STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555287	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diamond Ridge Healthcare Center	2351 Loveridge Road Pittsburg, CA 94565

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40968 Based on interview and record review, the facility failed to ensure one of three closed resident records sampled (Resident 112) was not coded correctly on the Minimum Data Set (MDS-a standardized assessment tool used to direct health care needs) when Resident 112 was discharged home. This deficient practice resulted in incorrect data transmitted to Centers for Medicare and Medicaid Services (CMS) regarding Resident 112's discharge status. Findings: During a review of Resident 112's admission record, dated 8/14/24, revealed Resident 112 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. The admission record also revealed, Resident 112 was discharged on [DATE] and was discharged to: Home. During a review of Resident 112's MDS, dated [DATE], Section A2105 indicated 04 which meant Resident 112 was discharged to an Acute Care Hospital. During a review of Resident 112's order summary dated 6/17/24, indicated Patient discharging home per request on 6/21/24 with family . During a review of Resident 112's post discharge plan of care and summary dated 6/20/24, indicated under recap of resident's stay, indicated Resident 112 was discharging home with daughter. During a review of Resident 112's physician's discharge summary, dated 6/21/24, indicated Resident 112 was discharged to: Home. During a concurrent interview and record review on 8/14/24 at 3:23 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 112's discharge MDS record was reviewed. MDSC stated Resident 112 was discharged home and not to the acute care hospital. MDSC further added, Resident 112's discharge MDS was encoded incorrectly.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36593 Based on interview and record review, the facility failed to timely develop and provide a baseline care plan for three of 32 sampled residents (Resident 108, 109, and 363) when the baseline care plans were not developed within 48 hours of Resident 108, 109 and 363's admission and the baseline care plan written summaries were not provided to the Resident 108, 109, 363 and the representatives. This failure had the potential to reduce the continuity of care and communication between Resident 108, 109, 363, the representatives, and the facility staff. Findings: During a review of Resident 108's Admission Record(AR), the AR indicated, Resident 108 was admitted to the facility on [DATE] with diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move on one side of the body). During a review of Resident 108's Baseline Care Plan dated 7/23/24, the Baseline Care Plan indicated Resident 108's baseline care plan was not developed within 48 hours of admission and Resident 108 and their representatives were not provided a summary of the baseline care plan. During an interview on 8/13/24 at 9:45 a.m., with Registered Nurse/Supervisor (RN 1), RN 1 stated it was not a practice for the facility to provide residents and family with a written summary of the baseline care plan. RN 1 stated she initiated residents' baseline care plan. RN 1 stated she was one of the staff that completed this task. During a concurrent interview and record review on 8/15/24 at 8:04 a.m., with the Licensed Vocational Nurse/ Case Manager (CM), Resident 108's Baseline Care Plan and Summary dated 7/23/24 was reviewed. The baseline care plan indicated Resident 108 and their representative were not provided a summary of base line care plan. CM stated she was responsible for scheduling and coordinating residents' care plan conferences. CM stated it was not facility's practice to provide residents and their representatives with written summary of base care plan after completion of care conferences. CM stated Resident 108 and representatives have not been provided a summary of baseline care plan. During a review of Resident 109's AR, dated 8/15/24, the AR indicated, Resident 109 was admitted to the facility on [DATE] with diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move on one side of the body). During a review of the Resident 109's Baseline Care Plan and Summary dated 8/9/24 indicated baseline care plan was not developed within 48 hours of admission and Resident 109 and representative were not provided with a written summary of baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/15/24 at 8:04 a.m., with the CM, Resident 109's Baseline Care Plan dated 7/23/24 and Interdisciplinary Care Conference (IDT) dated 7/19/24 were reviewed. CM stated it was not facility's practice to provide residents and their representatives with written summary of base care plan after completion of care conferences. CM stated Resident 109 and representatives have not been provided a summary of baseline care plan. During an interview on 8/13/24 at 9:55 a.m., with Assistant Director of Nursing (ADON), ADON stated facility had identified timely completion of baseline care plan and provision of written summary to residents and representatives as an issue and had addressed it on Quality Assurance Performance Improvement (QAPI, Quality Improvement is about giving the people closest to issues affecting care quality the time, permission, skills, and resources they need to solve them). During an interview on 8/14/24, at 10:35 a.m., with Director of Nursing (DON), DON stated facility was aware that residents' baseline care plans were not developed within 48 hours and written summaries of residents' base line care plans were not provided to residents and family representatives. 