3. Two kitchen staffs did not completely cover their hair while handling food; 4. Ice machine had a black substance inside; and 5. Food prep sink drain was too close to the floor drain. These failures had the potential to cause food contamination and spread food-borne illness to residents who received their food from the kitchen. Findings: 1.During a concurrent kitchen observation and interview on 11/27/23 at 10:53 a.m. with the Registered Dietician (RD), there was a bottle of opened bottle of sauce without an open date in the dry storage area. The food label on the bottle also indicated, refrigerate after opening. The RD confirmed the above observations and stated the bottle was open with no open date. During a review of the facility's policy and procedure (P &P) titled, Food Storage dated 2017, the P&P indicated, When a food package was opened, the food item should have been marked to indicate the open date. This is used to determine when to discard the food. During a review of the facility's P &P titled, Food Safety and Sanitation dated 2017, the P&P indicated,4. Food storage. a. Stored food handled to prevent contamination and growth of pathogenic organisms. Refrigerated food was stored at or below 41 F. 2. During a concurrent kitchen observation and interview 11/27/23 at 10:49 a.m. with the RD, there was one large, dented can in the dry storage area. The RD confirmed the above observations and stated the dented can should have been taken out and placed in the designated area. During a review of the facility's P &P titled, Food Safety and Sanitation dated 2017, the P&P indicated, Bulging or leaking cans, cans with severe dents on the seams, or broken containers of food will not be used. Review of the United States Food and Drug Administration's 2022 Food Code indicated, pitted, or dented cans may present a serious potential hazard. (continued on next page)

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	055866	A. Building B. Wing	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plum Tree Care Center	2580 Samaritan Drive San Jose, CA 95124

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a kitchen observation on 11/29/23 at 8:45 a.m., a Dietary [NAME] and a [NAME] Aide were preparing food to serve to the residents. Both staffs did not have their hair inside of their hair nets. During an interview on 11/29/23 at 9:38 a.m., with the Dietary Supervisor, confirmed the above observation and stated staff should have had their hair completely covered while handling food. During a review of the facility's P &P titled, Food Safety and Sanitation dated 2017, the P&P indicated, 2. Employees. C. Employee are required to have their hair styled so that it does not touch the collar, [.] Hair restraints are required and should cover all hair on the head. 4.During a concurrent observation of the ice machine and interview on 11/27/23 at 11: 10 a.m. with the Maintenance Supervisor (MS), there was a brown substance on the outside of the water curtain. The MS confirmed above finding, he stated he cleaned the ice machine once a month, the last cleaning was on 11/4/23, and it was due for a cleaning. During a concurrent observation and interview on 11/27/23 at 3:37 p.m. with the MS, the kitchen staffs were continuing using the ice from the ice machine, requested the MS to reopen the ice machine over, observed black matters at the bottom of the splash shield which touched the ice, wiped with a white napkin, the black matters stained the entire napkin with black substance. The MS stated the ice machine should have not a black substance. During a review of the facility's P &P titled, Ice Machines and Ice Storage Chest revised 2012, the P&P Indicated, 3. Our facility has established procedure for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instruction. During a review of facility provided document titled Indigo Ice Machines Installation, Operation and Maintenance Manual rev 2/6/17, the manual indicated, Section 4 Maintenance. Cleaning and Sanitizing. General. Clean and sanitize the ice machine every six months for efficient operation. [.] An extremely dirty ice machine must be taken apart for cleaning and sanitizing. 5. During an observation on 11/27/23 at 3:32 p.m., in the kitchen with the MS, the food prep sink drain (an air gap is the unobstructed vertical space between the water outlet and the flood level of a fixture) was touching the dirty water in the floor drain. During an interview 11/29/23 at 10:25 a.m., with the MS, he verified the sink drain should have been at least one inch above the floor drain. During a review of the facility's P&P titled, AIR GAP DRAINAGE date 11/2017, the P&P indicated, 3. The air gap of any drainage pipe shall measure two times the diameter of the pipe. 5. Air gaps provide an empty unobstructed vertical space that prevents potable and non -potable water from intermingling. