STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555723	A. Building B. Wing	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Post-Acute	247 E. Bobier Drive Vista, CA 92084

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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** 39660 Based on observation, interview, and record review, the facility did not assure the plan of care for Resident 3's suprapubic catheter (tube inserted into your bladder through a small hole in your belly that drains urine) was implemented for one of three residents (3) with catheters. As a result, Resident 3 had the potential to have a urinary tract infection that was untreated. Findings: Per the Admission Record, Resident 3 was admitted to the facility on [DATE] with a suprapubic catheter. Resident 3's record was reviewed. Per Resident 3's physician's orders, dated 1/28/22, the resident was to receive monitoring of his urine for any signs of infection every shift. Per Resident 3's revised plan of care dated, 4/11/22, he was to receive monitoring of urine output for signs of infection such as sediment (white particles) in the urine, foul odor, blood in the urine, lower back pain. The nurses were to monitor the urine output every shift, identify the signs of potential urinary tract infection, and notify the doctor. On 7/12/22 at 8:15 A.M. an observation and interview with Resident 3 of his suprapubic catheter was conducted. Resident 3 stated I have UTIs quite often and they treat them with antibiotics. Resident 3's urine in the urinary bag was dark yellow with white sediment. Resident 3 stated the sediment in the urine could be a sign of infection. On 7/12/22 at 11:43 AM and at 4 P.M. Resident 3's urine displayed white sediment in the urine. On 7/13/22 at 10:12 A.M. an interview and observation of Resident 3's urine was conducted with LN 11. LN 11 stated Resident 3's urine had sediment and that could be a sign of urinary tract infection. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/13/22 at 3:40 P.M., an interview and observation of Resident 3's urine was conducted with CNA 11. CNA 11 stated Resident 3 was supposed to be monitored for signs of infection. CNA 11 confirmed that Resident 3's urine had a dark yellow-colored urine, had sediment, that might be a sign of infection. On 7/13/22 at 3:55 P.M., an interview and observation of Resident 3's urine was conducted with LN 12. Resident 3's urine in the urinary bag, had sediment. LN 12 stated that could be a sign of urinary tract infection and the doctor should have been notified about Resident 3's sediment in the urine. On 7/14/22 at 10:15 A.M., an interview was conducted with the DON. The DON stated the nurses should be monitoring Resident 3's urine output every shift and notify the doctor of any potential signs of infection. Per the facility policy, dated 9/2014, titled Catheter Care, Urinary, . the purpose of this procedure is to prevent catheter associated urinary tract infections Observe for signs and symptoms of urinary tract infection Report findings to the physician or supervisor immediately .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42250 Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 27) received a shower when requested. This failure put the resident at risk for poor hygiene and decreased quality of life. Findings: Resident 27 was admitted to the facility on [DATE], with diagnoses that included Respiratory Failure (a condition affecting the lungs), per the Admission Record. On 7/13/22, a review of Resident 27's MDS (a health status screening and assessment tool), dated 4/22/22, indicated a BIMS (Brief Interview for Mental Status-test for cognitive function) score of 15 out of 15, which indicated cognition was intact. In addition, the resident required assistance with activities of daily living (ADL). On 7/13/22 at 10:08 A.M., an interview was conducted with Resident 27. Resident 27 was observed in his room sitting up in a chair dressed in his own clothes, no obvious odors noted, hair was uncombed. Resident 27 stated, he had requested a shower from several staff members and that he had not received a shower for over a week or more. Resident 27 stated, he was not able to recall the last time he had a shower. On 7/14/22 at 8:12 A.M., an interview was conducted with CNA 6. CNA 6 stated, he was the assigned CNA for Resident 27 and was familiar with Resident 27's care. CNA 6 stated, Resident 27 was alert, awake and oriented x 3 and able to make his needs known to staff and was cooperative with his care. CNA 6 stated, Resident 27's shower days are Mondays and Thursdays on the PM shift and he does not refuse showers. CNA 6 stated, he did not know when Resident 27's last shower was or that Resident 27 was not getting his showers. CNA 6 further stated, Resident 27 should be getting his showers per the schedule. On 7/14/22 at 9:33 A.M., a concurrent interview and record review was conducted with LN 6. LN 6 stated, she was familiar with Resident 27 and that he was awake, alert oriented x 3, cooperative with care provided by the staff; and was not known to refuse care. LN 6 stated, Resident 27 was scheduled for showers on Mondays and Thursdays per the unit schedule. LN 6 stated, she was unable to locate a documentation in the EMR (electronic medical record) of Resident 27's last shower. LN 6 stated, the CNAs did not report that Resident 27 was refusing showers or getting showers, and did not know that Resident 27 had been requesting showers. LN 6 further stated, Resident 27 should have been getting his showers. On 7/14/22 at 9:46 A.M., a concurrent interview and record review with the DON was conducted. The DON stated, each unit had a schedule for each resident scheduled shower days and times. The DON stated, per Resident 27's EMR the last documented shower was 7/1/22. The DON stated, it was the expectation for staff to follow the resident shower schedule and the policy, and they were not. The DON stated, Resident 27 should have received a shower as per the unit shower schedule and when he requested. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's policy, titled Dignity, revised February 2020, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39220 Based on observation, interview, and record review, the facility failed to ensure one of three residents' shower rooms (Station 2's secured unit) was free of hazards when: 1. The shower drain was not covered and was left open and exposed; 2. A wall mounted sharp container was full and not replaced in a timely manner; and, 3. Shaving cream canisters were left in the shower room area. These failures had the potential for residents to injure themselves due to the environmental hazards. Findings: 1. On 7/12/22 at 11:05 A.M., an observation of the shower room in the secured unit was conducted. The shower room adjacent to the main hall (used for activities and dining) was unlocked, and no drain cover was present in the shower stall. On 7/13/22 at 8:13 A.M., and on 7/14/22 at 8:35 A.M., the shower drain remained uncovered and exposed. On 7/13/22 at 9:03 A.M., review of the station 2 units' maintenance log was conducted. There was no documentation that the missing shower drain cover was reported for repair. On 7/14/22 at 8:38 A.M., an observation and interview of the secured unit's shower room was conducted with CNA 1. CNA 1 stated there was no drain cover in the shower and residents' could trip and fall. 2. On 7/12/22 at 11:05 A.M. an observation of the shower room in the secured unit was conducted. The sharp container mounted on the wall, was full of blue razors and congested. The lid could not fully open, and the opening gap on the lid was 3/4 to one inch in width. On 7/13/22 at 8:13 A.M., and on 7/14/22 at 8:35 A.M., the sharp container mounted on the wall, remained full with the lid partially opened. On 7/14/22 at 8:38 A.M., an observation and interview of the secured unit's shower room was conducted with CNA 1. CNA 1 stated the sharp container was too full and someone could cut themselves if they reached in to disposed of a razor. 3. On 7/13/22 at 8:13 A.M., an observation of the shower room in the secured unit was conducted. A small canister of shaving cream was left lying sideways on a tabletop. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/14/22 at 8:35 A.M. a small canister of shaving cream was observed in the same position, lying sideways on the shower room's tabletop. On 7/14/22 at 8:44 A.M., an observation and interview was conducted with CNA 2 of the secured unit's shower room. CNA 2 stated the shaving cream canisters should have been put away because a resident with dementia could ingest them on accident. On 7/14/22 at 8:46 A.M., an observation and interview was conducted with LN 1 of the secured unit's shower room. LN 1 stated the shower room contained hazard. LN 1 stated, the drain needed to have a drain cover, the sharp's container should have been replaced, and the shaving canisters should have been removed. LN 1 stated the drain and sharps container should have been reported to her, so she could have reported to the maintenance to fix them promptly. On 7/14/22 at 9:03 A.M., an interview was conducted with the DSD. The DSD stated she expected the CNAs to remove all shampoos, shaving cream canisters after each use. The DSD stated the CNAs should have logged the missing drain cover in the maintenance book and they should have reported the full sharp container to the charge nurse for replacement. On 07/14/22 at 9:34 A.M., an interview was conducted with the ICN. The ICN stated she expected sharp containers to be replaced when full, because someone could get cut or injure themselves when trying to dispose a sharp object into the container. The ICN stated if the shower room remained unlocked, any resident could wander into the room unsupervised. On 7/14/22 at 12:43 P.M., an interview was conducted with the DON. The DON stated she expected all shower room hazards be removed by staff, so residents remained safe. According to the facility's policy, titled Needlesticks and Cuts, dated August 2013, The personnel must follow . established procedures to help prevent injuries caused by needle sticks, sharp blades .or other sharp instruments. The facility was unable to provide a policy related to other environmental hazards.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview, and record review, the facility failed to consistently document post (after) dialysis (a procedure for filtering toxins from the blood) assessments for two of two sampled residents (33, 81) and three of seven unsampled residents (49, 79, 96), reviewed for dialysis care. As a result, Resident's 33, 81, 49, 79, and 96 had the potential risk for complications related to delayed assessments from dialysis sessions. Findings: 1. Resident 33 was readmitted to the facility on [DATE], with diagnoses which included end-stage renal (kidney) failure, per the Admission Records. On 7/13/22, Resident 33's clinical records were reviewed: According to the Admission MDS, dated [DATE], a cognitive score of 15 (15 out of 15), indicated cognition was intact. According to the physician's order, dated 7/11/22, .Dialysis .Complete post dialysis assessment upon return. In the evening every Tuesday, Thursday, Saturday . The Dialysis Communication Records from 6/2/22 through 7/2/22 were reviewed. Resident 33 had completed nine dialysis treatments. Six dialysis treatments did not have documentation of post dialysis assessments on the dialysis communication forms. According to the facility's Care Plan, titled Dialysis, dated 5/2/22, an intervention included Monitor/document/report signs/symptoms of infection to access site. 2. Resident 81 was readmitted to the facility on [DATE], with diagnoses which included end-stage renal disease, per the Admission Record. On 7/13/22, Resident 81's clinical records were reviewed: According to the last quarterly MDS, dated [DATE], a cognitive score documented 15 (15 out of 15) indicated, cognition was intact. According to the physician's order, dated 4/29/22, .Dialysis .Review post-dialysis notes special instructions and new orders. One time a day every Tuesday, Thursday, Saturday . The Dialysis Communication Records from 6/2/22 through 6/25/22 were reviewed. Resident 81 had completed four dialysis treatments. All four dialysis treatments did not have documentation of post dialysis assessments on the dialysis communication forms. According to the facility's Care Plan, titled Dialysis, dated 6/3/21, an intervention included Monitor/document/report signs/symptoms of infection to access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 49 was admitted to the facility on [DATE] with diagnoses which included end-stage renal failure, per the Admission Record. On 7/13/22, Resident 49's clinical records were reviewed: According to the physician's order, dated 6/15/22, .Dialysis .2 hour post dialysis monitor pressure dressing and access site for bleeding and skin integrity, in the afternoon every Monday, Wednesday, Friday . The Dialysis Communication Records from 6/6/22 through 7/6/22, were reviewed. Resident 49 had completed eight dialysis treatments. All eight dialysis treatments did not have documentation of post dialysis assessments on the dialysis communication forms. According to the facility's Care Plan, titled Dialysis, dated 6/29/22, an intervention included Monitor/document/report signs/symptoms of infection to access site. 4. Resident 79 was readmitted to the facility on [DATE], with diagnoses which included end-sage renal disease, per the Admission Record. On 7/13/22, Resident 79's clinical records were reviewed. According to the physician's order, dated 4/29/22, .Dialysis .2 hour post dialysis monitor pressure dressing and access site for bleeding and skin integrity, in the afternoon every Tuesday, Thursday, Saturday . The Dialysis Communication Records from 6/7/22 through 7/12/22 were reviewed. Resident 79 had completed eleven dialysis treatments. All eleven dialysis treatments did not have documentation of post dialysis assessments on the dialysis communication forms. According to the facility's Care Plan, titled Dialysis, dated 4/15/20, an intervention included Monitor/document/report signs/symptoms of infection to access site. 5. Resident 96 was readmitted to the facility on [DATE], with diagnoses which included end-stage renal failure, per the Admission Record. On 7/13/22, Resident 96's clinical records were reviewed: According to the physician's order, dated 4/25/22, .Dialysis .2 hour post dialysis monitor pressure dressing and access site for bleeding and skin integrity, in time a day every Tuesday, Thursday, Saturday . The Dialysis Communication Records from 6/7/22 through 7/7/22 were reviewed. Resident 96 had completed nine dialysis treatments. All nine dialysis treatments did not have documentation of post dialysis assessments on the dialysis communication forms. According to the facility's Care Plan, titled Dialysis, dated 8/8/18, an intervention included 2-hour post dialysis, monitor pressure dressing and access site for bleeding and skin integrity. Monitor/document/report signs/symptoms of infection to access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/13/22 at 9:27 A.M., an interview was conducted with LN 2. LN 2 stated post dialysis assessments consisted of vital signs, checking the dressing for bleeding or signs of infection, and assessing the shunt (a surgical arterial/venous connection, used as an access site for dialysis) for bruit (listen) and thrill (feel). LN 2 stated the pressure dressing to the shunt was usually removed after two hours. LN 2 stated if the shunt site was not assessed or checked after dialysis, the resident could bleed out, the shunt could become clogged requiring surgical intervention, or identifying an infection could be delayed in treatment. LN 2 stated it was a nursing standard of care to routinely assesses shunts for complications. LN stated she had not received any dialysis assessment training at this facility, but utilized her previous training from nursing school and her previous job to conduct assessments. On 7/13/22 at 9:45 A.M., an interview was conducted with the DSD. The DSD stated she provided training to the CNAs and the DON provided training to all the licensed nurses On 7/13/22 at 10:22 A.M., an interview was conducted with the DON. The DON stated she had not provided any in-services regarding dialysis assessments since she started working at the facility. The DON stated pre (before) and post dialysis assessments were important for early identification of complications at the dialysis sites. According to the facility's policy, titled End-stage Renal Disease, Care of a Resident with, dated September 2010, .Education and training of staff included, specifically: .d. How to recognize and intervene in medical emergencies such as hemorrhages and septic infections .g. The care of grafts and fistulas .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13095 Based on record review, facility staff interview, and policy and procedure the facility failed ensure that the following systems were in place for 2 unsampled Residents (35 and 84) out of 4 unsampled Residents and 1 sampled Resident (Resident 54): 1)The facility's medication refrigerated emergency drug kit had not been replaced within 72 hours after opening for the retrieval of one medication for (Resident 54), 2) no expired drugs were available at the facility for administration to any of the facility's residents either in the facility's drug storage rooms or on the facility's medication carts, 3) medications which had been ordered for Resident 35 had been administered as ordered by the resident's physician, and 4) Resident 84's medical record contained documentation indicating why his Gabapentin (Neurontin) had been held. This deficiency had the potential for the residents at the facility to receive expired medications as well as medications which had not been administered in accordance with their physician's orders, which could have resulted in negative outcomes for these residents. Findings include: 1) Inspection of the facility's medication refrigerator on Station 2, on 7/11/2022 at 4:13 PM revealed that the facility's refrigerated emergency drug supply had been opened by the facility's staff on 6/21/2022 and NPH (Neutral Protamine [NAME] insulin), a long-acting insulin had been removed for one sampled Resident (54). Review of the facility's policy and procedure entitled: Medication Ordering and Receiving From Pharmacy, from the facility's Pharmacy Provider Manual, which was undated, read: .opened kits are replaced with sealed kits within (72 hours) of opening . This refrigerated emergency kit had been opened from 6/21/2022 to 7/11/2022 (20 days) without this emergency kit being replaced within 72 hours, as outlined in the facility's policy and procedure above. 