40968 50474 During a review of Resident 363's AR, dated 8/14/24, the AR indicated Resident 363 had a diagnosis of right femur fracture (broken upper leg bone). During a review of Resident 363's Baseline Care Plan and Summary dated 8/2/24 indicated Resident 363 was admitted on [DATE] and the Baseline Care Plan and Summary was electronically signed by the ADON on 8/2/24. During a concurrent interview and record review on 8/14/24, at 11:22 a.m. with the DON, Resident 363's Baseline Care Plan and Summary dated 8/14/24 was reviewed. The DON stated the Interdisciplinary Team members (IDT) did not develop a baseline care plan for Resident 363 within 48 hours from admission and no written summary was provided to Resident 363 and family representatives. During a record review of the facility's policy and procedure (P&P) titled, Baseline Care Plan dated 12/19/22, the P&P indicated the baseline care plan will be developed within 48 hours of a resident's admission. The P&P further indicated, A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the initial goals of the resident, a summary of resident's medications and dietary instructions, and any services and treatments to be administered by the facility and personnel acting on behalf of the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50474 Based on observation, interview, and record review, the facility failed to ensure four of four sampled residents (Residents 28, 21, 63 and 84) received necessary care to maintain good grooming and personal hygiene when: 1. Resident 28 had long facial hair and long fingernails with black matter underneath, 2. Resident 21 had long fingernails with black matter underneath, 3. Resident 63 had long, thick facial hair, and 4. Resident 84 had long facial hair. This failure resulted in Residents 28, 21, 63 and 84 at risk for skin irritation and infection. Findings: 1. During a record review of Resident 28's Admission Record dated on 8/13/24, the record indicated Resident 28 had diagnoses of dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior) and legal blindness. During a record review of Resident 28's Minimum Data Set (Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.) assessment dated [DATE], the MDS assessment indicated Resident 28 needed staff's maximum assist (Helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort.) in maintaining personal hygiene and grooming. The MDS assessment indicated Resident 28's Brief Interview of Mental Status (BIMS- an assessment for cognition status) score was 3 out of 15 which indicated severely impaired mental status. During a record review of Resident 28's Care Plan for Activities of Daily Living (ADLs, are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating) with revision date on 12/16/21, the care plan indicated Resident 28 had ADL self-care performance deficit related to diagnosis of dementia and blindness. During an observation on 8/12/24 at 8:45 a.m. in Resident 28's room, Resident 28 had long facial hair and long fingernails on both hands with black matter underneath. During a concurrent observation and interview on 8/13/24 at 9:01 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated CNAs were responsible for maintaining the residents' personal hygiene and grooming. CNA 1 stated Resident 28 was partially blind and totally dependent with staff. CNA 1 further stated Resident 28's facial hair was long, and nails were long and dirty. CNA 1 stated residents with long and dirty fingernails were at risk for infection. CNA 1 stated residents with long facial hair could have made them feel not good about their looks. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/13/24, at 11:05 a.m. with Licensed Vocational Nurse 3 (LVN), LVN 3 spoke to Resident 28 in Spanish. LVN 3 stated Resident 28 wanted his facial hair shaved and his fingernails cleaned and clipped. LVN 3 stated Resident 28 did not refuse when she offered the personal grooming. 2. During a record review of Resident 21's Admission Record dated 8/13/24, the record indicated Resident 21 had diagnoses of cerebrovascular disease (also called a stroke, occurs when blood flow to a part of the brain stops) and dementia. During a record review of Resident 21's MDS assessment dated [DATE], the MDS assessment indicated Resident 21 was totally dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff in maintaining personal hygiene. The MDS assessment indicated Resident 21 had severe impairment for cognitive skills in daily decision making. During a record review of Resident 21's Care Plan for Activities of Daily Living dated 10/6/20, the record indicated Resident 21 had ADL self-care performance deficit related to impaired balance, limited mobility, and diagnosis of dementia and stroke. The record further indicated Resident 21 had goals of will be clean, dry, odor-free and well-groomed daily. During an observation on 8/12/24 at 8:52 a.m. in Resident 21's room, Resident 21 had long fingernails with black matter underneath on both hands. During a concurrent observation and interview on 8/13/24 at 9:37 a.m. with CNA 1, in the shower room, CNA 1 stated Resident 21 was unable to verbalize needs. CNA 1 stated Resident 21's left fingernails were shorter than the right fingernails, but both were dirty with black matter underneath. CNA 1 stated Resident 21 was at risk for infection since Resident 21 mostly ate with her hands. 3. During a record review of Resident 63's Admission Record dated 8/13/24, the record indicated Resident 63 had diagnosis of Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination. Symptoms usually begin gradually and worsen over time. As the disease progresses, people may have difficulty walking and talking. They may also have mental and behavioral changes, sleep problems, depression, memory difficulties, and fatigue.). During a record review of Resident 63's MDS assessment dated [DATE], the MDS assessment indicated Resident 63 needed maximum assist to maintain personal hygiene and grooming. The MDS assessment indicated Resident 63's BIMS score was 14 out of 15 which indicated intact mental status. During a record review of Resident 63's Care Plan for ADLs dated on 2/2/24, the record indicated Resident 63 had ADL self-care performance deficit related to diagnosis of Parkinson's disease. During a concurrent observation and interview on 8/12/24 at 09:00 a.m. with Resident 63 in Resident 63's room, Resident 63 had long and thick facial hair that was touching his neck and chest. Resident 63 stated he preferred his facial hair trimmed but the facility had not offered it to him. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/13/24 at 9:05 a.m. with CNA 1, in Resident 63's room, CNA 1 stated Resident 63 needed maximum assistance from staff. CNA 1 stated Resident 63 had long and thick facial hair and needed a facial grooming. CNA 1 asked Resident 63 if he wanted his facial hair trimmed to which Resident 63 replied, Yes. 4. During a record review of Resident 84's Admission Record dated 8/13/24, the record indicated Resident 84 had diagnosis of dementia. During a record review of Resident 84's MDS assessment dated [DATE], the MDS assessment indicated Resident 84 needed staff's supervision, verbal cues and/or touching assistance to maintain personal hygiene and grooming. The MDS assessment indicated Resident 84's BIMS score was 3 out of 15 which indicated severely impaired mental status. During a record review of Resident 84's Care Plan for Activities of Daily Living, with revision date on 5/11/23, the record indicated Resident 84 had ADL self-care performance deficit related to diagnosis of dementia. During a concurrent observation and interview on 8/12/24 at 11:18 a.m. in Resident 84's room, Resident 84, a female resident, had long facial hair on her chin. Resident 84 stated she had her facial hair on her chin for a long time and the facility had not offered her to be shaved. Resident 84 was observed pulling the hair on her chin and stated she preferred it to be shaved. During an observation on 8/13/24 at 4:33 p.m. in the hallway, with Activity Director (AD) and CNA 2, Resident 84 stated to AD and CNA 2 that she wanted her facial hair on her chin to be shaved. During an interview on 8/14/24 at 4:13 p.m. with CNA 2, CNA 2 stated she did not notice Resident 84 had long facial hair on the chin. CNA 2 stated the risk of not providing facial hair grooming to female residents could make them feel uncomfortable. During an interview on 8/14/24 at 11:38 a.m. with the Director of Nursing (DON), the DON stated CNAs had the responsibility in providing residents with personal grooming. The DON stated having long and dirty fingernails were unsanitary that could have caused infection to the residents. The DON further stated the CNAs should have offered the residents for facial hair trimming or shaving especially with female residents. The DON stated food may get stuck in a resident's facial hair and may cause skin irritation. During a record review of the facility's policy and procedure (P&P), titled, Nail Care, dated 12/19/22, the record indicated, Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. and Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises. During a record review of the facility's P&P, titled, Activities of Daily Living (ADLs), dated 12/19/22, the record indicated, A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 46487 Based on interview and record review, the facility failed to develop new interventions to address behavioral care and treatment for one of 32 sampled residents (Resident 264) with dementia (a disorder of mental processes caused by brain disease or injury and marked by memory disorder, personality changes, and impaired reasoning) when Resident 264 exhibited physical and/or verbal aggression towards others 24 days of out 31 days in May 2024. This deficient practice had the potential for Resident 264 to harm herself and other residents in the facility. Findings: Review of Resident 264's Admission Record dated 8/13/24 indicated, Resident 264 was admitted with diagnosis of dementia with behavioral disturbance. Review of Resident 264's Minimum Data Set (MDS, a comprehensive assessment tool), dated 4/16/24, indicated Brief Interview for Mental Status (BIMS, a screening tool to identify resident's cognitive status) score of 5 out of 15, indicated Resident 264 had severely impaired cognition. The MDS indicated Resident 264 had episodes of physical symptoms (hitting, kicking, pushing, scratching, grabbing .) and verbal symptoms (threatening, screaming, cursing .) directed toward others. Review of Resident 264's Physician's Orders (PO), dated 5/1/24, indicated Quetiapine Fumarate (antipsychotic medications are a class of drugs commonly used to treat serious mental disorders) 50 milligrams (mg., a form of measurement) two times a day for aggression to others. The PO had a start date of 4/25/24. Review of Resident 264's Medication Administration Record (MAR) dated May 2024, indicated Resident 264 was observed with behaviors of aggression toward others related to schizophrenia for 15 out of 31 mornings and 24 out of 31 evenings in May 2024. During an interview and concurrent review of Resident 264's behavior care plan with the Minimum Data Set Coordinator (MDSC) on 8/14/24 at 12:44 p.m., MDSC stated, all nursing staff were responsible in updating Resident 264's care plan. MDSC stated, Resident 264's behavior care plan was not revised when the resident exhibited multiple aggression towards others in May 2024 until 5/26/24. MDSC stated she could not find a documentation the Interdisciplinary Team (IDT, a group of individuals representing different departments of the facility) met to discuss Resident 264's dementia care since the resident was admitted to the facility. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent review of Resident 264's behavior care plan with the Director of Nursing (DON), on 8/14/24 at 1:27 p.m., DON acknowledged, behavior care plan interventions/approaches for May 2024 was only revised on 5/26/24. DON stated to minimize Resident 264's aggressive behaviors, the care plan should have been reviewed and revised before 5/26/24. DON further stated was not able to find a documentation the IDT met to address Resident 264's dementia care. DON further stated, IDT should have met to discuss Resident 264's dementia care, to evaluate the root cause of the resident's aggression and, to discuss if the antipsychotic medication Quetiapine Fumarate was effective in controlling the Resident 264's aggression. During an interview and concurrent review of Resident 264's social services notes with the Social Services Director (SSD) on 8/14/24 at 1:40 p.m., SSD stated she did a psychosocial evaluation on Resident 264 but was unable to find documentation. Review of the facility's policy and procedure (P&P) titled, dementia care, revised December 2022, indicated, . The care plan goals and interventions will be monitored on an ongoing basis for effectiveness, and will be reviewed/revised as necessary .

