STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056076	A. Building B. Wing	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Terrace Care Center	141 South Knott Avenue Anaheim, CA 92804

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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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41418 Based on observation, interview, and facility document review, the facility failed to ensure two nonsampled residents (Residents 28 and 68) were served their lunch meal in a timely manner. This failure posed a risk to the residents' physical and emotional well-being. Findings: On 7/21/21 at 1400 hours, a tray line observation was conducted in the kitchen. The last food cart was observed leaving the kitchen at 1400 hours. Review of the facility's posted mealtimes showed the first cart must be out at the posted time. The posted lunch time was 1215 hours. On 7/21/21 at 1410 hours, a concurrent interview was conducted with Residents 28 and 68. Resident 28 stated his lunch tray usually came at 1230 hours; however, his tray came at 1410 hours today. Resident 28 stated this was a new record for being late. Resident 28 stated he was hungry. Resident 68 stated his tray arrived late at 1410 hours. On 7/22/21 at 0935 hours, an interview was conducted with Food Service [NAME] 2. Food Service [NAME] 2 verified the last food cart left the kitchen at 1400 hours, during lunch service on 7/21/21. When asked, Food Service [NAME] 2 stated he miscalculated the amount of food needed for lunch and ran out of the Italian sausage, garlic and rosemary roasted red skin potatoes, broccoli florets, and mashed potatoes. Food Service [NAME] 2 stated lunch service was late because the kitchen ran out of food. On 7/22/21 at 0941 hours, an interview was conducted with the Dietary Manager. The Dietary Manager verified the above findings. The Dietary Manager stated the kitchen had to cook more Italian sausage which caused the trays to be late.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45299 Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services for one of 20 final sampled residents (Resident 686). The facility failed to ensure Resident 686's call light was answered in a timely manner when she needed to go to the bathroom. This failure led to the resident feeling upset and posed a risk to the residents' physical and emotional well-being. Findings: Review of the Resident 686's medical record was initiated on 7/19/21. Resident 686 was admitted to the facility on [DATE]. Review of the physician's H&P examination dated 7/11/21, showed Resident 686 needed assistance with her ADL care. On 7/19/21 at 0956 hours, during an initial tour, Resident 686 was observed sitting on her bed with a plaster cast on her left leg. Resident 686 stated she was not able to ambulate by herself when she needed to go to the bathroom. Resident 686 stated she had concerns about the facility staff not answering her call light in a timely manner. Resident 686 stated she checked the time on her phone, and it would take about 20 minutes to get assistance from the staff for her to go to the bathroom. Resident 686 stated she felt ticked and had thought of buying incontinence briefs instead of waiting for staff to assist her. On 7/20/21 at 1343 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 686 needed extensive assistance from two facility staff when going to the bathroom because of pain on her foot.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45299 Based on observation, interview and medical record review, the facility failed to provide a homelike environment for one of 20 final sampled residents (Resident 63). A blank wall and cork board were observed by Resident 63's bedside. This failure posed the risk for Resident 63 to develop emotional distress. Findings: On 7/19/21 at 1057 hours, during an initial tour, Resident 63 was observed lying in bed, awake, and staring at the ceiling. A cork board at Resident 63's bedside was observed with no posting. There were no personal belongings observed at Resident 63's bedside. On 7/21/21 at 1658 hours, Resident 63's room was observed with the bare wall and board, no pictures and no personal belongings or mementos at bedside. On 7/22/21 at 1435 hours, a concurrent observation and interview was conducted with the Activities Director. Resident 63 was observed lying in bed and staring at the ceiling. The Activity Director acknowledged the absence of personal items like pictures and mementos from home to ensure a homelike environment was provided to Resident 63.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45299 Based on interview and medical records review, the facility failed to ensure the baseline care plans related to the specific care needs were provided to two of the 20 final sampled residents (Residents 686 and 687). This had the potential for the residents to not receive the necessary care and services in accordance with their care needs. Findings: 1. Review of the Resident 686's medical record was initiated on 7/19/21. Resident 686 was admitted to the facility on [DATE]. Review of the medical record did not show any documentation of a baseline care plan provided to Resident 686. On 7/19/21 at 1035 hours, during initial tour, an interview was conducted with Resident 686. Resident 686 stated she was not aware of her plan of care and did not know when she would be discharged back to her home. Resident 686 stated she did not receive a copy of her plan of care. 2. Review of the Resident 687's medical record was initiated on 7/19/21. Resident 687 was admitted to the facility on [DATE]. Review of the medical record did not show any documentation of a baseline care plan provided to Resident 687. On 7/20/21 at 1405 hours, an interview was conducted with the ADON. The ADON verified there was no baseline care plan provided to Residents 686 and 687 when they got admitted . The ADON stated the baseline care plan was for the residents to know their initial plan of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41418 Based on interview and medical record review, the facility failed to develop a comprehensive care plan for one of 20 final sampled residents (Resident 61). Resident 61 was readmitted to the facility with an unstageable pressure ulcer (an ulcer with full thickness tissue loss covered by extensive dead tissue) on the sacrococcyx (sacrum and coccyx region). The facility failed to develop a care plan problem to address Resident 61's pressure ulcer. This posed the risk of the resident not receiving the necessary care and services. Findings: Medical record review for Resident 61 was initiated on 7/19/21. Resident 61 was readmitted to the facility on [DATE]. Review of Resident 61's Skin Check assessment form dated 4/6/21, showed Resident 61 had an unstageable sacrococcyx pressure ulcer, measuring 7 cm (length) x 7 cm (width). Review of Resident 61's Order Summary Report showed a physician's order dated 6/25/21, to provide treatment to an unstageable sacrococcyx pressure ulcer by cleansing with normal saline, patting dry, applying triad cream, and covering the pressure ulcer with a foam dressing every day shift for 30 days. Review of Resident 61's plan of care failed to show a care plan problem was developed to address Resident 61's unstageable sacrococcyx pressure ulcer. On 7/22/21 at 1153 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. RN 1 stated Resident 61 should have a comprehensive care plan problem developed to address the unstageable sacrococcyx pressure ulcer.