STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor the Ridge Rehabilitation Center	350 Iris Drive Salinas, CA 93906

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45853 Based on observation, interview, and record review, the facility failed to ensure respect and dignity was maintained for five of 24 sampled residents (Residents 94, 199, 91, 3, and 44) when staff failed to provide privacy sleeves for above residents' indwelling catheter (a catheter placed in the bladder to drain urine) urinary bags. This failure had the potential to affect the emotional and psychosocial well-being of the residents. Findings: 1. During an observation on 3/24/24 at 2:40 p.m. at the entrance of Resident 94's room, Certified Nursing Assistant (CNA) N was preparing to empty Resident 94's urinary bag inside his room, the resident's urinary bag was visible from outside of the room. During a follow up observation on 3/24/24 at 3:30 p.m. in Resident 94's room, the resident's urinary bag was not covered with a privacy sleeve. 2. During an observation on 3/25/24 at 9:18 a.m. at the entrance of Resident 199's room, the resident's urinary bag was not covered with a privacy sleeve, and the bag was visible from outside of the room. During an interview on 3/29/24 at 9:30 a.m. with the Administrator (ADM), the ADM stated any resident with an urinary bag should have their bag covered with a privacy sleeve. 44583 3. Review of Resident 91's Admission Record indicated, Resident 91 was admitted to the facility with diagnoses including aphasia (a language disorder wherein the person is unable to communicate effectively to others) following cerebral infarction (also called stroke), hemiplegia (paralysis of one side of the body/a severe or complete loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength in the arm, leg, and sometimes face on one side of the body) following unspecified cerebrovascular disease (CVA - also referred to as stroke) affecting right dominant side (more skillful side), and benign prostatic hyperplasia (an enlarged prostate [a gland just below the bladder]) with lower urinary tract symptoms (examples include leaking urine, having sudden and frequent urges to pee, having a weak stream or feeling like unable to empty the bladder). (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 91's minimum data set (MDS - an assessment tool) Admission/5-day assessment, dated 3/2/2024, indicated, Resident 91's brief interview for mental status (BIMS - an assessment to test a person's cognition level) was 7 [a BIMS score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact] which meant Resident 91 had severe cognitive impairment. During an observation on 3/24/2024 at 3:43 p.m., inside Resident 91's room, Resident 91 was sitting up on wheelchair with urine bag hanging under the wheelchair without a cover. It was observed, Resident 91's roommate had two visitors inside the room. During another observation on 3/25/2024 at 10:25 a.m., inside Resident 91's room, Resident 91 was observed sitting on his wheelchair with urine bag hanging under the wheelchair without a cover. It was observed, Resident 91's roommate had one visitor inside the room. 4. Review of Resident 3's Admission Record indicated, Resident 3 was admitted to the facility with diagnoses including pneumonia (infection of one or both lungs), dysphagia (difficulty in swallowing), neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well resulting to bladder may not fill or empty correctly), and retention of urine (a condition in which the resident is unable to empty all urine from the bladder). Review of Resident 3's MDS Admission/5-day scheduled assessment, dated 2/28/2024, indicated, Resident 3's BIMS score was 15, which meant Resident 3 had an intact cognition. During an observation on 3/24/2024 at 4:00 p.m., at the hallway in front of Resident 3's room, Resident 3's bed was positioned near the door and the urine bag was placed at the right lower side of Resident 3's bed. Resident 3's urine bag was not covered, had urine, and could easily be seen by passersby at the hallway. During a concurrent observation and interview with certified nurse assistant F (CNA F) on 3/25/2024 at 9:37 a.m., inside Resident 3's room, CNA F confirmed Resident 3's urine bag was not covered. CNA F could not confirm the importance of covering the urine bag. During a concurrent observation and interview with licensed vocational nurse G (LVN G) on 3/25/2024 at 9:48 a.m., inside Resident 3's room, LVN G confirmed the urine bag was not covered. LVN G stated the urine bag should be covered for others not to see Resident 3's urine. During an interview with minimum data set coordinator (MDSC - a nurse who does residents' assessment) on 3/27/2024 at 2:19 p.m., MDSC stated residents' urine bag should be covered for resident's dignity. During a review of the facility's policy and procedure titled, Privacy/Dignity, date revised 10/24/17, indicated, Always ensure privacy and/or dignity of resident is respected . 46553 5. During an observation on 3/25/24 at 9:18 a.m., Resident 44 was lying in bed. His urinary bag for his indwelling catheter was hanging on the portable commode next to his bed. The urinary bag was not covered, and the contents were visible. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/25/24 at 9:26 a.m. in Resident 44's room with Licensed Vocational Nurse (LVN) M, verified Resident 44's urine bag was not covered. LVN M stated the urinary bag should be covered even though when it was hanging on the commode. During a review of the facility's policy and procedure (P&P) titled, Dignity , revised 10/24/17, the P&P indicated, All employees shall treat residents' families and visitors, and fell ow workers with kindness, respect, and dignity. [.] Always ensure privacy and /or dignity of resident is respected during care [.]. A nursing home resident has the right to personal prIvacy of not only his/her own physical body, but also his/her person space, including accommodations and personal care.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 44583 Based on observation, interview, and record review, the facility failed to implement their policies on self-administration of medication (resident takes medication without staff assistance) when there were no assessments performed for self-administration of medications, and medications were left at the bedside for 2 of 24 sampled residents (Residents 84 and 3). These failures had the potential for unsafe and improper administration of medications. Findings: 1. Review of Resident 84's Admission Record indicated, Resident 84 was admitted to the facility with diagnoses including displaced intertrochanteric fracture of right femur (broken thigh bone), Alzheimer's disease (a progressive disease that destroys memory and mental functions), fall on same level from slipping, tripping, and stumbling, and cognitive communication deficit (problems with a person's ability to think, learn, remember, use judgement, and make decisions). Review of Resident 84's Minimum Data Set (MDS - an assessment tool) Significant