2) Inspection of the facility's medication storage room on Station 2, on 7/11/2022 at 4:20 PM revealed the following expired medications: one bottle of Loperamide HCL oral solution (120 ml for the treatment of diarrhea) with an expiration date of 9/2021 and one bottle of Complete Multivitamin for Women tablets with an expiration date of 6/2022. Inspection of the facility's medication carts on 7/13/2022 between 2:30 PM and 3:15 PM with LN 6 on Station 1 revealed the following expired medications: one bottle of Loperamide HCL oral solution (120 ml) with an expiration date of 9/2021, two bottles of Hyoscyamine 0.125mg sublingual (under the tongue, for the treatment of gastro intestinal disorders) tablets with an expiration date of 4/2022, one box of Nicotine 4 mg gum (to help with cravings and urges to smoke cigarettes) with an expiration date of 1/2022, one bottle of Morphine Sulfate oral solution 100 mg per 5 ml (for the treatment of pain) with an expiration date of 9/1/2021. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure from the facility's Pharmacy provider manual entitled: Storage of Medications, dated 4/2019, read: 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. As outlined in the facility's policy and procedures, the expired medications above should not have been available for resident use. 3) Review of the medical record for unsampled Resident 35 on 7/13/2022 at 11:21 AM revealed that this resident had a physician's order for Metoprolol Tartrate 25mg (Lopressor for the treatment of high blood pressure) to be given once a day .Hold for Systolic Blood Pressure less than 110 . On 7/8/2022 this resident's blood pressure had been documented in the resident's medical record as: 107/57. The upper number of the blood pressure (systolic) was 107, yet his medication Nurse administered this blood pressure medication to Resident 35, contrary to the physician's order above. Concurrent interview with the facility's Director of Nurses (DON) revealed that the medication Nurse had indeed administered this medication to Resident 35, even though the physician's order indicated that this medication should have been held for this administration and documented in the resident's medication record. Review of the facility's policy and procedure entitled: Preparation and General Guidelines, which was undated, read: 2) Medications are administered in accordance with written orders of the attending physician. This medication was administered to this resident contrary to the facility's policy and procedure above. 4) Review of the medical record for unsampled Resident 84 on 7/12/2022 at 3:56 PM revealed that this resident had a physician's order to receive Gabapentin (Neurontin) 300 mg on 6/27/2022 at 5:00 PM, yet his medication Nurse decided to hold this medication. Concurrent interview with the DON revealed that the medication Nurse had held the resident's Gabapentin on 6/27/2022 and the medication Nurse had not documented in the medical record, the reason why this Nurse had withheld or did not administer this medication. Review of the facility's policy and procedure entitled: Documentation of Medication Administration, dated 4/2007, read: The facility shall maintain a medication administration record to document all medications administered . 3. Documentation must include, as a minimum: e. Reason(s) why a medication was withheld, not administered, or refused (as applicable) . This resident's Gabapentin had been held without any documentation as outlined in the facility's policy and procedure above. The facility did not re stock the Ekit in a timely manner and expired medication was not remove from medication room and medication cart, in addition a blood pressure medication when there was no indication of need.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39660 Based on observation, interview, and record review the facility did not assure that one of five residents (60) reviewed for unnecessary medications received a medication regimen review (a review that promotes appropriate use of medications and compliance with drug therapy) that provided clinical indication for use and need for gradual dose reduction of Resident 60's Seroquel (mood altering medication used for schizophrenia [a disorder that affects a person 's ability to think, feel, and behave clearly]). As a result, Resident 60 potentially suffered side-effects of Seroquel that was not indicated for use in the resident's medical condition. Findings: Per the facility's Admission Record, Resident 1 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's (progressive mental deterioration leading to an inability to verbalize needs and discomfort) disease. Resident 60's records were reviewed. Per the physician's orders dated 1/31/22, Resident 60 received Seroquel medication 1 tablet by mouth three times a day . for schizophrenia. Per the resident's medical records, there was no psychiatric clinical assessment in January 2021 when the Seroquel was initiated. Per the resident's medication administration record (MAR), there was no monitoring for sedation, a key side effect of Seroquel. Per the same MAR, Resident 60 had not displayed symptoms of schizophrenia. Per the resident's records, Resident 60 had been on the same dose of Seroquel since January of 2021. Per the medication regimen review, the pharmaceutical consultant had not identified the lack of clinical assessment and need for a gradual dose reduction for Seroquel. The pharmaceutical consultant was on vacation and could not be reached for interview at the time of the survey. On 7/14/22 at 2:50 P.M. an interview and record review was conducted with the DON. The DON stated the medication regimen review had not identified the lack of clinical assessment and need for a gradual dose reduction for Resident 60's Seroquel. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility policy, undated, titled Consultant Pharmacist Reports, .in performing medication regimen review, the consultant pharmacist incorporates federally mandated standards of care , in addition to other applicable professional standards . documented objective findings support each medication order . resident is monitored for adverse effects of the medication .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39660 Based on observation, interview, and record review the facility did not assure one of five residents (60) reviewed for unnecessary medication use received: 1. A psychiatric clinical assessment for a diagnosis of Schizophrenia (inappropriate behaviors and thought processes) 2. Monitoring for side effects such as sedation related to the use of Seroquel (antipsychotic (mind altering) medication used to treat certain mental conditions such as schizophrenia). As a result, Resident 60 received a drug that was not indicated for the resident's condition and was sedated for large amounts of time. Findings: Per the Admission Record, Resident 60 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (progressive mental deterioration leading to an inability to verbalize needs and discomfort) disease. Resident 60's records were reviewed. Per the physician's orders, dated 1/31/22, Resident 60 received Seroquel medication 1 tablet by mouth three times a day . for schizophrenia. Per the resident's medical records, there was no psychiatric clinical assessment that determined that Resident 60 had developed schizophrenia in January of 2021 when the use of Seroquel was initiated. Per the resident's medication administration record (MAR), there was no monitoring for sedation, a key side effect of Seroquel. Per the same MAR, Resident 60 did not display symptoms of schizophrenia. On 7/12/22 at 10:52 A.M., 11:15 A.M., 12:45 P.M., 1:15 P.M., and 3:41 P.M. Resident 60 was observed sleeping in her bed. Resident 60 did not respond to a knock on the door or request to enter her room. Resident 60 did not display inappropriate behaviors and thought processes. On 7/13/22 at 8:50 A.M. an interview and observation was conducted with CNA 12. CNA 12 stated that Resident 60 got up for meals but slept most of the time on the day shift. CNA 12 observed Resident 60 sleeping in her bed. Resident 60 did not display inappropriate behaviors and thought processes. On 7/13/22 at 10:09 A.M. an interview was conducted with LN 11. LN 11 stated that Resident 60 got up for meals but slept most of the time on day shift. LN 11 stated that Resident 60 did not display inappropriate behaviors and thought