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45299 Based on observation, interview, and medical record review, the facility failed to revise the plan of care for one of 20 final sampled residents (Resident 63). Resident 63's care plan problem addressing GT feeding was not updated to reflect the resident's current care needs. This had the potential to affect the provision of care. Findings: Review of Resident 63's medical record was initiated on 7/19/21. Resident 63 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], showed Resident 63 had impaired cognition. Resident 63 was on GT feeding. Review of the Order Summary Report dated 7/21/21, showed a physician's order dated 6/21/21, for enteral feed to administer Glucerna 1.5 at 40 ml/hour via pump from 12 pm to 8 am. Review of the care plan problem addressing the enteral feeding dated 2/9/18, showed an intervention to administer Jevity 1.2 Cal via pump. On 7/19/21 at 1052 hours, during an initial tour, Resident 63 was observed in bed with the bottle of Glucerna 1.5 dated 7/18/21, hanging at bedside. On 7/21/21 at 1255 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON stated Resident 63's current enteral feeding order was Glucerna 1.5. The ADON acknowledged Resident 63's care plan problem addressing enteral feeding was not updated to show the change of the enteral feeding. The ADON stated Resident 63's plan of care should have been revised and updated to ensure it reflected the most current interventions to meet her care needs.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45299 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide an individualized activity program to meet the needs and interests of one of 20 final sampled residents (Resident 63). Resident 63 was observed on multiple occasions to be inside her room without any type of activity. This failure had the potential for the residents to experience feelings of social isolation and depression. Findings: According to the facility's P&P titled Recreation Services Policies and Procedures Manual revised on 4/1/18, showed recreation services will be designed to meet the individual's interest, abilities, and preferences through group and individual programs. Review of Resident 63's medical record was initiated on 7/19/21. Resident 63 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], showed Resident 63 had impaired cognition. Resident 63 was totally dependent on staff for her ADL care. Resident 63 considered music as important. Review of the care plan problem addressing risk for limited meaningful engagement dated 6/17/21, showed interventions to offer music, brush her hair, apply hand lotion, current events, religious catholic worship/prayers, one-to-one in room visits, and manicures. Resident 63 enjoyed listening to music with preference to Spanish and Mexican music. Resident 63 enjoyed watching the television. On 7/19/21 at 1057 hours, during the initial tour, Resident 63 was observed lying in bed, awake, staring at the ceiling. Resident 63's television was off, and no radio was observed. Resident 63's room was very quiet. When talked to, Resident 63 was observed to be able to track the sound of voice. On 7/19/21 at 1315 and 1339 hours, an observation and concurrent interview was conducted with CNA 1. Resident 63 was observed sitting on a recliner and staring at the ceiling. Resident 63's television was off. A loud sound of English music coming from Resident 63's television was heard. CNA 1 stated Resident 63 needed total assistance with her ADL care. When asked about activity programs provided to Resident 63, CNA 1 stated there was no activity provided. CNA 1 stated Resident 63 just stayed in her room all day. On 7/21/21 at 0930 and 1044 hours, Resident 63 observed lying in bed with her eyes open and staring at the ceiling. Resident 63's television was off, and no radio was observed. Resident 63 was alone in her room. On 07/21/21 at 1144 hours, an interview was conducted with CNA 1. CNA 1 verified the resident's TV was not working. When asked if Resident 63 had a radio, CNA 1 stated there was none. CNA 1 stated the staff in charge of providing activities to Resident 63 had not yet visited. On 7/21/21 at 1644 hours, Resident 63 observed in bed, awake. Resident 63's television was off. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/21 at 1435 hours, a concurrent observation and interview was conducted with the Activities Director. Resident 63 was lying in bed and staring at the ceiling. Resident 63's television was off and no music in the room. The Activities Director acknowledged Resident 63 was not provided music and television while in her room.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45299 Based on observation, interview, and medical record review, the facility failed to ensure the necessary treatment and services were provided to maintain or improve ROM functions and prevent further development of contractures for one of 20 final sampled residents (Resident 63). The facility failed to ensure the OT evaluation was conducted for Resident 63 when it was ordered on 11/15/20. In addition, Resident 63 was not provided RNA services when her plan of care included RNA services as interventions to address her risk for developing contractures and limited range of movements. These failures posed the risk for residents to develop complications from immobility and not achieve their highest practicable level of independence. Findings: Review of Resident 63's medical record was initiated on 7/19/21. Resident 63 was admitted on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], showed Resident 63 had impaired cognition. Resident 63 was totally dependent on staff for her ADLs. Resident 63 had impairment to both sides of the upper and lower extremities. Review of the Physician's Order dated 11/15/20, showed the OT evaluation and treatment as recommended for Resident 63. Review of Resident 63's care plan showed a care plan problem dated 9/16/19, addressing the risk for decline in range of motion, risk for decreased muscle strength, decrease functional use of extremity, limitation of range of motion, risk for deformity or contraction and actual decline in range of motion on the right shoulder. Interventions for Resident 63 was for the RNA to provide passive ROM exercise to the BUE (bilateral upper extremities) and BLE (bilateral lower extremities) daily 5 times a week as tolerated. Another care plan problem dated 10/28/19, addressing Resident 63's risk for decline in range of motion and contracture formation showed an intervention for RNA to apply the left elbow splint 4-6 hours as tolerated daily seven days a week. Further review of the medical records did not show RNA services was provided for Resident 63 since she got readmitted on [DATE]. On 7/21/21 at 1048 hours, a concurrent observation and interview was conducted with CNA 1. Resident 63 was observed sitting on a reclining chair with her legs elevated and both feet extended. Resident 63's both hands were observed in a closed fist. When asked if RNA services was provided to Resident 63, CNA 1 stated she was not sure. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/21 at 1059 hours, an interview was conducted with RNA 1. RNA 1 stated Resident 63 was not included in the list of residents for RNA services. RNA 1 stated she was waiting for an RNA services order from the OT since the time she got readmitted . On 7/21/21 at 1103 hours, a concurrent interview and medical record review was conducted with the ADON. The ADON stated Resident 63 was readmitted to the facility and had an order for an evaluation by the OT. When asked for a documentation of the OT evaluation done in November 2020, the ADON stated she was not sure if Resident 63 was seen by the OT. When asked if Resident 63 received RNA services, the ADON verified there was no physician's order for Resident 63's RNA services. When asked about the plan of care to address Resident 63's risk for contracture and limited range of motion, the ADON acknowledged the plan of care was not updated and revised to reflect Resident 63's current care needs. On 7/21/21 at 1135 hours, a concurrent observation, interview and medical record review was conducted with the OT. The OT acknowledged Resident 63's right hand developed contractures. The OT stated Resident 63's hands were at risk for developing contractures. The OT acknowledged Resident 63 may benefit from RNA services to prevent the development of further contractures. The OT verified Resident 63 was not evaluated by the OT when it was ordered by the physician in November 2020. When asked about the RNA services, the OT verified Resident 63 was not receiving RNA services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37726 Based on observation and interview, the facility failed to ensure the environment remained free from accident hazards. * The railing attached to the wall adjacent to the entrance of the resident's shower room was observed with structural damage resulting in exposed sharp edges. This failure had the potential to cause skin tears or cuts on the skin of the residents who utilized the railing. Findings: On 7/21/21 at 1420 hours, an observation and concurrent interview was conducted with the DON. The railing attached to the wall adjacent to the entrance of Shower Room A was observed with structural damage, resulting in exposed sharp edges. The DON stated the residents utilized the railing and Shower Room A. The DON verified the findings and stated the facility would repair the railing.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and medical record review, the facility failed to ensure one of 20 final sampled residents (Resident 84) remained free from accident hazards due to the use of elevated side rails as evidence by: * The facility failed to conduct the assessment for the risk of entrapment from elevated side rails and failed to obtain the informed consent prior to the use of side rails for Resident 84. This had the potential to place the resident at risk for entrapment and serious injury. Findings: Review of the FDA issued Safety Alert titled Entrapment Hazards with Hospital Bed Side Rails showed the residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc., that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Medical record review for Resident 84 was initiated on 7/19/21. Resident 84 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident 84's plan of care showed a care plan problem dated 8/1/21, addressing Resident 84's risk for falls related to weakness and the use of psychoactive medications. Review of Resident 84's medical record failed to show the assessment for the risk of entrapment from the side rails was conducted and the informed consent for the use of side rails was obtained. On 7/19/21 at 0900 hours, an observation and concurrent interview was conducted with Resident 84. Resident 84 was observed lying in bed with bilateral side rails elevated at the head of the bed. Resident 84 stated she utilized the side rails to reposition herself while in bed. On 7/22/21 at 0750 hours, an observation, interview, and concurrent medical record review was conducted with the DON. Resident 84 was observed lying in bed with bilateral side rails elevated at the head of the bed. The DON was asked to describe the facility's process for the implementation of side rails for resident use. The DON stated before the side rails were implemented, alternatives to the use of side rails should first be attempted. The DON stated if the alternatives to the side rails were successful, the alternatives would be utilized in place of the side rails. If the alternatives to the side rails were unsuccessful, the informed consent would be obtained and entrapment assessment would be conducted before the side rails were implemented. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 84's Bed Rail Evaluation dated 8/28/20, showed the alternatives to the use of side rails were attempted. The alternatives attempted were consisted of elevating the head of Resident 84's bed and conducting the physical therapy/occupational therapy screening. The evaluation showed the alternatives attempted were successful and not to use the side rails for Resident 84. The DON reviewed Resident 84's medical record and verified the facility failed to conduct the assessment for the risk of entrapment from the elevated side rails and failed to obtain the informed consent prior to the use of side rails for Resident 84.