change in status and 5-day scheduled assessment, dated 2/10/2024, indicated Resident 84's brief interview for mental status (BIMS - an assessment to test a person's cognition level) was 9, (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact] which meant Resident 84 had moderately impaired cognition. During a concurrent observation and interview with Resident 84 on 3/24/2024 at 3:21 p.m., inside Resident 84's room, Resident 84 was lying in bed. A bottle of medication for upset stomach/antidiarrheal was observed on top of Resident 84's bedside drawer. Resident 84 stated, I brought that medicine from home. During a concurrent interview and record review on 3/24/2024 at 3:35 p.m., Registered Nurse (RN) H reviewed Resident's physician orders. RN H confirmed Resident 84 had no order for the medication for upset stomach/antidiarrheal. RN H further confirmed Resident 84 had no order to leave the medication at bedside. During a follow up observation and interview with RN H and Resident 84 on 3/24/2024 at 3:45 p.m., inside Resident 84's room, RN H confirmed Resident 84 had the medication for upset stomach/antidiarrheal on top of the bedside drawer. RN H stated Resident 84 should not have medication at bedside. Resident 84 stated, I need it and I will take it if needed. 2. Review of Resident 3's Admission Record indicated, Resident 3 was admitted to the facility with diagnoses including pneumonia (infection of one or both lungs), dysphagia (difficulty in swallowing), neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well resulting to bladder may not fill or empty correctly), and retention of urine (a condition in which the resident is unable to empty all urine from the bladder). Review of Resident 3's MDS Admission/5-day scheduled assessment, dated 2/28/2024, indicated, Resident 3's BIMS score was 15, which meant Resident 3 had an intact cognition. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Resident 3 on 3/24/2024 at 4:00 p.m., inside Resident 3's room, Resident 3 was lying in bed and a bottle of eye drop medication was observed on top of Resident 3's overbed table. Resident 3 stated she used the eye drop medication for her dry eyes. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) G on 3/25/2024 9:48 a. m., inside Resident 3's room, LVN G confirmed Resident 3's eye drop medication was placed on top of her overbed table. LVN G stated Resident 3 should not have the eye drop medication at bedside. During a follow up interview and record review on 3/25/2024 at 9:50 a.m., LVN G reviewed Resident 3's physician orders. LVN G confirmed Resident 3 did not have orders of eye drops for dry eyes and order for Resident 3 to have medication at bedside. During an interview on 3/29/2024 at 9:33 a.m. with the MDS Coordinator (MDSC), the MDSC stated they have a policy that residents should not have medications stored at bedside unless it was ordered by the physician and the assessment indicated resident was safe to self-administer the medication. During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medication, date revised 11/2012, the P&P indicated, If the resident expresses a desire to self-administer their medications, or a physician orders self-administration, the facility will not allow the resident to self-administer meds (medications) until the following procedure are one: Licensed Nurse will complete the Self-Administration Assessment which includes the resident's physical and cognitive ability to safely administer and store their medication(s) .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45853 Based on interview and record review, the facility failed to provide two of three sampled residents (Resident 13 and 83) with the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, a financial liability notice). This failure could lead to resident unknowingly assume financial liability for receiving services that were not covered by Medicare. Findings: During a review of Resident 13's face sheet (a document that contains a summary of a resident's personal and demographic information) and Notice of Medicare Non-Coverage ((NOMNC, a notice that indicates when a resident's stay at a SNF is no longer paid by Medicare), it indicated Resident 13 was admitted to the facility on [DATE] and his stay was paid by Medicare (federal health insurance for anyone age 65 and older, and some people under 65 with certain disabilities) until 12/19/23 and currently resided at the facility. During a review of Resident 83's face sheet and NOMNC, it indicated Resident 83 was admitted to the facility on [DATE] and her Medicare benefits was from 12/2/23 until 1/12/24 and currently resided at the facility. During an interview on 3/27/24 at 10:31 a.m. with the Business Office Manager (BOM), the BOM confirmed Resident 13 and 83's stay were partially covered by Medicare, after their Medicare benefits ended, they stayed at the facility. She stated she never issued a SNFABN before and was not aware of anything about SNFABN until 3/11/24 when she was provided a training webinar regarding SNFABN. She further stated she would start to issue SNFABN based on the regulation moving forward. During an interview on 3/29/24 at 9:30 a.m. with the Administrator (ADM), the ADM stated the two residents were supposed to receive SNFABN when their Medicare benefits ended. During a review of the facility's policy and procedure (P&P) titled SNF Expedited Review NOMNC, SNFABN, Denial Letters, & ABN R-131, revised August 2021. The P&P indicated, 6. Part A covered stay: SNF determines Part A stay ending due to skilled services ending. Medicare days remain and Beneficiary stays in the center (even if for just 1 day). Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage Form CMS-10055 (SNFABN) deliver with the NOMNC to ensure timely delivery. - YES

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45853 Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS, a clinical assessment tool) for one of 24 sampled residents (Resident 63). Failure to accurately assess the resident had the potential to compromise the facility's ability to provide resident-centered care plan interventions. Findings: During a review of Resident 63's face sheet (a document that contains a summary of a resident's personal and demographic information), it indicated Resident 63 was admitted to the facility on [DATE] with diagnosis of bipolar disorder (a serious mental illness that causes unusual shifts in mood). During a review of Resident 63's level I Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure individuals with mental disorders and intellectual disabilities are not inappropriately placed in nursing homes for long-term care) dated 6/1/22, the PASRR indicated Yes for Section III - Serious Mental Illness Screen: 10. Does the individual have a diagnosed mental disorder such as Depression, Anxiety, Panic, Schizophrenia/Schizoaffective Disorder, Psychotic, Delusional, and/or Mood Disorder? During a concurrent interview and record review on 3/27/24 at 3:33 p.m. with the MDS Coordinator (MDSC), Resident 63's MDS dated [DATE] was reviewed. MDS section A1500 PASRR indicated No for question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The MDSC confirmed that section A1500 on the MDS dated [DATE] should have been coded Yes for that question. During a review of the facility's policy and procedure (P&P) titled Resident Assessment Instrument (RAI/MDS) revised 11/2012. The P&P indicated, The Resident Assessment Instrument will be completed timely and accurately, per Federal Guidelines, and will serve as a foundation for the comprehensive care planning process.