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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. 50474 Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 364) received Cromolyn Sodium Ophthalmic Solution (a prescription eye drop medication used to treat allergic eye conditions) according to physician's order. This failure resulted in Resident 364 not receiving appropriate treatment to control eye allergy symptoms and experiencing very itchy eyes. Findings: During a record review of Resident 364's Minimum Data Set (Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.) dated 7/8/24, the MDS assessment indicated Resident 364's Brief Interview of Mental Status (BIMS- an assessment for cognition status) score was 8 out of 15 which indicated mildly impaired mental status. During an observation on 8/13/24 at 4:38 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 only administered oral medications to Resident 364 during the medication pass observation. During a record review of Resident 364's Medication Administration Record (MAR), dated 8/1/24 through 8/31/24, the record indicated Resident 364 had a routine Cromolyn Ophthalmic Solution to be administered at 9:00 a.m. and 5:00 p.m. daily. During an interview on 8/14/24 at 3:07 p.m. with LVN 5, LVN 5 stated she did not give the Cromolyn Ophthalmic Solution eye drops to Resident 364 because it had been out of order for quite some time. LVN 5 further stated she did not call the MD to inform about the missing eye drops and to ask for advice. During a concurrent record review and interview on 8/14/24 at 3:42 p.m. with the Director of Nursing (DON), Resident 364's MAR, dated 8/13/24 was reviewed. The DON stated Resident 364's Cromolyn Ophthalmic Solution had a status of reordered since 8/5/24. The DON further stated the status meant the eye medication had not been delivered by the pharmacy. During an interview on 8/15/24, at 8:35 a.m. with Resident 364, Resident 364 stated she had been taking the prescription Cromolyn Ophthalmic Solution eye drops for two years. Resident 364 stated she noticed the nurses had not been giving it to her. Resident 364 stated without the eye medication, it made her eyes feel very itchy. (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 phone interview on 8/15/24, at 9:07 a.m. with the facility's Consultant Pharmacist (CP), CP stated Cromolyn Sodium Ophthalmic Solution was a prescription eye drops used to treat eye allergies. CP stated Cromolyn Sodium Ophthalmic Solution was a stronger eye medication that would have prevented inflammation around Resident 364's eyes due to allergies. CP stated licensed nurses should have followed up with the pharmacy and should have contacted the MD for alternatives if the eye medication was unavailable. CP stated without the eye medication, Resident 364 was at risk for worsening of eye allergy symptoms such as redness and itchiness. During an interview on 8/15/24, at 11:48 a.m. with Nurse Consultant (NC), NC stated there were no documentations from licensed nurses the pharmacy had been followed up or if MD was notified about the missing Cromolyn Sodium Ophthalmic Solution. During a record review of the facility's policy and procedure (P&P), titled, Provider Pharmacy Requirements, dated April 2008, the record indicated the .pharmaceutical service is available to provide residents with prescription and nonprescription medications . The record further indicated, The provider pharmacy agrees to perform the following pharmaceutical services . 2) Accurately dispensing prescriptions based on authorized prescriber's orders . 6) Providing routine and timely pharmacy service seven days per week and emergency pharmacy service 24 hours per day, seven days per week. During a record review of the facility's P&P titled, Medication Orders, dated April 2008, the record indicated, The prescriber is contacted for direction when the medication will not be available.

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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. 40968 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 52) was free from unnecessary medication, when Resident 52 was prescribed and given Risperidone (medication to treat symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions)) and did not have schizophrenia. This failure resulted in Resident 52 being administered an unnecessary medication and had the potential for increased morbidity (the condition of suffering from a disease or medical condition) and mortality (death). Findings: During a review of Resident 52's admission record, dated 8/13/24, indicated, Resident 52 had diagnoses of Unspecified Dementia (symptoms affecting thinking and social abilities interfering with daily functioning), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. During a review of Resident 52's Minimum Data Set (MDS - an assessment tool used to guide care), dated 4/25/24, indicated Resident 52's vision was severely impaired. MDS showed, Resident 52 had a Brief Interview for Mental Status (BIMS, a screening tool used to assess cognition) score of 3 out of 15 which indicated severely impaired cognition. The MDS revealed, Resident 52 did not have indicators of psychosis (not in touch with reality) such as hallucination (false perceptions of sensory experiences) and/or delusions (fixed false belief). The MDS also showed, Resident 52 did not exhibit physical and behavioral symptoms (hitting or scratching self, pacing .) and did not exhibit verbal behavioral symptoms (threatening others, creaming at others, cursing at others). During an interview on 8/14/24 at 2:50 p.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated, Resident 52 required special attention because Resident 52 was blind. CNA 8 further added, Resident 52 was not physically abusive towards others. During an interview on 8/14/24 at 3:04 p.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated, Resident 52 was blind, forgetful, and confused. LVN 6 added, Resident 52 screamed for help but when attended to, Resident 52 said I don't need you, I'm sorry. During an interview on 8/15/24 at 10:35 a.m. with the Director Of Nursing (DON), DON stated, Resident 52 was taking Risperidone due to manifestation of screaming. DON revealed, Resident 52 was non-violent and non-threatening. During a review of Resident 52's physician order dated, 8/6/24, indicated Resident 52 was prescribed Risperidone oral tablet, 0.5 mg give 1 tablet by mouth at bedtime for Schizophrenia manifested by screaming. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 52's Pharmacy Recommendation dated 6/20/24, indicated, Antipsychotics are not approved for the treatment of dementia-related psychosis in geriatric adults; avoid use of risperidone if possible due to an increase in morbidity and mortality in geriatric patients with dementia receiving antipsychotics. Please consider discontinuing the medication. During a review of Resident 52's Preadmission Screening and Resident Review (PASRR is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.), dated 9/13/22, indicated Resident 52's Level II Mental Health Evaluation was not scheduled for the following reason: The individual had no serious mental illness (SMI). During a review of the facility's Policy and Procedures (P&P), titled Use of Psychotropic Medication, dated 12/19/22, indicated, Resident are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record .4. The indications for use of any psychotropic drug will be documented in the medical record. a. Pre-admission screening and other preadmission data shall be utilized for determining indication for use of medications ordered upon admission to the facility. b. For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed 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. 50474 Based on observation, interview, and record review, the facility failed to ensure safe medication storage and labeling practices with census of 110, when: 1. Resident 5's inhalation medication with limited shelf life after opening was not dated for beyond used date in medication cart #2b, and 2. Resident 59's intravaginal (insertion through the vagina or birth canal) medication was stored together with the oral medications in medication cart #2a. These failures had the potential to contribute to unsafe use of medications and potential for medication error. Findings: 1. During a concurrent interview and observation on 8/13/24, at 11:10 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 5's opened and undated Symbicort (an inhalation drug used to treat breathing problems) was stored in medication cart #2b. The manufacturer label on the box indicated Discard within three months after removing from foil pouch. LVN 3 stated there was no open date written on the box nor on the inhaler. LVN 3 stated when an inhalation medication was opened, it should have been dated per the facility's standard of practice. During an interview on 8/13/24, at 1:11 p.m. with the Director of Nursing (DON), the DON stated the licensed nurses should have dated the opened inhaler. The DON stated if there was no open date, the licensed nurses would not be able to identify the expiration date of the inhalation medication. 2. During a concurrent observation and interview on 8/13/24, at 12:04 p.m. with LVN 1, Resident 59's Estradiol 10 microgram tablet (a hormonal medication that reduces vaginal symptoms such as vaginal irritation, dryness, burning, or itching) had an instruction to administer one tablet intravaginally three times a week, was stored in medication cart #2a with other oral medications. LVN 1 stated the intravaginal medication should have been separated and not stored with oral medications. LVN 1 stated storing the intravaginal medication with oral medications was potential for infection due to its different administration routes. During an interview on 8/13/14, at 1:15 p.m., with the DON, the DON stated she expected the licensed nurses to store all medications with different routes in separate storages. The DON further stated storing the intravaginal medication with the oral medications was an unacceptable practice because it had a potential risk for spread of infection due to its different routes. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24, at 9:07 a.m. with the facility's Consultant Pharmacist (CP), CP the inhalation medication Symbicort had a shelf life of eight weeks. CP stated licensed nurses should have dated the inhalation medication, to determine until when the medication can be used effectively. CP further stated the Estradiol intravaginal tablet should have not been stored with any other medications that had different routes especially with oral medications. CP stated the Estradiol intravaginal tablet stored with oral medications had a potential risk to be given orally that could have led to accidents and medication errors. During a record review of the facility's policy and procedure (P&P), titled, Labeling of Medications and Biologicals, dated 12/19/22, the record indicated All medications used in the facility will be labeled in accordance with current state and federal regulations to facilitate considerations of precautions and safe administration of medications. During a record review of the facility's P&P, titled, Medication Storage dated 12/19/22, the record indicated medications to be administered by mouth are stored separately from other formulations (i.e. eye drops, ear drops, injectables).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49498 Based on observation, interview, and record review the facility failed to store and prepare foods in a sanitary manner that prevented foodborne illness for the facility when: 1. Eleven unlabeled and undated sandwiches were stored in the refrigerator, 2. Multiple food items were stored in the dry storage room beyond use by date, and 3. Two outdated sandwiches and eight grapes with mold was stored on Resident 54's bedside table. These failures had the potential for residents to be exposed to food borne illness. Findings: 1. During a concurrent observation and interview on [DATE] at 7:30 a.m. with the Dietary Supervisor (DS) in the kitchen, eleven unlabeled and undated sandwiches and a paper with written ,d+[DATE] and UBD [use by date] ,d+[DATE] was inside a rectangular plastic container stored in the refrigerator. The DS stated the sandwiches was prepared on [DATE] and should have been thrown away after use by date. During an interview on [DATE] at 10:25 a.m. with the Registered Dietitian (RD), the RD stated sandwiches should be labeled with a date of when it was prepared and should be thrown once it was past their use by date. During a review of the facility's policy and procedure (P&P) titled, Food Storage, dated [DATE], indicated, Any expired or outdated food products should be discarded . All products should be inspected for safety and quality and be dated upon receipt, when open, and when prepared. 2. During a concurrent observation and interview on [DATE] at 8:03 a.m. with the DS inside the dry storage room, three bags of 5 pound pancake mix with [DATE] used by date label, one 48 ounce bag of dried cranberries with [DATE] best before date printed at the back of the packaging, and seven hamburger buns with [DATE] received date and [DATE] used by date written on the plastic packaging were in the dry storage room. The DS took the three bags of pancake mix, one bag of dried cranberries and burger buns out of the dry storage. The DS stated would discard the food items. During a review of the facility's P&P titled, Food Storage, dated [DATE], indicated, Any expired or outdated food products should be discarded. During a review of the facility's Dry Storage Quick Reference Guide, dated [DATE], indicated, Unopened Bread (hamburger) recommended storage was four to five days. 3. During an observation on [DATE] at 9:09 a.m. in Resident 54's room, two sandwiches with [DATE] and [DATE] date and label and a plastic cup of eight grapes with white fuzzy material and dark spots resembling mold was on Resident 54's bedside table. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on [DATE] at 8:32 a.m. with Certified Nursing Assistant (CNA) 3, two sandwiches with [DATE] and [DATE] date and label and a plastic cup of grapes with white fuzzy material and dark spots resembling mold was on Resident 54's bedside table. CNA 3 stated Resident 54 could get food poisoning symptoms such as stomachache, vomiting or diarrhea if Resident 54 accidentally ate the old sandwich and moldy grapes. During an interview on [DATE] on 8:43 a.m. with the Director of Nursing (DON), the DON stated the CNA are responsible to remove old food items from the resident's table and Resident 54 could be at risk for food borne illness if accidentally ingested old food items. During a review of Resident 54's Minimum Data Set (MDS, an assessment tool used to guide care) dated [DATE], the MDS indicated Resident 54 had a Brief Interview for Mental Status (BIMS, a screening tool used to assess cognition) score of 12 out of 15, which indicated intact cognition. The MDS indicted Resident 54 required partial/moderate assistance with eating. During a review of the facility's P&P titled, Food Storage, dated [DATE], the P&P indicated, Food items should be stored . in accordance with good sanitary practice . Any expired or outdated food products should be discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40968 Based on observation, interview, and record review, the facility failed to maintain and observe infection control practices when: 1. Certified Nursing Assistant (CNA) 4 did not wear face shield inside COVID-19 isolation room, 2. CNA 5 did not perform hand hygiene before entering Resident 166's room, 3. a glucometer (a device used to check blood sugar level) was stored inside the medication cart had traces of dark red stains around it, 4. a tray full of multiple single-use lancet supplies (a small sharp device that pricks the skin to draw a blood sample for testing blood sugar levels), a bottle of blood sugar test strips, alcohol pads and a glucometer device was placed on top of Resident 35's bed was not disinfected by Licensed Vocational Nurse (LVN) 4 after use, 5. LVN 5 dropped the bottle cap for Resident 363's Famotidine (an over-the-counter medicine that is used to prevent and treat acid indigestion and sour stomach) on the floor, picked it up and placed it back without disinfecting it, 6. one opened and unlabeled toothbrush and two used tubes of toothpaste were observed on top of the sink of the shared bathroom of Residents 10, 13, 59 and 95, 7. Resident 90's wheelchair, an off-loading cushion (type of chair cushion to relieve pressure on bony areas) and an abduction wedge (knee separator block) were found stored in the shared bathroom of Residents 16, 33, 55, 77, 85 and 90, 8. one used single-use razor was stored inside Resident 54, 68, 81, and 113's shared bathroom, 9. two unlabeled reusable wash basin was stored inside Resident 14, 15, 19, and 48's shared bathroom, and 10. LVN 2 did not perform hand hygiene when wound care treatment was performed for Resident 167. These failures had the potential for cross contamination and spread of infections among residents at the facility. Findings: 1. During a review of Resident 213's Admission Record (AR), dated 8/13/24, the AR showed Resident 213 had diagnosis COVID-19 (Corona Virus Disease- highly contagious respiratory disease). During a review of Resident 213's Order Summary report, dated, 8/7/24, the order summary indicated, Admit to room isolation and services provided in room. In contact, droplet, airborne precaution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/13/24 at 8:50 a.m. with CNA 4, CNA 4 was seen inside Resident 213's room not wearing face shield. CNA 4 stated, she was supposed to wear face shield inside Resident 213's room because Resident 213 had COVID infection. CNA 4 also said, face shield was for the safety of other residents, staff, and self. During a concurrent interview and record review on 8/13/24 at 9:35 a.m. with the Infection Preventionist (IP), IP stated, CNA 4 should have worn face shield inside Resident 213's room because Resident 213 was on droplet/airborne precaution due to COVID-19 infection. During a concurrent interview and record review on 8/13/24 at 11:23 a.m., with the IP, Resident 213's Infection, Isolation, and Precaution Details document dated 8/13/24 revealed Resident 213 had COVID-19 infection. The document indicated contact, airborne, and droplet precaution were required. The document further indicated personal protective equipment (PPE is equipment used to prevent or minimize exposure to hazards) requirements included Eye protection (Face Shield or Goggles) . The document indicated Resident 213 will be out of isolation on 8/14/24. During a review of the facility's policy and procedures (P&P) titled, Corona Virus Prevention and Response, dated, 12/19/22, indicated under Policy: This facility will respond promptly upon suspicion of illness associated with a SARS-CoV-2 infection in efforts to identify, treat, and prevent the spread of the virus. The P&P also indicated, under Policy Explanation and Compliance Guidelines: .15. Health Care Providers (HCP) who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection. During a review of the facility's P&P titled, Personal Protective Equipment, dated 12/19/22, indicated, The facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff . Face protection: .Wear goggles or face shield as added face/eye protection. Personal eyeglasses are not substitute for goggles. During a review of facility's undated sign titled Droplet & Airborne Precaution, the sign indicated, Before entering zone: [NAME] face shield & N-95 respirator [a type of face mask]. 