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43382 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure accurate accountability, documentation, and reconciliation of the controlled medications (medications that can cause physical and mental dependence, whose use and distribution is tightly controlled due to its potential or risk for abuse) as evidenced by: * The facility staff failed to follow their P&P on reconciling and reporting the narcotic medication discrepancies for one controlled medication. * The facility failed to ensure accurate drug accountability and documentation when administering the controlled medication for one nonsampled resident (Resident 55). * The facility failed to ensure the physical inventory of the controlled medications was conducted during every shift change as per the facility's P&P for one of three medication carts (Medication Cart A) inspected. This failure posed the risk for the diversion (illegal transfer of any legally prescribed controlled substance) of controlled medications. These failures posed the risk for diversion of controlled medications and residents not receiving their medications as ordered. Findings: 1. Review of the facility's P&P titled Automated Medication Dispensing System (AMDS) for Interim/State/Emergency Supply (Omnicell/Pyxis) revised 1/15/18, showed a designated nurse will check the AMDS (an electronic medication dispensing machine which automatically keeps track of all medications added or removed) device for discrepancy alerts daily and attempt to resolve the same day. A reconciliation of controlled drugs must be done daily on any medication bin that was accessed in the past 24 hours. If a discrepancy is related to controlled drugs, the discrepancy should be reported immediately to the supervisor and the pharmacy manager. Review of the facility documented titled Automated Drug Dispensing System Daily Temperature and Cycle Count Log showed the staff were to complete at least one daily cycle count and record the signature of the two attending nurses. This document had the dates, times, and signatures on the following dates/times: - 4/27/21 at 0900 hours, - 4/28/21 at 0900 hours, - 4/29/21 at 0900 hours, - 4/30/21 at 0900 hours, - 5/1/21 at 0900 hours, (continued on next page)

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Anaheim Terrace Care Center	141 South Knott Avenue Anaheim, CA 92804

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/2/21 at 0900 hours, and - 5/3/21 at 1330 hours. On 7/20/21 at 1041 hours, an interview and concurrent facility document review of the Emergency Medication Binder was conducted with the ADON in Medication Room A. The Emergency Medication Binder showed a discrepancy report occurred on 5/3/21, with the following information: - On 4/27/21 at 0954 hours, a receipt showed the quantity of Norco 5/325 mg tablets in Drawer 2, Bin 1 was 25 tablets. - On 4/29/21 at 1044 hours, the staff accessed a controlled medication container and discovered a discrepancy for Norco 5/325 mg. The staff entered 27 tablets were found, but only 25 tablets were expected. - On 5/3/21 at 1352 hours, the staff accessed the same drawer and entered 27 tablets were expected, but only 25 tablets were found. The discrepancy receipt showed the ADON had adjusted the quantity by two tablets to resolve the discrepancy on 5/3/21 at 1352 hours. The ADON verified the findings and stated she was responsible for performing the reconciliation of the AMDS with another licensed nurse every 24 hours. The ADON stated she had corrected the discrepancy above by adjusting the total count of tablets without reporting it to anyone or documenting it formally. When asked, the ADON stated the facility policy was to report discrepancies right away to the DON and pharmacy so an investigation could be conducted. The ADON stated the staff should check for discrepancies and report the findings immediately to prevent drug diversion. When asked how it was possible that the staff had not discovered the discrepancy during their daily reconciliation and documentation on the Automated Drug Dispensing System Daily Temperature and Cycle Count Log, the ADON showed the discrepancy receipt and stated no staff had accessed the controlled medication container from the date the discrepancy was created on 4/29/21, until the day it was resolved on 5/3/21. On 7/22/21 at 1210 hours, an interview and concurrent facility document review was conducted with Clinical Resource Nurse 1. Clinical Resource Nurse 1 verified the above findings and stated the staff should have notified the pharmacy and resolved the discrepancy immediately as per the facility's P&P. Clinical Resource Nurse 1 verified no staff had accessed the controlled medication container from the date when the discrepancy was created on 4/29/21, until the day it was resolved on 5/3/21. When asked, Clinical Resource Nurse 1 stated the discrepancies should be reported immediately to make sure the controlled medications were not missing. 2. Review of the facility's P&P titled Policy and Procedures for Medication Administration: General revised 6/1/21, showed the individual who administers the medication dose records the administration on the resident's Medication Administration Record directly after the medication is given. Medical record review for Resident 55 was initiated on 7/20/21. Resident 55 was admitted to the facility on [DATE]. Review of Resident 55's Controlled or Antibiotic Drug Record from June 2021 to July 2021 showed two tablets of oxycodone 5 mg were removed for Resident 55 on the following dates: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/13/21 at 2000 hours, -On 7/10/21 at 1800 hours, and -On 7/12/21 at 0900 hours. Review of Resident 55's Controlled or Antibiotic Drug Record from May 2021 to July 2021 showed one tablet of Oxycodone 5 mg was removed for Resident 55 on the following dates: -On 6/25/21 at 1800 hours. However, review of Resident 55's Medication Administration Records from 6/1/21 to 7/20/21, failed to show documentation the oxycodone was administered to Resident 55 on the above dates and times. On 7/20/21 at 1444 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 reviewed the electronic Medication Administration Record and verified the missing entries for the oxycodone on the above dates and times for Resident 55. On 7/20/21 at 1458 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified the missing entries for the oxycodone for Resident 55 on the electronic Medication Administration Record for the above dates and times. When asked, the ADON stated there was no way to determine if the resident received the medications if the staff did not document the medication administration in the Medication Administration Record. 3. Review of the facility's P&P titled Controlled Drugs: Management Of revised on 6/1/21, showed the nursing staff must count the controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the nursing supervisor immediately. On 7/20/21 at 1137 hours, an inspection of the medication cart and concurrent facility document review was conducted with LVN 3. LVN 3 stated two licensed nurses had to count the controlled medications at every shift change and document the counts in the Controlled Medication Reconciliation Count Sheet. Review of the Controlled Medication Reconciliation Count Sheet failed to show documentation the reconciliation of the controlled medications was conducted on the following dates: - 7/2/21, on the 1500 hours to 2300 hours shift, for the outgoing shift, - 7/9/21, on the 1500 hours to 2300 hours shift, for the incoming shift, and - 7/9/21, on the 2300 hours to 0700 hours shift, for both the outgoing and incoming shifts. LVN 3 verified the findings and stated it was important to reconcile the controlled medications and sign the log every shift to keep track of the controlled medications. On 7/20/21 at 1538 hours, an interview and concurrent facility document review was conducted with the ADON. The ADON verified two licensed staff were required to count the controlled medications and sign the Controlled Medication Reconciliation Count Sheet to prevent the drugs from being diverted away from residents.