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 48935 Based on interview and record review, the facility failed to ensure a Level II PASRR (Pre-Admission Screening and Resident Review, a federal requirement to help ensure individuals with mental disorders and intellectual disabilities are not inappropriately placed in nursing homes for long-term care) was completed for two of 24 residents (Residents 41 and 61). This failure had the potential to put the residents at risk for not receiving appropriate care and services for their mental health conditions. Findings: Review of Resident 41's clinical record indicated they had diagnoses including paraplegia (the inability to move the lower part of the body, schizophrenia (a mental condition) and morbid obesity (too much body weight). Review of Resident 41's record, indicated Resident 41 had a positive Level I PASRR screen, completed on 9/28/21. Review of Resident 41's record also indicated the Level II PASRR was not completed due to the reason The Individual was isolated as a health and safety precaution, in a letter dated 2/18/22. During an interview on 3/27/24 at 1:52 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated the Level I PASRR was done either on admission or prior to admission, and that all PASRR letters were uploaded into the electronic health record (EHR). The MDSC also stated It's a team effort as to who is responsible for making sure the PASRR is done. During a follow up interview on 3/28/24 at 9:43 a.m. with the MDSC, the MDSC stated the state portal website for PASRR does not trigger if a Level II was not done. 46939 During a review of Resident 61's PASRR dated 9/28/21, the PASRR indicated, the level I PASRR was positive, and Resident 61 would need a level II PASRR completed. During an interview on 3/28/24, at 10:13 a.m. with the MDSC, MDSC stated, Resident 61 was in isolation due to an infectious disease when he was scheduled for the level II PASRR, so it was closed. They never followed through to complete a new level II PASRR. Resident 61 did not get the required level II PASRR Screen. Review of the facility's policy Preadmission Screening and Resident Review (PASRR), dated July 2016, indicated A PASRR will be completed and submitted online for new admission within 24 hours, and Recommendations from the Determination Letter will be included in the individuals 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** 44583 Based on observation, interview, and record review, the facility failed to develop and implement individualized, resident-centered care plans for 3 of 24 sampled residents (Residents 74, 3 and 18) when care plans for: 1. Resident 74's feeling of sadness was not developed and implemented; 2. Oxygen (a colorless, odorless gas) and anticoagulant (sometimes called blood thinning medications) used for Resident 3 was not developed; and 3. Oxygen used for Resident 18 was not developed. These failures had the potential to result in the residents not receiving the care and services necessary to maintain their health, safety and well-being. Findings: 1. Review of Resident 74's Admission Record indicated, Resident 74 was admitted to the facility on [DATE] with diagnoses including hypo-osmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (low sodium [can be found in table salt or in processed foods] level in blood), adult failure to thrive (when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), alcohol use, and weakness. Review of Resident 74's clinical records titled, Social Services Assessment & Documentation, dated 2/29/2024, indicated, .Wife dies 3 weeks ago .b. Typical mood throughout life: sad. Further review indicated, resident verbalized feeling sad and depressed since the passing of his wife 3 weeks ago . Review of Resident 74's Minimum Data Set (MDS, an assessment tool) Admission/5-day assessment dated [DATE], indicated, Resident 74's Brief Interview for Mental Status (BIMS, an assessment to test a person's cognition level) was 15 [a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact], which indicated Resident 74 had an intact cognition. Further review of the MDS indicated, Resident 74 had a total severity score of 07 in the mood interview which indicated, Resident 74 had mild depression. During a concurrent observation and interview on 3/24/2024 at 3:00 p.m. inside Resident 74's room, Resident 74 was sitting up on wheelchair. Resident 74 stated he lost his wife in February. During an interview with Social Service Director (SSD) on 3/27/2024 at 1:13 p.m., SSD stated Resident 74 did not get up upon admission, had lack of motivation, and preferred to stay in his room. SSD further stated Resident 74 refused to participate therapy. SSD confirmed she offered a psychiatry or psychology consult but Resident 74 declined. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview and record review on 3/27/2024 on 3:25 p.m., SSD reviewed Resident 74's MDS, list of care plans and social services (SS) documentations. SSD confirmed Resident 74 had mild depression, and no other mood interventions were implemented after the 2/29/2024 assessment. SSD further confirmed there was no care plan to address Resident 74's mild depression. SSD stated a care plan regarding Resident 74's mild depression should have been developed. SSD further stated care plan is important for staff to determine the psychosocial needs of residents and to get the whole picture of how to take care of the resident. 2a. Review of Resident 3's Admission Record indicated, Resident 3 was admitted to the facility with diagnoses including pneumonia (infection of one or both lungs), dysphagia (difficulty in swallowing), heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), unspecified asthma (inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath), acute embolism (a sudden block in an artery [blood vessel] caused by blood clots or other substances) and thrombosis (a blood clot within blood vessels that limits the flow of blood) of unspecified deep veins of unspecified lower extremity (lower leg), other pulmonary embolism (a sudden blockage of an artery in the lung), and dependence on supplemental oxygen. Review of Resident 3's MDS Admission/5-day scheduled assessment, dated 2/28/2024, indicated, Resident 3's BIMS score was 15, which indicated Resident 3 had an intact cognition. Review of Resident 3's Order Summary Report dated 3/27/2024, indicated, Oxygen - Oxygen at 2L/min [liters - a metric unit of capacity, per minute] Via [thru] NC [nasal cannula - a device that consists of plastic tube that fits behind the ears, and a set of two prongs that are placed in the nostrils for oxygen administration] as needed for SOB [shortness of breath] as needed related to DEPENDENCE ON SUPPLEMENTAL OXYGEN . Further review indicated, the use of oxygen was ordered on 2/24/2024. During an observation on 3/24/2024 at 4:00 p.m., inside Resident 3's room, Resident 3 was lying in bed and had oxygen at 2 L/min via NC in placed. During another observation on 3/25/2024 at 9:18 a.m., inside Resident 3's room, Resident 3 was lying in bed, overbed table was placed in front of her and had oxygen at 2 L/min via NC in placed. During a concurrent interview and record review on 3/27/2024 at 2:07 p.m., MDS Coordinator (MDSC) reviewed Resident 3's order summary report and list of care plans. MDSC confirmed Resident 3 had an order for oxygen use as needed and a care plan for oxygen used was not developed. MDSC stated there should have been a care plan developed for oxygen used to guide staff on how to care of resident with oxygen. 