processes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/13/22 at 2:31 P.M., 2:53 P.M., and 4:15 P.M. Resident 60 was observed sleeping and did not respond to verbal stimuli. Resident 60 did not display inappropriate behaviors and thought processes. On 7/13/22 at 4:20 P. M. an interview and record review was conducted with LN 12. LN 12 stated Resident 60 slept most of the time on evening shift. LN 12 stated they did not monitor Resident 60 for the amount of time the resident was sleeping every day. LN 12 stated there was no clinical psychiatric assessment for the diagnosis of schizophrenia in Resident 60's medical record. LN 12 stated according to the monitoring for behaviors, Resident 60 did not display inappropriate behaviors and thought processes. On 7/14/22 at 10:15 A.M., an interview was conducted with the DON. The DON stated it was the policy of the facility to determine the need for Resident 60 to receive drugs like Seroquel through a clinical diagnostic assessment conducted by a psychiatrist. The DON stated Resident 60 had not received a psychiatric clinical assessment for a diagnosis of schizophrenia. The DON stated Resident 60's sleeping patterns should have been monitored and the doctor should have been notified. Per the facility policy, revised 12/2016, titled Antipsychotic Medication Use, .antipsychotic medication may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13095 Based on record review, facility staff interview, and policies and procedures the facility had failed to ensure that 1 unsampled Resident (16) of 4 unsampled Residents reviewed, were free of any significant medication errors during the Medication Pass Observation process on 7/12/2022 between 8:30 am and 10:30 am. This medication error had the potential to require that this resident be sent back to the hospital for the treatment of Atrial Fibrillation (A-Fib), an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart. A-fib increases the risk of stroke, heart failure and other heart-related complications which could have also potentially led to this resident's death. Findings include: Review of Resident 16's medical record revealed that this resident had been previously diagnosed with Paroxysmal Atrial Fibrillation (a condition which results in an irregular heart rhythm) along with unspecified Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities. This resident's physician had ordered Eliquis (Apixaban) 5 mg twice a day (9:00 am and 5:00 PM), which had been started at the facility on 8/9/2021 for A-fib. According to the drug manufacturer of Eliquis (Bristol-[NAME] Squibb), ELIQUIS is used for reducing the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation. During a medication pass observation with LN 21 on 7/12/2022 between 8:30 am and 10:30 am, the medication Nurse was passing medications to Resident 16, and the Nurse noticed that she did not have Resident 16's Eliquis for the morning administration. The State surveyor had asked LN 21 to let him know when Resident 16's Eliquis had arrived at the facility from the Pharmacy. Interview with LN 21 on 7/12/2022 at 9:31 am, the Nurse confirmed that she could not find this resident's morning Eliquis in the facility's medication cart. Review of the facility's Policy and procedure entitled: Administering Medications, dated 4/2019, read: 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . During an interview with the Medical Records Director (MRD) on 7/12/2022 at 3:04 PM, he indicated that the facility did not have a consistent system for reordering needed medications, he also stated during the interview that he could not find any record to indicate that Resident 16's Eliquis had been reordered after 6/6/2022, which explained why this resident's Eliquis was not available for administration. Review of the facility's policy and procedure entitled: Medication Ordering and Receiving From Pharmacy, which was undated, read: Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the facility's DON on 7/13/2022 at 11:42 am revealed that the Pharmacy had been sending the facility a 14-day supply of the resident's Eliquis to the facility. Based on an concurrent interview with the facility's DON in regards to a phone call that she had with the provider Pharmacy, the Pharmacy confirmed that they had last sent a 14-day supply of Eliquis to the facility on [DATE]. This meant that the facility must have run out of Resident 16's Eliquis by 7/4/2022. Further interview with the DON revealed that she had spoken with her Nursing staff, who were responsible for administering Resident 16's Eliquis on a daily basis and her Nursing staff indicated to the DON, that the staff had been borrowing this medication from other residents supplies since 7/4/2022 to give to Resident 16. This meant that the facility's Nursing staff had been borrowing this medication from 7/4/2022 to 7/11/2022 (for a total of 7 days). Review of the facility's policy and procedure entitled: Preparation and General Guidelines, which was undated, read: 12) Medications supplied for one resident are never administered to another resident. Further review of the facility's policy and procedure entitled: Administering Medications, dated 4/2019, read: 26. Medications ordered for a particular resident may not be administered to another resident . Further interview with the DON on 7/13/2022 at 11:42 am revealed that the facility did not receive this resident's Eliquis until midnight on 7/12/2022, so Resident 16 did not receive his 9:00 am and 5:00 PM doses for the entire day on 7/12/2022. Review of the facility's drug reference source entitled: Nursing 2017 Drug Handbook by Wolters Kluwer (copyright 2017) read: half life of this medication is 12 hours, meaning that this medication will only remain in the body for 12 hours. The drug reference also read: if the patient does not take dose at scheduled time, he should take the dose as soon as possible on the same day . This means that this resident had been unprotected and put at risk of a possible stroke, systemic embolism, and A-fib during the 24-hour drug free period, endangering this resident's health.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 13095 Based on medication room inspection, interview with facility staff, and review of the facility's policies and procedures the facility failed to: 1) ensure that medication room temperatures had been consistently documented on the facility's temperature logs and 2) that the medication refrigerator on Unit 2, had been secured and locked, as outlined in the facility's policies and procedures. This deficiency had the potential for medications to be stored outside of the drug manufacturer's recommendations and creating the possibility of controlled drug diversion. Findings include: 1) Review of the facility's medication room temperature logs between 5/2022 and 7/2022 revealed several days each month where facility staff had failed to document the medication room temperatures. For the month of 5/2022 the facility's Nursing staff had failed to document the medication room's temperatures. For example, review of the facility's room temperature log for 5/5/2022 on the evening shift, no room temperature had been documented on the facility's log. The same had been true for 5/11/2022, 5/13/2022, 5/14/2022, 5/17/2022, 5/26/2022, and 5/27/2022, all of the evening shift room temperatures had been left blank on the log. On 5/22/2022, the morning shift temperature log had been left blank, so no one could tell me if the medication room temperature had exceeded the facility's acceptable room temperature. Review of the facility's temperature log for 6/2022 revealed the following blanks for the room temperature log: 6/3/2022 and 6/7/2022 on the evening shift had been left blank. Review of the facility's room temperature log for 7/2022, for the first half of the month revealed the following blanks on the facility's room temperature log: 7/4/2022, 7/5/2022, 7/7/2022 7/8/2022, 7/9/2022 for the evening shift. For 7/10/2022, no room temperatures had been documented for both the morning and evening shifts on 7/10/2022. 2) Inspection of the facility's Unit 2 medication refrigerator on 7/11/2022 at 3:15 PM revealed that the padlock on this refrigerator had been left unlocked. The refrigerator's open/unlocked status had been confirmed by LN 1 during a concurrent interview, in which this LN indicated that it was the facility's policy that this refrigerator remain locked at all times, because the refrigerator contained controlled substances such as Lorazepam (Ativan), (a schedule IV medication). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's following policies and procedures confirmed this LN's understanding that this refrigerator should have remained locked at all times. The facility's policy and procedure entitled: Storage of Medications, dated 4/2019, read: 8. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Review of the facility's policy and procedure entitled: Preparation And General Guidelines, which was undated, read: JJ. Medications are obtained from the locked cabinet or safe, or medication cart (if a Schedule .IV .medication).