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43382 Based on observation, interview, medical record review, and facility document review, the facility failed to ensure two nonsampled residents (Residents 64 and 72) were free from unnecessary medications. * Resident 72 was administered gabapentin (medication used to prevent seizures and nerve pain) for an additional 11 days, or a total of 21 additional doses, beyond what the physician had ordered. * The facility failed to follow the physician's order to hold carvedilol (antihypertensive medication) when Resident 64's systolic blood pressure was less than 110 mmHg. * The facility failed to ensure Resident 686's pain medication had adequate monitoring or parameters for its use. These failures had the potential for the residents to receive unnecessary medication and develop significant side effects. Findings: 1. On 7/21/21 at 0848 hours, an observation of the medication administration for Resident 72 was conducted with LVN 2. LVN 2 was observed administering gabapentin 300 mg to Resident 72 on 7/21/21. Medical record review for Resident 72 was initiated on 7/21/21. Resident 72 was admitted to the facility on [DATE]. Review of the Order Summary Report showed an active order dated 6/15/21, to administer gabapentin 300 mg three times a day. However, review of the Physician and Telephone Order form showed a more recent order dated 7/9/21 at 0923 hours, to decrease the gabapentin medication from three times a day to two times a day for three days, and then to further decrease the frequency from two times a day to one time a day. On 7/21/21 at 1135 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the physician's order dated 7/9/21 at 0923 hours, to decrease the gabapentin medication from three times a day to two times a day for three days, and then to further decrease the gabapentin medication from two times a day to one time a day. LVN 2 stated this order was missed by the licensed nursing staff resulting in Resident 9 receiving unnecessary medication dosages for an additional 11 days beyond what the physician had ordered. LVN 2 stated the risk of the resident receiving unnecessary medications was that it could cause harm to the residents. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/21 at 1324 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified there was a physician's order on 7/9/21 at 0923 hours, to reduce the gabapentin medication. The ADON verified the gabapentin was given to Resident 72 on 7/21/21, despite the order to reduce the dose. The ADON verified Resident 72 was administered the gabapentin medication three times a day for an additional 11 days or a total of 21 additional doses beyond what the physician had ordered. Cross reference to F759 37726 2. Medical record review for Resident 64 was initiated on 7/19/21. Resident 64 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the physician's order dated 3/18/20, showed to administer carvedilol 3.125 mg orally two times per day for hypertension and to hold the medication for a systolic blood pressure (the top number in a blood pressure measurement) less than 110 mmHg. Review of Resident 64's Medication Administration Records for 12/2020, 2/2021, and 3/2021 showed carvedilol 3.125 mg was administered on the following dates/times when Resident 64's systolic blood pressure was less than 110 mmHg: - 12/20/20 at 1700 hours; 2/19/21 at 0900 hours; and 3/5/21 at 1700 hours. On 7/21/21 at 1236 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the findings and stated the antihypertensive medications administered outside of the ordered hold parameters could potentially cause negative health outcomes associated with hypotension. 45299 3. Review of the Resident 686's medical record was initiated on 7/19/21. Resident 686 was admitted to the facility on [DATE]. Review of the Order Summary Report dated 7/10/21, showed an order dated 7/10/20, to monitor Resident 686 for pain and document the pain level: 1-4 mild pain, 5-7 moderate pain, 8-9 severe pain, and 10 horrible pain every shift. Another order dated 7/10/21, showed to administer hydrocodone-acetaminophen (narcotic pain medication) 5-325 mg one tablet every six hours as needed for pain management. There was no order to show what pain level for the hydrocodone-acetaminophen to be given to Resident 686. Review of the Medication Administration Record (MAR) dated 7/1/21-7/31/21, showed Resident 686 was administered hydrocodone-acetaminophen on the following days and pain levels: -on 7/12, 7/17, and 7/18/21, for the pain level of 5 -on 7/19/21, for the pain level of 6. On 7/13 and 7/16/21, during the 11-7 shift, Resident 686 reported a pain level of 6 but was not administered the hydrocodone acetaminophen medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/20/21 at 1511 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 686 had episodes of pain. When asked what pain level should the hydrocodone-acetaminophen be administered, LVN 1 verified there was no pain level parameter provided for Resident 686's pain medication. LVN 1 stated the physician's order for hydrocodone acetaminophen should have been clarified to ensure it was administered with the correct parameters for opioid medications.

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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** 37726 Based on interview and medical record review, the facility failed to ensure one of 20 final sampled residents (Resident 40) was free from unnecessary psychotropic medications (any medication that affects brain activity). * The facility failed to ensure Resident 40's order for alprazolam (medication treating anxiety and panic disorder) PRN (as needed) was limited to 14 days. This had the potential to negatively impact the resident's well-being. Findings: Medical record review for Resident 40 was initiated on 7/19/21. Resident 84 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the physician's order dated 2/3/21, showed to administer alprazolam 0.5 mg by mouth every 24 hours PRN for anxiety. The physician's order for alprazolam failed to show a duration for use. On 7/21/21 at 0930 hours, and interview and concurrent medical record review was conducted with the DON. The DON verified Resident 40's physician's order for alprazolam had no end date for duration of use.