2b. Review of Resident 3's Order Summary Report dated 3/27/2024, indicated, Eliquis [a brand name of Apixaban - anticoagulant/blood thinner medication] Oral Tablet 2.5 MG [milligrams, unit of measurement] Give 1 tablet by mouth two times a day for DVT [deep vein thrombosis, a medical condition that occurs when a blood clot forms in a deep vein] prophylaxis [protective or preventive treatment] related to ACUTE EMBOLISM AND THROMBOSIS OF UNSPECIFIED DEEP VEINS OF UNSPECIFIED LOWER EXTREMITY. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/28/2024 at 10:27 a.m., the Director of Staff Development (DSD) reviewed Resident 3's order summary report and list of care plans. The DSD confirmed Resident 3 was taking Eliquis as ordered and a care plan for used of Eliquis was not developed. The DSD stated used of Eliquis should have been care planned for staff to know how to managed Resident 3's used of anticoagulant. 46939 3. During an observation on 3/27/24, at 1:02 p.m., in Resident 18's room, Resident 18 was noted to have oxygen on at his bedside, delivered via a NC. During a review of Resident 18's Order Summary Report dated 1/13/24, an order for On continuous O2 [oxygen] per NC @ 2Lmin. During a review of Resident 18's Care Plan dated, 3/28/24, indicated no care plan for the use of oxygen. During an interview on 3/29/24, at 9:28 a.m., with Interim Director of Nursing (IDON), IDON stated, if a resident was receiving oxygen, they should have a care plan for it. IDON stated, Resident 18 did not have a care plan for oxygen use. During a review of the facility's policy and procedure (P&P) titled, Care Plan, Baseline and Comprehensive, revised 2017, the P&P indicated, 4. A comprehensive person-centered care plan consistent with resident rights will include measurable objectives and time frames to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.

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	555060	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 44583 Based on observation, interview, and record review, the facility failed to ensure the residents received the necessary care and services for two of six residents (Residents 148 and 15) when licensed nurses did not follow the physician's order for oxygen supplement (a therapy that provides extra air to breathe in) for Residents 148 and 15. These failures had the potential to affect the residents' care and could jeopardize their health and well-being. Findings: 1. Review of Resident 148's Admission Record indicated, Resident 148 was admitted to the facility with diagnoses including chronic respiratory failure (a condition when lungs cannot release oxygen to blood causing shortness of breath) with hypoxia (occurs when oxygen level in the body organs are low), and chronic obstructive pulmonary disease (COPD - a long lasting lung disease). Review of Resident 148's Order Summary Report, indicated Resident 148 had an order for continuous oxygen administration at 2 liters (L, metric unit of volume) per minute (min) via (thru) nasal cannula (NC, a device that consists of plastic tube that fits behind the ears, and a set of two prongs that are placed in the nostrils for oxygen administration). During observations on 3/24/2024 at 3:43 p.m. and 3/25/2024 at 10:25 a.m., in Resident 148's room, Resident 148 was lying in bed and was on oxygen at 2.5 L/min via NC. During a concurrent observation and interview on 3/26/2024 at 11:17 a.m. in Resident 148's room with Licensed Vocational Nurse (LVN) L, Resident 148 was on oxygen at 2.5 L/min via NC. LVN L confirmed the observation. During a follow up interview and record review on 3/26/2024 at 11:22 a.m. with LVN L, LVN L reviewed Resident 148's order summary report. LVN L confirmed Resident 148's oxygen administration order was supposed to be at 2 L/ min. LVN L stated, we should follow whatever the order is. 2. Review of Resident 15's Admission Record indicated, Resident 15 was admitted to the facility with diagnoses including respiratory failure with hypoxia, chronic diastolic heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), and unspecified asthma (inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath). Review of Resident 15's Order Summary Report, indicated Resident 15 had an order for continuous oxygen administration at 3 L/min via NC. Further review indicated, Resident 15 had the oxygen order since 1/29/2024. During an observation on 3/25/2024 at 10:28 a.m., in Resident 15's room, Resident 15 was seated on a wheelchair, using oxygen at 2 L/min via NC. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/26/2024 at 11:19 a.m. in Resident 15's room with LVN L, Resident 15 was seated on a wheelchair and was using oxygen at 2 L/min via NC. LVN L confirmed the observation. LVN L stated the order for the oxygen was decreased from 3 L to 2 L per minute. During a follow up concurrent interview and record review on 3/26/2024 at 11:25 a.m. with LVN L, LVN L reviewed Resident 15's order summary report. LVN L confirmed Resident 15's oxygen administration order was supposed to be at 3 L per minute. LVN L stated he was not sure why the oxygen administration to Resident 15 was dropped to 2 L per minute. LVN L further stated Resident 15's oxygen administration level should be at 3 L per minute as ordered by the physician. During an interview on 3/29/2024 at 9:23 a.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated if it was non urgent, nurses should refer to the physician's order prior to administration of oxygen. During a review of the facility's policy and procedure titled, OXYGEN (Emergency/Documentation/Humidifier/Precautions/Mode of Delivery/Storage/Use/Transporting), date revised 11/2012, indicated, .verify physician's order. Written orders for oxygen therapy are to include: a. Mode of delivery; b. Liter flow rate; c. Duration of therapy. Oxygen is a drug, and excessive levels may be harmful.