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 42250 Based on observation, interview, and record review, the facility failed to ensure the kitchen staff carried out the tasks of the food and nutrition services department in accordance with the standard of practice for the following kitchen competencies: 1. The kitchen dish washers did not know how to correctly test PPM (parts per million) concentration of the dishwashing solution with the chlorine test strip. 2. Kitchen staff did not follow the facility policy and procedure for fortifying resident diets. These failures had the potential to expose 120 residents who consume food from the kitchen to practices associated with the transmission of foodborne illness. Findings : 1. On 7/12/22 at 9:50 A.M., an observation and interview with DA 6 was conducted. DA 6 pulled out a chlorine test strip from a container and dipped it in the dishwasher machine reservoir water; a color change indicated a reading of 50-100 PPM. DA 6 stated, she saw the chemical representative do it this way and she was just copying what he did. DA 6 further stated, I think it is ok. On 7/12/22 at 10:09 A.M., an observation and interview with DA 7 was conducted. DA 7 stated, she had tested the dishwasher PPM this morning and recorded it on the log. DA 7 pulled out a chlorine test strip from a container and dipped it in the dishwasher machine reservoir water; a color change indicated a reading of 50-100 PPM. DA 7 further stated, it is ok, right? On 7/12/22 at 10:14 A.M., a concurrent observation and interview with the CDM was conducted. The CDM stated, it was the expectation that staff follow the facility policy and procedure for dish washing. The CDM stated, the chlorine test strip needs to be put on the plate and not dipped in the water. The CDM further stated, it was important for dishes to be sanitized in the dishwasher to prevent residents from getting potential food borne illnesses from dirty dishes. A review of the kitchen department competency for DA 6 and DA 7, dated 4/22/22, titled, Verification of Competency - Diet Aids, the document indicated, Record dish machine temps, concentration of sanitizer, and what to do when these are out of range - competency verified competent by the CDM. A review of the facility Food and Nutrition, dated 4/22/22, titled Competency Checklist - Food Service Worker, the document indicated, .State proper sanitizer solution range .test concentration . A review of the facility document, dated 2018, titled, Dishwashing machine temperature log - instructions, the document indicated, all dishes will be properly sanitized through the dishwasher .the Chlorine should be 50-100 PPM. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 7/12/22 at 11:43 A.M., an observation the lunch tray line was conducted. Several fortified diet trays consistently missed the 1/2 ounce of butter on either vegetable - zucchini or squash. Instead, a pre-package pat of margarine was placed onto each fortified diet tray. On 7/12/22 at 12:07 P.M., a concurrent observation and interview on the tray line with the CDM was conducted. The CDM stated, when the tray gets to the resident, the nursing staff will put the butter on the item. On 7/12/22 at 12:11 P.M., a concurrent observation and Interview on the tray line with the cook was conducted. The cook stated, he was aware of the fortified foods menu but he did not know he needed to put extra margarine on the vegetables to ensure the meal was fortified. The cook further stated, he did not know about this. On 7/13/22 at 2:33P.M., an interview with the RD was conducted. The RD stated, It is the expectation that the kitchen staff follow the menu for fortification of food so that residents get the calories they need. A review of the facility policy, dated 2018, titled, Fortification of Foods, indicated, .Extra margarine 1/2 oz (ounce) melted margarine will be added to 1-2 food items per meal. Keep melted margarine on the steam table or on the stove top with a one oz ladle. Use 1/2 of the ladle contents on each item. Can use a #64 scoop for each 1/2 oz. A review of the facility policy, dated 2018, titled, Fortified Diet, the diet indicated, .add extra margarine or butter to food items such as vegetable .1 tsp butter or margarine . A review of the facility job description, dated 2018, titled Cook, the document indicated, .Knowledge of basic principles of quantity food cooking and equipment use . A review of the facility Food and Nutrition, dated 5/11/22, titled Competency Checklist - Cook, the document indicated, .Knowledge of Food - Read menu and Spreadsheets .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 42250 Based on observation, staff interviews, and record review, the facility failed to follow the facility's policy related to recipes and therapeutic menus as planned. This failure had the potential to result in weight loss of 120 of 126 residents who consumed food from the kitchen due to reduced food intake, and may have further compromised their nutritional status. Findings: 1. On 7/12/22 at 10:29 A.M., an observation, interview, and recipe review in the prep area of the kitchen with the cook was conducted. The cook stated, I have to make pureed chicken for twenty-six (26) residents. The cook put an unmeasured amount of cooked chicken, broth, and food thickener intermittently into a blender, and proceeded to blend all the items together. The cook stated, I just put it in the blender. The cook further stated, I don't understand. On 7/12/22 at 10:31 A.M., a concurrent interview and menu review in the prep area of the kitchen with the CDM was conducted. The CDM stated, the expectation is for the staff to follow the dietary recipes as written. The CDM further stated, the cook did not follow the recipe for pureed meat. On 7/13/22 at 2:51 P.M., an interview with the RD was conducted. The RD stated, it was the expectation that staff follow the dietary recipes as written to assure residents get their dietary needs met. A review of the facility job description, dated 2018, titled Dietary Aide, the document indicated, .Knowledge of basic principles of quantity food cooking and equipment use . 2. On 7/12/22 at 11:43 A.M., an observation of the lunch tray line was conducted. Several fortified diet trays consistently missed the 1/2 ounce of butter on either vegetable - zucchini or squash. Instead, a pre-package pat of margarine was placed onto each fortified diet tray. On 7/12/22 at 12:07 P.M., a concurrent observation and interview of the tray line with the CDM was conducted. The CDM stated, when the tray gets to the resident, the nursing staff will put the butter on the item. On 7/12/22 at 12:11 P.M., a concurrent observation and Interview of the tray line with the cook was conducted. The cook stated, he was aware of the fortified foods menu, but he did not know he needed to put extra margarine on the vegetables to ensure the meal was fortified. The cook further stated, he doesn't know about this. A review of the Cook's therapeutic spreadsheet menu for 7/12/22 indicated the lunch meal was oregano chicken, polenta, baked fresh zucchini, parsley garnish, fresh green salad, dressing, frosted cake and milk. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/13/22 at 2:33P.M., an interview with the RD was conducted. The RD stated, it is the expectation that the kitchen staff follow the menu for fortification of food so that residents get the required calories they need. A review of the facility policy, dated 2018, titled, Fortification of Foods, indicated, .Extra margarine 1/2 oz (ounce) melted margarine will be added to 1-2 food items per meal. Keep melted margarine on the steam table or on the stove top with a one oz ladle. Use 1/2 of the ladle contents on each item. Can use a #64 scoop for each 1/2 oz. A review of the facility policy, dated 2018, titled, Fortified Diet, the diet indicated, .add extra margarine or butter to food items such as vegetable .1 tsp butter or margarine . A review of the facility job description, dated 2018, titled Dietary Aide, the document indicated, .Knowledge of basic principles of quantity food cooking and equipment use . 