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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** 43382 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 8%. One of two licensed nurses (LVN 2) observed was found to have made errors during the medication administration observations. * LVN 2 gave a dose of a medication to Resident 72 that had been previously modified by the physician to a lower dose and reduced frequency. * LVN 2 failed to give the full dose of the medication to Resident 9. These failures created the risk for the residents to not receive the therapeutic dose or response of the medications and could negatively affect the residents' health. Findings: 1. On 7/21/21 at 0848 hours, an observation of the medication administration for Resident 72 was conducted with LVN 2. LVN 2 prepared and administered the following seven medications to Resident 72 by mouth: - sevelamer carbonate (lowers high blood phosphorus) 0.8 grams one packet, - Eliquis (treats and prevents blood clots) 2.5 mg one tablet, - vitamin C 500 mg one tablet, - docusate sodium (stool softener) 250 mg one tablet, - gabapentin (treats seizures) 300 mg one capsule, - pioglitazone hydrochloride (diabetes medication) 15 mg one tablet, and - [NAME]-Vite (supplement for residents on dialysis) one tablet. Medical record review for Resident 72 was initiated on 7/21/21. Resident 72 was admitted to the facility on [DATE]. Review of the Physician and Telephone Order form showed an order dated 7/9/21 at 0923 hours, to decrease the gabapentin medication from three times a day to two times a day for three days, and then to further decrease the frequency from two times a day to one time a day. On 7/21/21 at 1135 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified she gave Resident 72 the gabapentin medication during the morning medication administration but should not have based on the missed physician order. LVN 2 stated the physician's order to reduce the dose of the medication had been missed since 7/9/21. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/21 at 1324 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified there was a physician's order on 7/9/21 at 0923 hours, to reduce the frequency of the gabapentin. 2. On 7/21/21 at 0903 hours, an observation of the medication administration for Resident 9 was conducted with LVN 2. LVN 2 prepared and administered the following seven medications to Resident 9 by mouth: - vitamin C 500 mg one tablet, - aspirin 81 mg one tablet, - labetalol (treats high blood pressure) 100 mg one tablet, - baclofen (muscle relaxant) 10 mg one tablet, - cholecalciferol (vitamin D3) 1000 IU one tablet, - docusate sodium 100 mg one tablet, and - lisinopril (treats high blood pressure) 5 mg one tablet. Medical record review for Resident 9 was initiated on 7/21/21. Resident 9 was admitted to the facility on [DATE]. Review of the Order Summary Report showed an active order dated 8/12/20, to administer two tablets of cholecalciferol 1000 IU once a day. On 7/21/21 at 1127 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the above findings and stated she did not administer the correct dosage of the cholecalciferol to Resident 9 as ordered by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43382 Based on observation, interview, and facility P&P review, the facility failed to ensure the medications were accurately stored and labeled. * The opened Glucose Quality Control Solution (a liquid used to validate the performance of the glucometer) bottle with an open date of [DATE], was in use 62 days beyond the manufacturer's recommended use date. This failure posed the risk for inaccurate blood sugar level results and inaccurate insulin dosing for residents. * The facility failed to ensure Resident 70's insulin pen (medication to decrease blood sugar level) was discarded 28 days after it was opened. This failure posed the risk for a decrease in the effectiveness of the medication. Findings: 1. Review of the facility's P&P titled Glucose Meter revised [DATE], showed staff must check the expiration date on the glucose control solution and discard the bottle of glucose control solution according to the manufacturer's guidelines. Review of the manufacturer's guidelines titled Assure Dose for the glucose control solution showed the solution should be discarded 90 days after the solution was opened. Review of the Blood Glucose Monitoring Quality Control Log showed the glucose quality control solution had been used since [DATE]. On [DATE] at 1402 hours, an observation of Medication Cart B was conducted with LVN 2. A box containing the opened glucose quality control solution had an open date of [DATE], and a hand-written expiration date of [DATE]. On [DATE] at 1402 hours, an interview was conducted with LVN 2. When asked about the open and expiration dates on the box containing the opened glucose quality control solution, LVN 2 stated she could not read the date. When asked about the expiration date of the glucose quality control solution, LVN 2 was not able to provide an answer. On [DATE] at 1420 hours, a concurrent observation, interview, and facility P&P review was conducted with the ADON. The ADON verified the glucose quality control solution was already expired based on the open date of [DATE]. The ADON stated the staff should have discarded the glucose quality control solution after 90 days from the open date. The ADON stated the glucose quality control solution was used on the residents' glucometer since [DATE]. The ADON stated this may affect the blood sugar values taken from residents and may result in inaccurate insulin dosing. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the Manufacturer's Guidelines for Insulin Lispro Injection showed Insulin Lispro Injection Pens that are being used and stored outside the refrigerator should be discarded after 28 days. On [DATE] at 1405 hours, an observation of Medication Cart B was conducted with LVN 2. Resident 70's insulin lispro injection Kwikpen 100 units per milliliter showed an open date of [DATE]. LVN 2 stated the insulin pen had to be discarded 28 days after opening. On [DATE] at 0956 hours, an interview was conducted with the ADON. The ADON acknowledged the finding and stated the insulin pen should have been discarded on [DATE], 28 days after it was first opened.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41418 Based on observation, interview and facility document review, the facility failed to follow the menu for one of 20 final sample residents (Resident 4) and two nonsampled residents (Residents 538 and 539). This failure posed the risk of the residents' nutritional needs not being met and/or residents' preference not being honored. Findings: 1. On 7/21/21 at 1353 hours, an observation and concurrent interview was conducted with the Dietary Manager. Resident 4's meal ticket showed he was to receive Italian sausage, garlic and rosemary roasted red skin potatoes, broccoli florets, parsley dinner roll, and lemon bar. Resident 4's tray was observed to have Italian sausage, mashed potatoes, chopped broccoli and parsley dinner roll. Resident 4 did not receive the lemon bar. The Dietary Manager verified the finding. 2. On 7/21/21 at 1354 hours, an observation and concurrent interview was conducted with the Dietary Manager. Resident 538's meal ticket showed she was to receive Italian sausage, garlic and rosemary roasted red skin potatoes, broccoli florets, parsley dinner roll, and lemon bar. Resident 538's tray was observed to have Italian sausage, mashed potatoes, chopped broccoli, and parsley dinner roll. Resident 538 did not receive the lemon bar. The Dietary Manager verified the finding. 3. On 7/21/21 at 1357 hours, an observation and concurrent interview was conducted with the Dietary Manager. Resident 539's meal ticket showed she was to receive ground Italian sausage, brown gravy, garlic mashed potatoes, chopped broccoli florets, parsley dinner roll, and lemon bar. Resident 539's tray was observed to have ground Italian sausage with gravy, buttered noodles, creamed style corn, and parsley dinner roll. Resident 539 did not receive the lemon bar. The Dietary Manager verified the finding. On 7/22/21 at 0941 hours, a follow-up interview was conducted with the Dietary Manager. The Dietary Manager verified the kitchen ran out of garlic and rosemary roasted red skin potatoes, broccoli florets, garlic mashed potatoes and lemon bars to serve to Residents 4, 538, and 539. The Dietary Manager stated it was her and the Food Service Cooks' responsibility to make sure there was enough food to meet the needs of the residents. The Dietary Manager stated she did not know why the kitchen ran out of the food items.