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 45853 Based on observation, interview, and record review, the facility failed to attempt, offer, and document the use of bed rail (adjustable metal or rigid plastic bars that attach to the bed) alternatives for 17 of 67 residents (Resident 6, 10, 15, 19, 24, 29, 31, 40, 43, 54, 61, 62, 66, 80, 81, 84, and 94) , and obtain informed consent for one of 67 residents (Resident 199) prior to installation of the bed rails. These failures had the potential to put the residents at risk for entrapment and serious injury. Findings: During the initial tour observation on 3/24/24 at 2:25 p.m., Resident 6, 10, 15, 19, 24, 29, 31, 40, 43, 54, 61, 62, 66, 80, 81, 84, 94, and 199 had upper bed rails elevated and in use. During a concurrent observation and interview on 3/27/24 at 3:02 p.m. with the Director of Staff Develement (DSD), the DSD confirmed above residents had bed rails elevated and in use. She stated the bed rails were for turning and repositioning. During a concurrent interview and record review on 3/28/24 at 9:08 a.m. with the Medical Record Director (MRD), Resident 199's bed rail consent was reviewed. The consent indicated it was signed on 3/25/24, and the MRD confirmed that there was no other bed rail consent. During a concurrent interview and record review on 3/29/24 at 8:44 a.m. with the administrator (ADM), Resident 6, 10, 15, 19, 24, 29, 31, 40, 43, 54, 61, 62, 66, 80, 81, 84, and 94's Bed Rail Evaluations and Resident 199's Bed Rail Consent were reviewed. The ADM stated bed rail evaluation and consent should be done and obtained before using the bed rails. She confirmed there were no documentation evidences indicated the use of alternatives for Resident 6, 10, 15, 19, 24, 29, 31, 40, 43, 54, 61, 62, 66, 80, 81, 84, and 94. She also confirmed Resident 199's bed rail consent was obtained after the bed rails were already installed and in use. During a review of the facility's policy and procedure (P&P) titled SIDE-RAIL SAFETY revised 11/2012, the P&P indicated, Bed rails should only be used to enable the resident to facilitate mobility. Bed rails will be used in a safe manner, which prevents injury, when any type of Rails is required to assist with bed mobility or used per resident's request for an increased sense of security; by the interdisciplinary team IDT as a physical restrict per restraint policy and procedure. Another alternative should be attempted prior to use of side rails as a restraint, such as low beds, mats, alarms, toileting schedules, or other less restrictive devices. 1. Side-rail safety assessment will be done by a licensed nurse and/or the IDT on admission (if rails are used); when side0rails are implemented; and no less often than quarterly as long as any type of side-rail is being used by a resident. [.] 5. If side-rails meet the definition of a physical restraint per facility policy, the Physical Restraint Policy and Procedure will be followed, including the requirements regarding assessment, consent and physician orders. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44583 46553 46939

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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. 46553 Based on interview and record review, the facility failed to ensure controlled medications (those with high potential for abuse and addiction) reconciled with the corresponding Medication Administration Records (MAR) for four of nine randomly sampled residents (Residents 7 ,37 ,58, and 76). The medications were signed out of the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medications) but did not document on the Medication Administration Record (MAR) to indicate the controlled medications were given to the residents. This failure had the potential for misuse or diversion of controlled medications. Findings: The CDR for four random residents (Residents 7 ,37 ,58, and 76) receiving as-needed controlled medications were requested for review during the survey. 1. During a review of Resident 7's medical record indicated a physician's order, dated 10/31/23, for Tramadol (a controlled pain medication) Hydrochloride (HCL a salt added to drugs to make them stable) 100 milligrams (mg, unit of measurement), take 1 tablet by mouth every 6 hours as needed for pain. During a review of Resident 7's CDR for Tramadol HCL 100 mg and MAR for March 2023 reflected the nursing staff removed and documented on the CDR: 1 tablet on 3/23/23 at 15:57 p.m., but did not document in the MAR. During a concurrent interview and record review on 3/27/24 at 2:13 p.m. with Licensed Vocational Nurse (LVN) K, Resident 7's CDR and MAR for March 2024 were reviewed. LVN K confirmed the above findings. 2. A review of Resident 37's medical record indicated a physician's order, dated 7/1/23, for Hydrocodone-Acetaminophen (a controlled pain medication) 5-325 mg, take 1 tablet by mouth every 6 hours as needed for severe pain. During a review of Resident 37's CDR for Hydrocodone-Acetaminophen 5-325 mg and MAR for March 2023 reflected the nursing staff removed and documented on the CDR: 1 tablet on 3/19/23 at 5:15 p.m., 3/26/24 at 4:36 p.m., and 3/27/24 at 03:25 a.m., but did not document in the MAR. During a concurrent interview and record review on 3/27/24 at 2:21 p.m. with LVN K, Resident 37's CDR and MAR for March 2024 were reviewed. LVN K confirmed the above findings. 3. A review of Resident 58's medical record indicated a physician's order, dated 7/1/23, for Hydrocodone-Acetaminophen 5-325 mg, take 1 tablet by mouth every 6 hours as needed for severe pain. During a review of Resident 58's CDR for Hydrocodone-Acetaminophen 5-325 mg and MAR for March 2023 reflected the nursing staff removed and documented on the CDR: 1 tablet on 3/23/23 at 4:04 p.m., but did not document in the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/27/24 at 2:16 p.m. with LVN K, Resident 58 CDR and MAR for March 2024 were reviewed. LVN K confirmed the above findings. 4. A review of Resident 76's medical record indicated a physician's order, dated 6/11/23, for Tramadol Hydrochloride100 milligrams, take 1 tablet by mouth every 6 hours as needed for moderate pain. During a review of Resident 76's CDR for Tramadol HCL 100 mg and MAR for March 2023 reflected the nursing staff removed and documented on the CDR: 1 tablet on 3/17/23 at 19:50 p.m., but did not document in the MAR. During a concurrent interview and record review on 3/27/24 at 1:57 p.m., with LVN J, Resident 76 CDR and MAR for March 2024 were reviewed. LVN J confirmed the above findings. During a phone interview on 3/28/24 at 3:33 p.m. with the Pharmacy Consultant (PC), the PC stated controlled medication should be charted in electronic MAR and count sheet. During an interview on 3/29/24 at 10:05 a.m., with the Interim Director of Nursing (IDON), the IDON stated staff should sign the narcotic book and document in electronic MAR. During a review of the facility 's policy and procedure (P&P) titled, Controlled Medication , dated 8/2014, the P&P indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and medication administration (MAR) . 3. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply; 4. Initials of the nurse administering the dose on the MAR after the medication is administered.