2. During a review of Resident 166's AR, dated 8/14/24, the AR indicated Resident 166 had diagnosis of immunodeficiency (weak immune system, allowing infections and other health problems to occur more easily). During an observation on 8/13/24, at 3:33 p.m., with CNA 5, CNA 5 picked up ice cube from wet floor with her right hand. CNA 5 entered Resident 166's room without performing hand hygiene. CNA 5 drew Resident 166's curtain close with the same hand (right) she used to pick up ice cube from wet floor. During an interview on 8/13/24, at 3:35 p.m., with CNA 5, CNA 5 acknowledged her hand became soiled from picking up dirty ice cube from the floor. CNA 5 stated, she did not perform hand hygiene before going into Resident 166's room because she was holding a cup with her other hand. CNA 5 further added, the expectation was to sanitize hands before going in and coming out of resident's room to prevent the spread of infection in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/24, at 10:30 a.m., with the IP, IP stated, the expectation from the staff was to gel in and gel out (term used to perform hand hygiene before and after entering and exiting a room) using Alcohol Based Hand Rub (ABHR), whenever staff go into the resident room. IP further added, if hand was visibly soiled staff should wash hands with soap and water for 20 seconds to prevent spread of infection to other residents. During a review of facility's P&P, titled Hand Hygiene, dated, 12/19/22, the P&P indicated, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility .Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. According to the Center for Disease Control (CDC) - Long Term Care Facilities guidance titled, Viral Respiratory Pathogens Toolkit for Nursing Homes, dated 3/28/24, the guidance indicated, Health Care Providers (HCP) who enter the room of a resident with signs or symptoms of unknown respiratory viral infection that is consistent with SARS-CoV-2 infection should adhere to Standard Precautions and use NIOSH-approved(R) particulate respirator with N95(R) (% filters or higher, gown, gloves and eye protection (i. e., goggles or a face shield that covers the front and sides of the face. This PPE can be adjusted once the cause of the infection is identified. 50474 3. During a concurrent observation and interview on 8/13/24, at 11:10 a.m. LVN 3, a glucometer stored inside the medication cart # 2B had dark red stains on the insertion port, on the side, and back of the device. LVN 3 stated the glucometer device looked dirty. LVN 3 stated the stain was from dried blood. LVN 3 stated not cleaning and disinfecting the glucometer device could spread infection in the facility. During an interview on 8/13/24, at 1:11 p.m. with the Director of Nursing (DON), the DON stated having a glucometer with blood stain was unacceptable practice. The DON stated the licensed nurses were responsible for cleaning and disinfecting the glucometer thoroughly to prevent the spread of infection. During an interview on 8/13/14, at 3:34 p.m. with the IP, IP stated the licensed nurses should have cleaned and disinfected the glucometer using the facility's approved disinfectant wipes from top to bottom and all the sides. IP stated the glucometer should have been free from stains and dirt. IP stated the risk of not properly cleaning and sanitizing the glucometer device may cause spread of blood infection among the residents and staff. During a record review of the facility's P&P, titled, Glucometer Disinfection, the P&P indicated, Cleaning is the removal of visible soil from objects and surfaces . and Disinfection is a process that eliminates many or all pathogenic microorganisms . P&P further indicated Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent observation and interview on 8/13/24, at 3:42 p.m. with LVN 4, in Resident 35's room, LVN 4 placed a tray that had multiple single-use lancets, a bottle of blood sugar test strips, glucometer, and alcohol pads on top of Resident 35's bed. After LVN 4 administered Resident 35's medication, LVN 4 returned to the medication cart and did not disinfect the tray. LVN 4 then proceeded with medication administration to other residents leaving the tray of supplies exposed on top of the cart. LVN 4 stated she brought the tray full of single-use lancets because she thought she needed to use the extra tray that was placed underneath. LVN 4 stated the risk of bringing the whole tray of single-use lancets supply to different resident rooms and not disinfecting the tray after placing it on a resident's bed could spread infection in the facility. During an interview on 8/14/24, at 10:33 a.m. with IP, IP stated when licensed nurses performed blood sugar checks, they should have only brought enough supplies in the resident's room. IP stated one to two single-use lancets in each blood sugar check should be enough. IP stated bringing a tray full of single-use lancets inside a resident's room and placing it on the bed may cause contamination of the lancets and could spread infection to residents. 5. During an observation and interview on 8/13/24, at 4:45 p.m. with LVN 5, outside Resident 364's room, LVN 5 was observed preparing Resident 364's scheduled medications. LVN 5 dropped the bottle cap for Famotidine on the floor. LVN 5 then picked up the bottle cap and placed it back to cover the Famotidine bottle without disinfecting the bottle cap. LVN 5 stated she should have cleaned and disinfected the bottle cap before putting it back to cover the medicine. LVN 5 stated not disinfecting the bottle cap could be risk for infection to other residents who was also taking the same medication. During an interview on 8/14/24, at 10:35 a.m. with IP, the IP stated when licensed nurses dropped something on the floor they were expected to disinfect or throw away the item. IP stated the risk of not disinfecting the medicine bottle cap could potentially contaminate the rest of the medicines in the bottle and could cause infection to residents who were taking the same medication. During a record review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Equipment, the P&P indicated reusable resident-care equipment will be cleaned and disinfected to break the chain of infection. The P&P further indicated single-used items were designed to be used once, for only one person and should be discarded after each use and multiple-resident use equipment shall be cleaned and disinfected after each use. 46487 6. During an interview with CNA and 1 initial tour observation of the facility on 8/12/24 at 7:35 a.m., one opened and unlabeled toothbrush exposed to air, and two used tubes of toothpaste were observed on top of the sink of the shared bathroom of Residents 10, 13, 59 and 95. When asked, CNA 1 stated she did not know whom the said items belonged to. CNA 1 also stated, the items should not be on top of the sink due to the risk of spread of infection. During a concurrent observation and interview on 8/12/24, at 7:36 a.m., with LVN 1, in the shared bathroom of Residents 10, 13, 59, and 95, LVN 1 stated the toothbrush, and tubes of toothpaste should not be stored on top of the bathroom sink because of the risk of spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview with LVN 1 and initial tour observation of the facility on 8/12/24 