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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. 41418 Based on observation, interview, and facility P&P review, the facility failed to follow proper sanitation and food storage practices. * The facility failed to ensure the opened food items were dated and not stored beyond the use by date. * The facility failed to ensure the dietary staff performed proper hand hygiene when preparing food. * The facility failed to ensure hair restraints were worn in the kitchen. * The facility failed to ensure personal belongings were stored away from the kitchen preparation area and away from dishware. * The facility failed to replace the cutting boards that were marred and did not have cleanable surfaces. These failures had the potential to cause the foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen. Findings: 1. During an initial tour of the kitchen on 7/19/21 at 0741 hours, an observation of the walk-in refrigerator, dry storage area and kitchen preparation area was conducted with Dietary Aide 1. The following items were opened and undated: - three cartons of thickened lemon-flavored water; - three cartons of thickened cranberry cocktail; - four cartons of thickened apple juice; - a carton of thickened dairy drink; - a carton of soy milk; - a bag of pancake mix; and, - a bag of hamburger buns. The following items were also identified: - a 12-quart container of cereal labeled Corn Flakes with a use by date of 7/1/21; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- a 12-quart container of cereal labeled Cheerios with a use by date of 7/2/21; - a 12-quart container of cereal labeled Raisin Bran with a use by date of 6/1/21; - a 12-quart container of cereal labeled Rice Crispies with no open or use by date; - a carton of lactose free milk with a best by date of 7/10/21; - a pitcher of brown liquid with two tea bags, unlabeled and dated 7/17/21; and, - a container of white thick liquid labeled vanilla pudding, undated. Dietary Aide 1 verified the findings and stated the food items should have been properly labeled and dated with the opened dates. Dietary Aide 1 stated the food items kept beyond the best by and use by date should have been discarded. Dietary Aide 1 stated the pitcher of iced tea should have been discarded on the day it was prepared. 2. According to the USDA Food Code 2017, Section 2-301.14, When to Wash, food employees shall clean their hands after handling soiled equipment or utensils. On 7/21/21 at 1317 hours, an observation and concurrent interview was conducted with Food Service [NAME] 1. Food Service [NAME] 1 was observed preparing ground turkey using a food blender. Food Service [NAME] 1 was observed wearing gloves on both hands. Food Service [NAME] 1 placed cooked turkey patties inside the blender with her gloved hands. Food Service [NAME] 1 proceeded to turn on the food blender's power switch while also touching the food blender's base using the same gloved hand. Food Service [NAME] 1 was then observed to reach in the blender, mixed the ground turkey with both of her gloved hands without performing proper hand hygiene and replacing her gloves. Food Service [NAME] 1 verified the findings and stated she should have used a spatula to mix the food. 3. According to the USDA Food Code 2017, under section 2-402.11 titled Hair Restraint, showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils and linens. On 7/22/21 at 0828 hours, an observation and concurrent interview was conducted with the RD. The RD was observed entering the kitchen and walking across the food preparation area without wearing any hair restraints. The RD verified the findings. 4. According to the USDA Food Code 2017, 6-501.110, personal belongings can contaminate, food, food equipment and food contact surfaces. a. On 7/19/21 at 0741 hours, an observation of the food preparation area was conducted during the initial tour of the kitchen with Dietary Aide 1. The following findings were identified: - a large white fan was observed on the top shelf of the food preparation area next to containers of spices; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- a red radio was observed on the top shelf of the food preparation area next to containers of spices; and, - a red purse was observed on the bottom shelf of the food preparation area next to coffee filters. Dietary Aide 1 verified the findings. b. On 7/22/21 at 0731 hours, an observation was conducted with the Dietary Manager. A black speaker was observed stored next to the pitcher covers on top of the beverage dispenser. The Dietary Manager verified the findings. 5. According to the USDA Food Code 2017, 4-501.12, Cutting Surfaces, surfaces such as cutting blocks that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. On 7/21/21 at 1043 hours, an observation was conducted with Dietary District Manager 1. A green cutting board was observed stored hanging in the food preparation area in the kitchen. The cutting board was observed to be marred. Dietary District Manager 1 verified the findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and facility P&P review, the facility failed to follow proper food storage practices. * The facility failed to ensure the food items brought from outside the facility by Resident 84's family were labeled with the expiration dates. * The facility failed to ensure the food items were stored in a sanitary manner. Resident 84's Ginger Ale cans were stored in the same drawer with her bed pan. These failures had the potential to cause the foodborne illnesses in a medically vulnerable resident population. Findings: 1. Review of the facility's P&P titled Food Brought in for Residents revised 6/15/18, showed food items must be labeled with resident's name and dated. Foods considered unsafe for consumption or beyond the expiration date will be discarded by staff upon notification of resident. On 7/19/21 at 0915 hours, an observation and concurrent interview was conducted with the DSD. A plastic container with approximately 50 assorted individually wrapped chocolates and mints was observed adjacent to Resident 84's bed. The chocolates and mints failed to show the expirations dates. A plastic bag was observed inside of Resident 84's bedside table, which contained approximately 60 assorted individually wrapped chocolates and pieces of butterscotch, without the expiration dates. Resident 84 stated her family brought her the food items at different times and Resident 84 was uncertain of the exact date her family bought her the food items. The DSD verified the findings and stated she was unable to determine the food items expiration date as the items failed to show the expiration dates, or dates in which Resident 84 received the items. 