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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. 46553 Based on observation, interview and record review, the facility had an eight percent medication error rate when two medication errors out of 25 opportunities were observed during medication pass for one of six residents (Residents 72). These failures had the potential to compromise the health and safety of the residents. Findings: During a medication pass observation on 3/25/24 at 9:54 a.m. with Licensed Vocational Nurse (LVN) I, LVN I was observed preparing and administering ten medications to Resident 72. Review of Resident 72's clinical record indicated a physician's order of Zyrtec (antihistamine to treat allergy, hives, and itching) 10 milligram (mg, unit of measurement) dated 3/11/23 and MiraLAX (laxative to treat constipation) Oral Powder 17 grams (gr, unit of measurement) /scoop dated 2/2/24 for medication to be given. During a concurrent interview and record review on 3/25/24 at 10:40 a.m., with LVN I, LVN I confirmed the order indicated Zyrtec 10 mg tablet and MiraLAX Oral Powder 17 grams and she did not administer those two medication to Resident 72. LVN I further stated she forgot to go to the next page of Medication Administration Record (MAR). During a review of the facility's policy and procedure (P&P) titled Medication Administration -General Guidelines, dated 10/2017, the P&P indicated, Medication are administered in accordance with written order of the attending 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. 46553 Based on observation, interview, and record review, the facility failed to ensure medications were labeled appropriately when: 1. One opened Refresh Tears lubricant eyedrop without resident's name and an open date was found in medication cart AA; 2. One opened Vyzulta (used to lower intraocular [eye] pressure with open - angle glaucoma [eye condition that can cause blindness] or ocular hypertension) 0.024 % Ophthalmic (used to treat eye infections) Solution was found without an open date; and 3. One opened Brimonidine Tartrate (used to treat open-angle glaucoma or high fluid pressure in the eye) ophthalmic solution was found without an open date. These failures had a potential for residents to receive medications with unsafe and reduced potency from being used past their discard date which could lead to unsafe and ineffective medications for the residents. Findings: During a medication cart inspection on 3/26/24 at 10:54 a.m., on South Wing of the facility, medication cart AA was inspected with Licensed Vocational Nurse (LVN) L. The inspection identified a bottle of opened Refresh tears eyedrop without a resident's name and an open date and a bottle of opened Vyzulta 0.024% Ophthalmic Solution and a bottle of opened Brimonidine Tartrate ophthalmic solution without open dates. During an interview with on 3/26/24 at 11:09 a.m. LVN L, LVN L confirmed the three bottles of eyedrop were not labeled with an open date. LVN L further stated they should have been labeled. During a phone interview on 3/28/24 at 3:27 p.m. with the Pharmacy Consultant (PC), the PC stated ophthalmic solution was good for 28 days after it was opened. Medication should be labeled with resident's name and an open date. During a review of the facility's policy and procedure (P&P) titled, MEDICATION LABELS' P&P, dated 10/2017, the P&P indicated, Medications are labeled in accordance with facility requirements and state and federal laws .A. Labels are permanently affixed to the outside of the prescription container.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 46939 Based on observation, interview and record review, the facility failed to ensure: 1. The recipe for Spinach was followed according to ingredient list for approximately 15 of 96 sampled residents 2. Accurate diets were not served according to resident preferences for two of 96 sampled residents (Resident 36 & Resident 51) These failures had the potential for adverse reactions to foods added to recipes without residents being aware, and for residents to not eat foods according to personal preferences. Findings: 1. During a concurrent observation and interview on 3/26/24 at 11:59 a.m. with [NAME] A, [NAME] A added cooked red bell peppers to the cooked spinach. [NAME] A stated, I am adding them for some more color. During a review of Club Spinach recipe (undated), recipe indicated, Ingredient spinach, chopped, granul [sic] garlic, black pepper, margarine. During an interview, on 3/28/24 at 10:04 a.m. with the Dietary Manager (DM), the DM stated, there are no red bell peppers in the spinach recipe. I told the cook to add them in for extra color. We should follow the ingredient lists. 2. During an observation on 3/26/24 at 12:15 p.m., [NAME] A plated spinach with red bell peppers added to them onto Resident 36's lunch plate. Dietary aide B read the meal ticket tray and placed Resident 36's lunch plate onto the meal cart, then moved onto the next plate. During a review of Resident 36's Noon Meal Ticket dated 3/26/24, the ticket indicated, Dislikes: BELL PEPPER. During an observation on 3/26/24 at 12:22 p.m., [NAME] A plated Resident 51's lunch tray with gravy poured over the turkey. Dietary Aid B plated the tray in the meal cart and moved onto the next resident. During a review of Resident 51's Noon Meal Ticket, dated 3/26/24, the ticket indicated, Dislikes: GRAVY. During an interview on 3/36/24 at 12:25 p.m. with the DM, the DM stated, Residents food preferences should always be followed, including their dislikes. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy & Procedure (P&P) titled, Standardized Recipes dated 2020, the P&P indicated, 1. Each recipe shall include the following: a. All ingredients in order of introduction to the recipe. 6. Each resident has specific food and beverage preferences detailed on a tray card or in a tray identification system, so accurate diets are served.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46939 Based on observation, interview and record review, the facility failed to serve food at an appetizing temperature for one test tray food item out of seven sampled food items. This failure had the potential for residents to not wish to eat the sampled food item due to colder temperature. Findings: During an observation on 3/26/24, at 11:59 a.m., [NAME] A added cooked red bell peppers to the cooked spinach, which completed the cooking process for the spinach at this time. During a concurrent observation and interview on 3/26/24, at 1:20 p.m. with the Dietary Manager (DM), the DM tested the internal temperature of 7 food items on the sampled test tray, after all residents in the facility were served the noon meal. One food item, the regular texture Club Spinach's internal temperature read 125 degrees Fahrenheit. DM stated, all hot foods on the tray line should be maintained to 140 degrees Fahrenheit. During a review of the facility's policy and procedure (P&P) titled, Food Preparation, dated 2013, the P&P indicated, B. Hot foods should be held prior to service at 140 degrees Fahrenheit.2. Serve vegetables promptly, do not hold on the steam table for long periods of time. A. Maximum- 1 hour prior to serving.