at 7:40 a.m., Resident 90's wheelchair, an off-loading cushion and an abduction wedge were found stored in the shared bathroom of Residents 16, 33, 55, 77, 85 and 90. When asked, LVN 1 stated the wheelchair belonged to Resident 90, but she did not know whom the off-loading cushion and the abduction wedge knee separator belonged to. LVN 1 also stated the said items should not be stored in the bathroom for infection control. During a review of Resident 90's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 7/25/24, the MDS indicated Resident 90 used a wheelchair and was dependent on the help of the staff for wheelchair mobility. During an interview on 8/13/24 at 9:26 a.m., with IP, IP stated a resident's toothbrush should be placed in a clean plastic bag and should be labeled and stored with the resident's clean belongings for infection control. IP stated the wheelchair, off-loading cushion, and the abduction wedge knee separator should not be stored in the bathroom due to the risk of spread of infection. During an interview on 08/13/24 at 1:58 p.m., with DON, DON stated, the residents' toothbrush, toothpastes, wheelchair, off-loading cushion, and the abduction wedge knee separator should not be stored in the bathroom due to the risk of spread of infection. DON further stated Resident 90's wheelchair should have been stored at the resident's bedside. During a review of the facility's P&P titled, Infection Prevention and Control Program, dated 2022, the P&P indicated, .All staff shall demonstrate competence in relevant infection control practices. Direct care staff shall demonstrate competence in resident care procedures established by our facility . 49498 8. During an observation on 8/12/24 at 8:56 a.m. in Resident 54, 68, 81, and 113's shared bathroom, one blue razor with two strands of black and white hair was on top of the paper towel dispenser. During a subsequent observation and interview on 8/12/24 at 2:12 p.m. with CNA 6 in Resident 54, 68, 81, and 113's shared bathroom, one blue razor with two strands of black and white hair was observed on top of the paper towel dispenser. CNA 6 took the razor, walked into the shower room and threw the razor in the sharps disposal container. CNA 6 stated the razor should have been discarded in the sharps container after use. During an interview on 8/14/24 at 9:05 a.m. with the IP, the IP stated razors should be used one time and disposed in the sharps container after resident use to prevent cross contamination. The IP stated sharps containers are located inside the shower room. During a review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Equipment, dated 12/19/2022, indicated, Resident-care equipment can be a source of indirect transmission of pathogens [a bacterium, virus, or other microorganism that can cause disease.] . 'Single-use items' are items that are designed to be used once, for only one person; These items are to be discarded after use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555287	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diamond Ridge Healthcare Center	2351 Loveridge Road Pittsburg, CA 94565

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. During an observation on 8/12/24 at 10:36 a.m. in Resident 14, 15, 19, and 48's shared bathroom, two unlabeled wash basins were on top of the paper towel dispenser. During a subsequent observation and interview on 8/12/24 at 2:36 p.m. with CNA 7 in Resident 14, 15, 19, and 48's shared bathroom, two unlabeled wash basin were on top of the paper towel dispenser. CNA 7 stated wash basins should be stored inside the resident's bedside cabinet. During a concurrent observation and interview on 8/12/24 at 3:40 p.m. with Resident 19, Resident 19 stated the staff took the basin with his stuff in the shower room. Resident 19 stated did not know to whom the basin in the bathroom belonged. During an interview on 8/12/24 at 3:44 p.m. with CNA 6, CNA 6 stated wash basin should be marked with resident's name and room number to prevent the spread of infection, loss and getting mixed up. During an interview on 8/14/24 at 9:05 a.m. with the IP, the IP stated wash basin can be reused but must be labeled and wiped with sanitizing wipes after use. During a review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Equipment, dated 12/19/2022, the P&P indicated, 'Reusable single-resident items' are items that may be used multiple times, but for one resident only. 36593 10. During a review of Resident 167's Order Summary Report, dated 8/8/24, the order summary report indicated physician prescribed Resident 167 to receive wound treatment for stage 3 pressure injury (full thickness tissue loss, subcutaneous (under the skin) fat may be visible, but bone, tendon, or muscle is not exposed. Slough (yellow or white material in wound bed) may be present but does not obscure the depth of tissue loss) on sacra-coccyx (tail-bone), cleanse with wound cleaner, pat dry with gauze, apply medi honey (medical grade honey used for promote wound healing), oil emulsion (oil to help support wound environment), top with calcium alginate (substance used to treat wounds), and cover with foam dressing every day. During a review of Resident 167's actual impairment to skin integrity care plan, dated 8/9/24, indicated Resident 167 had stage 3 wound on his tailbone and intervention included follow facility policies/protocols for the prevention/treatment of skin breakdown. During a wound dressing change observation on 8/14/24 at 9:58 a.m., with LVN 2, in Resident 167's room, Resident 167 was positioned lying in bed on his left side, with the tailbone wound exposed for wound treatment. Resident 167 requested to use the urinal, LVN 2 with same gloved hands used to cleanse Resident 167's wounds assisted Resident 167 with urinal and provided penile care. LVN 2 then removed his gloves, put on a new pair of gloves without performing hand hygiene or hand washing, continued wound treatment to Resident 167's tail bone. During an interview on 8/14/24 at 11:02 a.m., with LVN 2, LVN 2 stated he did not perform hand hygiene or hand washing after he offered Resident 167 urinal, penile care, removed gloves and before continued wound treatment to Resident 167 tail-bone area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/24 at 12:02 p.m., with IP, IP stated licensed nurses were expected to use hand sanitizer or wash hands with soap and water after penile care, removing gloves and before continuing wound care treatment. During a review of the facility's P&P titled, Clean Dressing Change, revised 12/19/22, the P&P indicated, It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Wash hands and put on clean gloves. Remove gloves, pulling inside out over the dressing. Wash hands and put on clean gloves.