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Food and Drug Administration (FDA) Food Code 2022, section 5-202.13, titled, Backflow Prevention, Air Gap, it indicated, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). And section 5-202.14, titled, Backflow Prevention Device, Design Standard, it indicated, A backflow or back siphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering (A.S.S.E.) standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44185 Based on observation, interview and record review, the facility failed to ensure, infection control practices were implemented when: 1. Licensed Vocational Nurse (LVN) B did not remove gloves, sanitize (to reduce or remove pathogenic agents) hands and put on new gloves, after she fixed the plastic liner of the trash can before handing the inhaler to Resident 115, 2. Registered nurse (RN) C did not change gloves, sanitize hands and put on new gloves, after she picked up the pills of Resident 7 that fell on the floor, then discarded them, and administer the new medication pills, 3. Foley catheter bag (bag that is connected to the foley catheter, where the urine that drains through the catheter is collected) of Resident 265 was touching the floor, and; 4. The maintenance supervisor (MS) did not do hand washing upon entering the kitchen. These failures could result in the spread of infection and cross-contamination that could affect the 58 residents residing in the facility. Findings: 1. During the medication administration observation of Resident 115 with licensed vocational nurse B (LVN B) on 11 /29/23 at 10:10 a.m., LVN B was administering Resident 115, Advair Diskus inhaler (used to control and prevent symptoms of wheezing and shortness of breath), 250-50 microgram (mcg, which is a weight-bsed measurement)/dose, 1 inhalation every 12 hours. LVN B already did hand hygiene and had her gloves on, but then she fixed the plastic liner of the trash can beside her and then handing the Advair Diskus inhaler to Resident 115, Resident 115 took the inhaler, LVN B did not wash her hands, and change the gloves During an interview with LVN B on 11/29/23 at 3:10 p.m., LVN B verified she should have taken off the gloves, did hand hygiene and then put on new gloves, before giving the Advair Diskus to Resident 115. During an interview with the director of nursing (DON) on 12/01/23 1:10 p.m., DON verified LVN B should have removed her gloves, do hand hygiene and put on new gloves before giving the Advair Diskus inhaler to Resident 115. 2. During the medication administration observation of Resident 7 with registered nurse C (RN C) on 11/29/23 at 5:10 p.m., RN C was about to crush the 2 tablets of 10 milligram (mg, a unit of measurement of mass) Baclofen (it can treat muscle spasms). The 2 tablets of Baclofen fell on the floor and RN C picked the 2 tablets on the floor with her sanitized and gloved hand. RN C then discarded the tablets, then got 2 new tablets of Baclofen, 10 mg and crushing the 2 new Baclofen tablets, removed her gloves, hand hygiene, and then putting on new gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with RN C on 11/29/23 at 5:20 p.m., RN C verified she should have removed her gloves, hand hygiene, and put on new gloves, after she picked up the 2 tablets of Baclofen on the floor. During an interview with infection preventionist (IP) on 11/30/23 at 4:14 p.m., IP verified that RN C should have removed her gloves, then do hand hygiene, and put on new gloves. During an interview with the DON on 12/01/23 1:10 p.m., DON verified that RN C should have removed her gloves, hand hygiene, and put on new gloves. Review of the facility's policy and procedure titled, Handwashing - Hand Hygiene, effective date 1/1/23, indicated, This facility considers hand hygiene, the primary means to prevent the spread of infections. All personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . before preparing or handling medications, . before donning sterile gloves, . after contact with objects . in the immediate vicinity of the resident, after removing gloves .The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Review of the facility's policy and procedure titled, Personal Protective Equipment - Using Gloves, effective date 1/1/23, indicated, To guide the use of gloves. To prevent the spread of infection . Use non-sterile gloves primarily to prevent the contamination of the employee's hands when providing treatment or services to the patient . 46553 3. During an observation on 11/27/23 at 9:31 am., with Resident 265's in her room, the indwelling (inside the body) urinary catheter (the catheter drains urine from the bladder into a bag outside the body) was touching the floor and was not covered by privacy bag (provides catheter bag users an inconspicuous [not visible} way to hide a urine collection bag). During an interview on 11/27/23 at 9:45 a.m., with LVN A she verified the indwelling urinary catheter was not covered and touching the floor. LVN A stated the indwelling urinary catheter should have not touching the floor. During an interview on 11/30/23 at 1:51 p.m., with the DON stated it should have not touching the floor During a review of the facility's P &P titled, Catheter Care-Urinary , dated 7/1/2020, indicated, Infection control #2. b. Be sure the catheter tubing and drainage bag are kept off the floor 4. During a kitchen observation on 11/29/23 at 3:25 p.m., the MS entered to the kitchen, he did not wash his hands and applied new pair of gloves. During an interview on 11/29/23 at 3:25 p.m., with MS confirmed he did not wash his hands before entering the kitchen and he applied new pair of gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/29/23 at 9:40 a.m., with Kitchen Supervisor (KS) stated the staff should have washed their hands upon entering the kitchen to prevent cross contamination in the kitchen. During an interview on 12/01/23 at 9:14 a.m., with IP, stated the staff should have washed their hands when entering the kitchen to prevent infection. During a review of the facility's P &P titled, Hand Washing , dated 2017, indicated, Employee will wash hands as frequently as needed throughout the day using proper hand washing procedures .when to was hands when entering the kitchen