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 46939 Based on observation, interview, and record review, the facility failed to provide the physician- prescribed therapeutic diet (a diet order as part of treatment for a disease or clinical condition to decrease or increase specific nutrients in the diet) to four of 96 sampled residents when: 1. Three residents (Resident 29, Resident 41 & Resident 57) who were ordered a Controlled Carbohydrate Diet (The focus of the diet is eating the same amount of carbohydrates every day in an attempt to keep blood sugar levels stable) were served the wrong dessert item; and 2. One resident (Resident 92) who was ordered a Fortified Diet (a diet with additional high calorie items to help prevent or treat weight loss), did not receive the fortified food item for noon meal. These failures had the potential to result in weight loss and/or unstable blood sugar for the residents who did not receive their therapeutic diets as ordered. Findings: 1. During a review of the Facility's Therapeutic Diet Spreadsheet, dated 3/26/24, the spreadsheet indicated, for the noon meal the dessert item for Controlled Carbohydrate (CC) meals was Vanilla Yogurt Mousse, and the fortified item was Super Soup 16 oz. During an observation on 3/26/24, at 12:10 p.m., Dietary Aide (DA) C plated Resident 41's plate with the dessert item Peach Cobbler Trifle. DA B placed Residents 41's plate on the meal cart and moved onto the next resident's plate. During a review of Resident 41's meal ticket dated 3/26/24, the ticket indicated, Diet Order: Controlled Carbohydrate. During an interview with Dietary Manager (DM) on 3/26/24 at 12:12 p.m., DM stated Resident 41 got the wrong dessert item. During an observation on 3/26/24, at 12:17 p.m., Dietary Aide (DA) C plated Resident 29's plate with the dessert item Peach Cobbler Trifle. DA B placed Residents 29's plate on the meal cart and moved onto the next resident's plate. During a review of Resident 29's meal ticket dated 3/26/24, the ticket indicated, Diet Order: Controlled Carbohydrate. During an interview with Dietary Manager (DM) on 3/26/24 at 12:18 p.m., DM stated Resident 29 got the wrong dessert item. (continued on next page)

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	555060	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor the Ridge Rehabilitation Center	350 Iris Drive Salinas, CA 93906

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/26/24, at 12:21 p.m., Dietary Aide (DA) C plated Resident 57's plate with the dessert item Peach Cobbler Trifle. DA B placed Residents 57's plate on the meal cart and moved onto the next resident's plate. During a review of Resident 57's meal ticket dated 3/26/24, the ticket indicated, Diet Order: Controlled Carbohydrate. During an interview with Dietary Manager (DM) on 3/26/24 at 12:23 p.m., DM stated Resident 57 got the wrong dessert item. 2. During an observation on 3/26/24, at 1:05 p.m., Dietary Aide (DA) C plated Resident 92's plate and did not add the fortified item (Super Soup) on the tray. DA B placed Residents 92's plate on the meal cart and moved onto the next resident's plate. During a review of Resident 92's meal ticket dated 3/26/24, the ticket indicated, Diet Order: Fortified. During an interview with Dietary Manager (DM) on 3/26/24 at 12:23 p.m., DM stated Resident 92's did not receive the fortified soup on their tray. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diet dated 2020, the P&P indicated, All therapeutic diets and texture modifications are referenced in the current diet manual and are prepared and served in the facility with daily written instructions.The Nutrition Services Manager (NSM) is and Dietician are responsible for training the dietary employees on proper diet and texture modifications.

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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. 46939 Based on observation, interview, and record review, the facility failed to follow proper sanitation and food handling practices in the kitchen when: 1. Dietary Aide (DA) C did not perform hand hygiene after cleaning the floor and touching dirty surfaces; 2. Multiple food items were kept in the freezer after the use by date; and 3. Canned food with major dents were not identified and removed from dry storage shelf These failures had the potential to spread food-borne illness to residents in the facility. Findings: 1. During an observation on 3/26/24, at 11:28 a.m., in the kitchen, DA C cleaned the floors with a broom, then threw trash into the trash can touching the surface of the trash can with his bare hands. DA C then went to the sink and washed his hands with only water for approximately 15 seconds, then dried his hands. DA C then walked over to the dishwasher and began unloading clean utensils with his bare hands. During an interview on 3/26/24, at 11:30 a.m., with DA C, DA C stated, I did not wash my hands with soap after cleaning, I should have used soap before unloading the clean dishes. 2. During a observation on 3/24/24 at 2:20 p.m., in the kitchen, Freezer #3 contained frozen hot dog and hamburger buns. One package of approximately 6 hot dog buns was labeled with an open date of 3/9/24, and a use by date of 3/16/24. One package of approximately 7 hamburger buns was labeled with an open date of 3/18/24, and no use by date. One package of approximately 6 hamburger buns was labeled with an open date of 3/7/24 with a use by date of 3/16/24. During an interview on 3/24/24, at 2:22 p.m., with [NAME] A, [NAME] A stated, those hot dog and hamburger buns should be thrown away if they were past the use by date. [NAME] A stated they were all past the use by dates. 3. During an observation on 3/24/24, at 2:30 p.m., in the kitchen, a dented can of black beans was on the shelf in dry storage area, with other canned foods for use. A cardboard box labeled dented cans for send back, was observed in the corner of the dry storage, the black bean can was not placed in this box, located on the shelf for use by staff. During a concurrent observation and interview on 3/26/24 at 10:35, with Dietary Manager (DM), the dented can of black beans was noted to be on the shelf in the same location. DM stated, we have a box for the dented cans, and that can should not be used because it has a major dent in it. (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 facility's policy and procedure (P&P) titled, Hand Hygiene, dated 2019, the P&P indicated, Employees are required to wash their hands thoroughly: .after touching objects that may be soiled. Handwashing: . wet hands.apply soap.