2. On 7/19/21 at 1100 hours, an observation and concurrent interview was conducted with the IP. 15 cans of Ginger Ale were observed in Resident 84's closet drawer. Resident 84's bed pan was observed inside of the drawer adjacent to the cans of [NAME] Ale. The IP verified the findings and stated Resident 84's bed pan should not be stored in the same drawer with the food items as the bed pan may contain feces or urine.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 41418 Based on observation and interview, the facility failed to ensure the garbage and refuse were properly stored. Failure of the facility to keep the garbage covered had the potential to attract pests/rodents that carried diseases. Findings: 1. On 7/19/21 at 0734 hours, an observation and concurrent interview was conducted during the initial tour of the kitchen with Dietary Aide 1. A garbage bin was observed uncovered at the food preparation area. A closer inspection of the garbage bin showed food waste inside. Dietary Aide 1 verified the above findings. 2. On 7/22/21 at 0704 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor. Two of the four dumpsters located outside of the facility adjacent to the kitchen were observed to have the lids propped open. The Maintenance Supervisor verified the findings. On 7/22/21 at 1440 hours, an interview was conducted with the RD. The RD stated the garbage bins and dumpsters should always be covered. 37726 3. On 7/20/21 at 0715 hours, an observation and concurrent interview was conducted with the Administrator. Four garbage dumpsters were observed outside adjacent to the facility. One dumpster was observed with the lid propped open by the trash bags full of garbage, which prevented the lid from fully closing. The Administrator verified the findings.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview and medical record review, the facility failed to maintain accurate medical records for one of 20 final sampled residents (Resident 84). * Resident 84 had conflicting information documented in the medical record as to whether Resident 84 had formulated an advance directive. This failure had the potential for the resident's care needs not being met as their medical information was inaccurate. Findings: Medical record review for Resident 84 was initiated on 7/19/21. Resident 84 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident 84's Physician Orders for Life-Sustaining Treatment (POLST) dated 8/28/20, showed Residents 84's advance directive was not available. However, review of Resident 84's Social Services Assessment and Documentation dated 6/29/21, showed Resident 84 had not formulated an advance directive. On 7/20/21 at 1428 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified the above findings and stated she would clarify the discrepancy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37726 Based on observation and interview, the facility failed to ensure infection control practices were followed to prevent the potential transmission of microorganisms * The facility failed to ensure a visitor removed her isolation gown before exiting the room of a resident (Resident 288) housed on the facility's COVID-19 observation unit. The visitor then walked through the facility's non-observational unit (COVID-19 negative unit). This failure posed the risk for transmission of COVID-19 to staff and residents. * The facility failed to maintain the sanitary condition in the laundry area. A thick layer of black and grey dust and debris was observed along the plumbing system, the back wall of the sink, and floor just behind the washing equipment. This failure posed the potential for the contamination of the clean linens provided to the residents which were processed just adjacent to the washing equipment. Findings: On 7/21/21 at 1300 hours, an observation and concurrent interview was conducted with Visitor 1. Visitor 1 was observed exiting Resident 288's room (Room A) without removing her isolation gown. Resident 288 was housed in Room A, the facility's COVID-19 observation unit (a unit in which newly admitted unvaccinated COVID-19 residents were placed while awaiting test results for COVID-19). After Visitor 1 exited Room A, Visitor 1 walked off of the COVID-19 observation unit and through the facility hallway towards the exit of the facility. Visitor 1 stated the facility staff had educated her on the need to remove her isolation gown before exiting Room A, however, she forgot. On 7/21/21 at 1324 hours, an interview was conducted with the IP. The IP stated Resident 288 resided in the facility's COVID-19 observation unit (Room A), as he had not received a COVID-19 vaccine and was awaiting the results of the COVID-19 test. The IP stated the visitors were required to first remove their isolation gowns before exiting Room A. The IP stated Visitor 1's failure to remove her isolation gown before exiting Room A and having walked through the facility's non-observational unit, posed the risk for exposing the residents and staff to COVID-19 in the event Resident 288 was to test positive for COVID-19 and Visitor 1 was to come into close contact with other residents or staff. 38489 2. On 7/22/21 at 1000 hours, an inspection of the laundry area was conducted with the IP and Laundry Aide. The plumbing system, the wall and floor at the back of the washing equipment were observed to be covered with a thick layer of black dust and debris. A thick layer of gray and black material was also observed on the plumbing system, faucet, and the back wall of the sink used for handwashing. Just immediately across the washer was a long table filled with the folded clean linen. The Laundry Aide stated the clean linens provided to the residents were processed on the long table located immediately across the washing equipment. When asked how often the laundry area was cleaned, the Laundry Aide stated the space at the back of the washers had to be cleaned every month. When asked when it was cleaned last, the Laundry Aide stated she could not recall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/22/21 at 1015 hours, a concurrent observation and interview was conducted with the Maintenance Director. The Maintenance Director verified the findings and stated the back area of the washers had to be cleaned. On 07/22/21 at 1016 hours, an interview was conducted with the IP. The IP stated inspecting the laundry area weekly but never looked at the back of the washers. The IP acknowledged the area behind the washing equipment and the sink used for hand hygiene was dirty. When asked why it was necessary to ensure the laundry area was clean and free from dust and dirt, the IP did not respond.