3. On 7/12/22 at 12:31 P.M., a tray line observation, interview, and review of the menu was conducted with the cook. The cook was using the same-colored handled scoop for portion control for each resident diet order. The cook stated, he knew how much of the food to dish up. The cook stated, if it was a small amount, it was half a scoop, if it was regular amount, it was one scoop, and if it was double amount then it was two scoops. The cook further stated, he did not use the different colored scoops, he was not sure about them. On 7/12/22 at 12:47 P.M., a concurrent observation and interview of the tray line with the CDM was conducted. The CDM stated, it was the expectation that the staff use the correct colored scoop for the correct portion size. The CDM stated, it was important that resident receive the correct amount of food and calories as per their diet order. The CDM further stated, the cook did not follow the correct portion size served to residents as ordered diet. On 7/13/22 at 2:33 PM an interview with the RD was conducted. The RD stated, it was the expectation that the kitchen staff follow the correct portion sizes for each resident diet. The RD further stated, the cook should have followed the therapeutic spread sheet for portion sizes to ensure residents' caloric intake and nutritional needs are met. A review of the facility policy, dated 2018, titled, Portion sizes, indicated, Various portion sizes of the food served will be available to better meet the needs of the residents .The small and large portion servings will be served as printed on the cook's spreadsheets for every meal . A review of the facility job description, dated 2018, titled Dietary Aide, the document indicated, .Knowledge of basic principles of quantity food cooking .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Post-Acute	247 E. Bobier Drive Vista, CA 92084

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42250 Based on observation, interview and record review, the facility failed to maintain sanitary kitchen equipment, safe, proper storage and handling of food practices, were met when: 1. A resident's refrigerator temperature was not within a safe temperature range; 2. A can opener had a build-up black colored substance and residue on it; 3. A utensil storage bin had a build-up of unknown particles and dust; and 4. Expired foods were found in the refrigerator. These failures had the potential to result in harmful bacteria growth and cross contamination that could lead to foodborne illnesses for residents in the facility. Findings: 1. On [DATE], at 3:02 P.M., an observation of the residents' refrigerator on Station 1 and a concurrent interview & facility policy review was conducted with LN 7 and the ADON: a. The resident's refrigerator temperature was 62 degrees. The temperature log was signed off by staff as having a temperature of 38 degrees. No documented time was found when the temperature was checked. b. One undated plastic store bag with unidentifiable homemade food labeled with with resident's name were stored in the refrigerator. c. One undated plastic store bag with unidentifiable homemade food, and partially consumed bottle of juice both with labeled with resident's name was stored in the refrigerator. d. One undated plastic store bag with unidentifiable store-bought food with labeled resident's name. LN 7 acknowledged she was not aware of the temperature range of resident's refrigerator temperature and stated she felt that 62 degrees seemed too hot. LN 7 stated that the documented temperature was 38 degrees on the temperature log. LN 7 validated the above listed food items were not properly labeled. LN 7 stated, the food items should have been labeled with the resident(s) name, date, when stored in the refrigerator by the staff per the undated posted instruction on the refrigerator. LN 7 stated, she was not familiar with the facility policy and procedure for storage of resident food; or who was responsible for disposing expired food from the resident refrigerator. LN 7 further stated, she was not sure how long the food were stored in the resident refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON validated the above listed items were not being correctly labeled. The ADON stated the food items should have been labeled with the resident(s) name and dated when placed in the resident refrigerator. The ADON stated, the process for resident food storage was the responsibility of the staff who placed the food in the refrigerator, and label per the facility's policy. The ADON stated, he was not sure how long the food should be kept/ stored in the resident refrigerator prior to being discarded. The ADON stated, he was not sure who was responsible for checking the resident refrigerator daily for expired food or the temperature. The ADON further stated, he would have to check the facility policy to see if staff were following it. On [DATE] at 3:29 P.M., an observation and interview with the RD was conducted. The RD stated, each nursing station has its own resident refrigerator. The RD stated, it was the nursing staff that was responsible for labeling, dating the resident food, and checking the refrigerator temperature. The RD stated, checking of expired food should be done by the dietary staff and was not sure who was responsible for cleaning the refrigerator. The RD further stated the food in the resident refrigerators was good for 72 hours before being discarded to prevent food borne illnesses. According to the facility's policy, titled Food Brought in by Family / Visitors, revised [DATE], indicated 7 .Food brought in by family / visitors .will be labeled and stored .8 .nursing staff / or food service staff will discard prepared foods by used by date and perishable foods after 72 hours . According to the facility's policy, titled Procedure for Refrigerated Storage, revised, 2018, indicated 1 . Refrigerator temperature - 41 degrees or lower . According to the 2017 Federal Food and Drug Administration (FDA) Food Code, section ,d+[DATE].17, titled Temperature, indicated . safe temperature of 40 degrees and below . 2. On [DATE] at 8:15 A.M., during an initial observation of the kitchen a can opener had a build-up of black colored substance and residue on it. On [DATE], at 8:17 A.M., a concurrent observation and interview with the CDM in the kitchen was conducted. The CDM stated The can opener should be clean and should not have residue on it to prevent the spread of foodborne illnesses. According to the 2017 Federal Food and Drug Administration (FDA) Food Code, section ,d+[DATE].15, titled Sanitation can opener, indicated . must be cleaned and sanitized . The facility did not provide a policy for review. 3. On [DATE] at 8:35 A.M., during an initial observation of the kitchen and utensil bin had a build-up of unknown particles and dust at the bottom of its basin. On [DATE], at 8:37 A.M., a concurrent observation and interview with the CDM in the kitchen was conducted. The CDM stated The utensil bin should be clean at all times and should not have dust in them to prevent contamination and potential foodborne illnesses. According to 2017 Federal Food and Drug Administration (FDA) Food Code, section ,d+[DATE].12, titled Storage utensils, indicated . storage bins and containers must be clean . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide a policy for review. 