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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. 44583 Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were implemented when: 1. Certified nursing assistant O (CNA O) did not perform hand hygiene while serving and setting up lunch trays in between residents (Residents 14, 71 and 58); and 2. Nasal cannula (NC - a device that consists of plastic tube that fits behind the ears, and a set of two prongs that are placed in the nostrils for oxygen administration) was not stored properly when not in use (Resident 44). These failures had the potential to compromise resident's health and safety in the facility. Findings: 1. During observation on 3/25/2024 at 12:07 p.m., inside dining room BB (DR BB), CNA O was observed assisting Resident 14 to drink. CNA O held Resident 14's cup of thickened water, pat Resident 14's shoulder and moved the cup of water towards Resident 14's mouth to drink. CNA O placed Resident 14's cup of water back on the table and went to Resident 71's table. CNA O did not perform hand hygiene. CNA O held Resident 71's cup of water, touched Resident 71's shoulder and moved the cup of water towards Resident 71's mouth to drink. At 12:10 p.m., CNA O stepped out of DR BB without performing hand hygiene. During another observation on 3/25/2024 at 12:15 p.m., inside dining room BB, CNA O served Resident 58's lunch tray, removed the plate's lid, and handed the utensils to Resident 58's hands. CNA O went to the meal cart and took Resident 71's lunch tray, without performing hand hygiene. CNA O started to served Resident 71's lunch tray, removed the plate's lid, and set up Resident 71's drinks. Then CNA O sat beside Resident 14, and started assisting Resident 14 with lunch without performing hand hygiene. During an interview with CNA O on 3/25/2024 at 12:48 p.m., CNA O confirmed above observations. CNA O stated, I don't want to keep on using the hand sanitizer because it's drying up the skin of my hands. During an interview with infection control preventionist (ICP) on 3/28/2024 at 3:22 p.m., ICP stated, Staff should perform hand hygiene in between resident care and even during meals. During a review of the facility's policy and procedure titled, Hand Hygiene P&P, date revised 1/10/19, indicated, All employees are required to practice effective hand hygiene .Employees are required to wash their hands thoroughly .Between patients . 46553 2. During an observation on 3/25/2024 at 9:18 a.m., Resident 44's was lying in bed, with oxygen concentrator at bedside and the NC was found on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/25/2024 at 9:31 a.m. in Resident 44's room with License Vocational Nurse (LVN) M, LVN M confirmed the NC tubing was on the floor. LVN M stated the nasal cannula tubing should not be on the floor because of infection control. During a review of the facility's policy and procedure (P&P) titled, Oxygen (Emergency /Documentation /Humidifier/ precaution / Mode of Delivery /Storage/Use /Transporting), revised 11/2012, the P&P indicated, 3. Usage e. change oxygen tubing, cannulas, and mask weekly and prn excessive soiling.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 45853 Based on observation, interview, and record review, the facility failed to ensure to provide a safe, functional, and comfortable environment for two of 24 sampled Residents: 1. Resident 94's bed controller was not functioning for two days; and 2. Resident 41's toilet paper holder was broken for three days without being reported and fixed. These failures had the potential to affect the comfort of the residents. Findings: 1. During a concurrent observation and interview on 3/25/24 at 9:21 a.m. in Resident 94's room, Resident 94's bed controller was disconnected from the bed, his head of the bed was elevated. Resident 94 stated, he came back from the hospital two days ago, and he had been sleeping with the head of the bed elevated for two nights now. It was not comfortable for him. During an interview on 3/25/24 at 9:30 a.m. with Occupational Therapist (OT) O, who stopped by Resident 94's room to drop off some clean clothes, she stated she was not aware of the bed situation, but she would let the maintenance know. During an interview on 3/26/24 at 4:14 p.m. with the Maintenance Director (MNTD), the MNTD stated he was working in the facility on Sunday [3/24/24], was notified by a nurse that Resident 94's bed controller was not working. He replaced four controllers and nothing worked, he realized it could be the bed being broken. He did not replace the bed and left Resident 94's head of the bed elevate on Sunday. He further stated Resident 94's bed was replaced at around 2 or 3 in the afternoon on Monday. During a review of the MNTD's Job Description updated 10/2010, the job description indicated, DUTIES AND RESPONSIBILITIES: 6. Inspects facility on regular basis to ensure that grounds, buildings and equipment are maintained in a safe, clean, attractive, efficient and fully operational manner [.]. During a review of the facility's policy and procedure (P&P) titled ACCOMMODATION OF NEEDS revised 11/2012. The P&P indicated, It is the policy of Windsor Healthcare to recognize and promote the residents rights to receive services in the facility with reasonable accommodations of individual needs and preferences [.] 1. Reasonable accommodations are those adaptations of the facility's physical environment and staff behaviors to assist residents in maintaining independent functioning, dignity, and well being. 48935 2. During an observation on 3/24/24 at 2:47 p.m., the toilet paper holder in the bathroom of Resident 41's room was broken. The bathroom was shared between two resident rooms. A roll of toilet paper sat on the bathroom sink, across from the bathroom toilet. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24 at 4:12 p.m. with the MNTD, the MNTD stated the process for putting in a work order was to specify what staff were putting in the work order for, take a picture of it and then send it. He further stated he was unable to find a work order for Resident 41's bathroom. All work orders, according to the MNTD, could be found in a mobile phone application called TELS. During an observation on 3/27/24 at 08:34 a.m., the toilet paper holder in the bathroom of Resident 41's room was still broken. During an interview on 3/27/24 at 8:43 a.m. with Certified Nursing Assistant (CNA) E, CNA E stated the process for notifying maintenance for anything broken in a resident room or elsewhere was to let maintenance know or by putting a work order in the computer. CNA E also stated she did not know about the broken toilet paper holder and I will call maintenance after I finish my rounds. During an interview on 3/27/24 at 9:29 a.m. with Licensed Vocational Nurse (LVN) D, LVN D said I washed my hands in [Resident 41's] bathroom. I didn't notice it, referring to the toilet paper holder. LVN D also stated she would put in a work order in the computer if there is anything broken in the facility. Review of the facility's policy titled Work Orders, Maintenance dated April 2010, indicated, In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director.