4. On [DATE] at 8:45 A.M., a concurrent observation and interview with the CDM of the kitchen refrigerator. The following expired/spoiled items had been found: a. Top shelf with three packages of red grapes with the use by date of [DATE]. b. The middle shelf with an open package of parsley, cilantro, and celery with the use by date of [DATE]. c. The middle shelf with several whole fruits: lemons, limes, apples with a used by date of [DATE]. d. The middle shelf with 5 yellow peppers and 4 green peppers with noted multiple black spoiled markings on them and a used by date of [DATE]. The CDM validated the above findings. The CDM stated the refrigerator should not have expired food in them to prevent cross contamination and potential foodborne illnesses being passed to the residents. According to the 2017 US Food and Drug Administration Food Code, section ,d+[DATE].11, Vegetable storage: Even if foods are held long enough, even under proper refrigeration, extended shelf life may be a problem. A study on fresh vegetables inoculated with harmful contaminants and the growth of these contaminants increased during that extended storage period . The facility did not provide a policy for review.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42250 Based on observation, interview, and facility policy review, the facility failed to implement their policy and procedure related to food brought from the outside to residents for one of two residents' refrigerators when the food inside the refrigerator were not labeled or dated, and expired food was not discarded. In addition, the resident refrigerator temperature was not within a safe range for food storage. This failure had the potential to expose the facility's residents to unsafe food storage practices which could lead to foodborne illness. Findings: On [DATE], at 3:02 P.M., an observation of the residents' refrigerator on Station 1 and a concurrent interview & facility policy review with LN 7 was conducted. The following food items were observed: a. The resident refrigerator temperature was 62 degrees. The temperature log was signed off by staff as having a temperature of 38 degrees and no time documented when this temperature was checked. b. One undated plastic store bag with unidentifiable homemade food labeled with resident's name. c. One undated plastic store bag with unidentifiable homemade food and partially consumed bottle of juice both labeled with resident's name. d. One undated plastic store bag with unidentifiable store-bought food labeled with resident's name. LN 7 acknowledged she was not aware of the temperature range of resident's refrigerator and stated she felt that 62 degrees seemed too hot. LN 7 stated that the documented temperature was 38 degrees on the temperature log. LN 7 validated the above listed food items as not being properly labeled. LN 7 stated, the food items should have been labeled with the resident(s) name and date it was placed in the refrigerator by the staff member who placed it in the refrigerator per the posted undated instruction on the refrigerator. LN 7 stated, she was not familiar with the facility policy and procedure for storage of resident food or who was responsible for disposing expired food from the resident refrigerator. LN 7 further stated, she was not sure how long the food were stored in the resident refrigerator. The ADON validated the above listed items were not being correctly labeled. The ADON stated the food items should have been labeled with the resident(s) name and dated when placed in the resident refrigerator. The ADON stated, the process for resident food storage was the responsibility of the staff who puts the food in the refrigerator to label it, per the facility policy. The ADON stated, he was not sure how long the food in the resident refrigerator was good for prior to being discarded. The ADON stated, he was not sure who was responsible for checking the resident refrigerator daily for expired food or the temperature. The ADON further stated, he would have to check the facility policy to see if staff are following it. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:29 P.M., an observation and interview with the RD was conducted. The RD stated, each nursing station has its own resident refrigerator. The RD stated, it was the nursing staff that was responsible for labeling, dating the resident food, and checking the refrigerator temperature. The RD stated, checking of expired food should be done by the dietary staff and was not sure who was responsible for cleaning the refrigerator. The RD further stated the food in the resident refrigerators was good for 72 hours before being discarded to prevent food borne illnesses. According to the facility's policy, titled Food Brought in by Family / Visitors, revised [DATE], indicated 7 .Food brought in by family / visitors .will be labeled and stored .8 .nursing staff / or food service staff will discard prepared foods by used by date and perishable foods after 72 hours .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to have a consistent method for documenting behaviors and side effects for two of three residents (Residents 54, 577), reviewed psychotropic medications. These failures had the potential for unnecessary medication to be administered when not required, based on the different documentation used for monitoring. Findings: 1. Resident 54 was admitted to the facility on [DATE], with diagnoses which included dementia (declining memory loss) without behavior disturbances, per the Admission Records. On 7/14/22, Resident 54's clinical records were reviewed: According to the admission MDS, dated [DATE], indicated a cognitive assessment score of 11 (11 out of 15), indicating moderately impaired cognition. Per the physician's order, dated 5/6/22, .Antipsychotic(s) Monitor side effects: .and tally with hashmarks for each episode on the MAR every shift ., The MAR for antipsychotic side effects was reviewed from 7/1/22 through 7/12/22: The documentation had varied entries of 0, y, n (none, yes, no) for all three shifts. Of the 36 opportunities only nine were numerical in nature. On 7/11/22 for the 7 a.m. to 3 p.m. shift, there were no entries. According to the care plan, titled Use of Psychotropic Medication, dated 5/12/22, listed an intervention of Monitor/document/report any reverse reactions of psychotropic medications. 2. Resident 577 was readmitted to the facility on [DATE], with diagnoses which included unspecified dementia without behavioral disturbances, per the Admission Record. On 7/14/22, Resident 577's clinical records were reviewed: According to the last quarterly MDS review, dated 4/15/22, a cognitive assessment score of 00 was listed, indicating severe impaired cognition. Per the physician's order, dated 6/27/22, Monitor antipsychotic side effects and tally with hashmarks every shift . Monitor Parkinson's psychosis as exhibited by visual hallucinations and tally with hashmarks for each episode every shift. Monitor Akathisia (a body movement disorder) such as inability to sit still every shift with hash marks. The MAR was reviewed from 7/1/22 through 7/12/22: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The documentation had check mark responses and no numerical values listed to indicate how often the monitor behaviors were observed or how often the side effects occurred. According to the care plan, titled Use of Psychotropic Medication, dated 5/12/22, listed an intervention of Monitor/document/report any reverse reactions of psychotropic medications. On 7/13/22 at 8:45 A.M., an interview and record review was conducted with LN 2, regarding the documentation on the MAR for monitoring Residents 54 and 577's behaviors and side effects. LN 2 stated the documentation should be consistent. LN 2 stated Resident 54's documentation was not accurate, and a writer could not determine if the side effects were present of not. LN 2 stated she always documented in numerical format and demonstrated how the numerical drop-down box was used for charting on the MAR. LN 2 stated if the physician's order said to tally with hashmarks, the LN should follow the order and not use a single check mark, because it does not tell the reader anything. LN 2 stated the monthly hashmarks were reviewed by the physician and psychotropic review committee monthly to determine if the medication was still needed or if the doses needed to be adjusted. On 7/14/22 at 12:43 P.M., an interview and record review was conducted with the DON of Resident 54 and 577's MAR. The DON stated the MAR had computer cliches and the documentation for monitoring should be consistent. According to the facility's policy, titled Charting and Documentation, dated July 2017, .6. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical record. According to the facility's policy, titled Antipsychotropic Medication use, dated December 2016, .16. The staff will observe, document and report to the Attending Physician information regarding the effectiveness . including antipsychotropic medication .18. The Physician shall respond appropriately by changing or stopping problematic doses or medications .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to ensure safe infection control practices when: 1. The shower curtain in one of three resident shower rooms (Station 2's secured unit), had a dried brown substance on the lower interior (inside) curtain. were left in the shower room; 2. Personal care objects and personal clothing was left in one of three resident shower rooms (Station 2's secured unit), and 3. A urinary catheter (a tube inserted into the bladder to aide in urine flow) bag and tubing was lying on the floor for one (Resident 124) of 2 residents, reviewed for urinary catheter care These failures had the potential for cross contamination. Findings: 1. On 7/12/22 at 11:05 A.M., an observation of the shower room in the secured unit was conducted. The shower room was unlocked and adjacent to the main hall used for activities and dining. A brown substance was smeared on the lower interior shower curtain. On 7/13/22 at 8:13 A.M., and On 7/14/22 at 8:35 A.M., the brown smear on the interior curtain remained. 2. On 7/12/22 at 11:05 A.M., an observation of the shower room in the secured unit was conducted. A black comb with hair on it was laying on the floor between the shower and the sink. A second black comb with brown/gray hair was resting on the right side of the sink, next to the faucet. Two different pairs of personal slippers were present, a dark gray pair on the floor next to a table, and a light gray pair on a shelve outside the shower stall. On 7/12/22 at 11:31 A.M., the comb on the floor was gone, however the comb on the sink remained. The two pairs of slippers remained. On 7/13/22 at 8:13 A.M., the two pairs of slippers remained on the floor and on the shelve. The comb with hair remained on the right side of the sink. On 7/13/22 at 9:30 A.M., the shower stall floor was wet and the comb remained on the sink, with two pairs of slippers still in their same location. On 7/13/22 at 3:13 P.M., the comb on the sink was gone, however the two pairs of slippers remained. On 7/14/22 at 8:35 A.M., a black comb with hair on it was left on a tabletop within the shower room. A personal blanket was next to the table and the two pairs of slippers remained. The shower stall floor was dry, indicating a shower had not recently been provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/14/22 at 8:38 A.M., an observation and interview with CNA 1 was conducted of the resident shower on the secured unit. CNA 1 stated the shower room appeared dirty and unkept. CNA 1 stated disinfectant wipes were not kept in the shower room, but if cleaning was needed, they should notify housekeeping. On 7/14/22 at 8:44 A.M., an observation and interview with CNA 2 was conducted of the shower room on the secured unit. CNA 2 stated the CNAs were responsible for cleaning up the shower room up after each shower. CNA 2 stated cleaning meant removing all personal belongings and getting it ready for the next person. CNA 2 stated housekeeping came to cleaned the shower around noon time. On 7/14/22 at 8:46 A.M., an observation and interview with LN 1 was conducted of the shower room on the secured unit. LN 1 stated the combs with hair, the soiled curtain, and the personal clothing items were all potentially infection control issues and should have been removed. On 7/14/22 at 8:53 A.M., an interview was conducted with HSKP 1. HSKP 1 stated the shower room was cleaned three times a day, (morning afternoon, evening). HSKP 1 stated the shower curtain was wiped with bleach wipes during the daily cleaning and removed during deep cleaning on Saturdays. On 7/14/22 at 9:03 A.M., an interview was conducted with the DSD. The DSD stated housekeeping as responsible for cleaning the shower rooms with disinfectant wipes, and the CNAs were responsible for removing personal items after each shower. On 7/14/22 at 09:34 A.M., an interview was conducted with the ICN. The ICN stated she expected the CNAs to wipe down shower equipment such as shower chairs and to remove all personal items to prevent cross contamination from one resident to another. On 7/14/22 at 12:43 P.M., an interview was conducted with the DON. The DON stated she expected all showers to be cleaned and maintained between resident's use, to prevent cross contamination. According to the facility's policy, titled Infection Prevention and Control Program, dated October 2018, .11. Prevention of Infection: a. (1) identifying possible infections or potential complications of existing infections: 45063 3. Resident 124 was admitted on [DATE] with diagnoses which included sepsis (body's overwhelming response to an infection) and neuromuscular dysfunction of bladder (lacks bladder control due to brain, spinal cord or nerve problems) per Admission Record. During an observation on 7/11/22, at 11:20 A.M., in Resident 124's room, Resident 124 was in the bed, with a urinary catheter. Resident 124's catheter bag was resting inside a privacy bag (a bag used to cover and conceal contents inside). Resident 124's privacy bag, with the catheter bag inside, and the catheter tubing were all in contact with the floor. During an on interview with LN 16 on 7/13/22 at 10:20 A.M., LN 16 stated Resident 124's urinary privacy bag and tubing should always be elevated or off the floor for infection control purposes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LN 17 on 7/14/22 at 8:44 A.M., LN 17 stated Resident 124's privacy bag and tubing should have not touched the floor for infection control issues. During an interview with the ADON on 7/14/22 at 9:01 A.M., the ADON stated indwelling catheter with privacy bag and tubing should be off the floor, at all times. ADON stated it was important for infection control. On 7/14/22 at 9:43 A.M., an interview was conducted with the ICN. The ICN stated indwelling catheter's privacy bag and tubing should have not touched the floor. The ICN stated it was important not to touched the floor to prevent cross contamination. Per the facility's policy titled Catheter care, urinary, revised September 2014, .Infection Control: 2. b. be sure the catheter tubing and drainage bag are kept off the floor .

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45063 Based on observation, interview, and record review, the facility failed to ensure a ceiling suspended privacy curtain, which extended around the bed to provide visual privacy, was provided to one of three residents (Resident 122), reviewed for privacy. This deficient practice violated Resident 122's right to privacy and had the potential for the resident to be exposed to others during personal care. Findings: Resident 122 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (brain disease that alters brain function and structure) and dementia (impaired reasoning and memory). On 7/13/22 at 9:30 A.M., an observation of Resident 122's room was made from the hallway. Resident 122 was in a room with three residents. Resident 122 was assigned to the second bed and a ceiling suspended privacy curtain was not provided for the second bed circumference area. On 7/13/22 at 10:45 A.M., an interview was conducted with CNA 16. CNA 16 stated privacy curtains were important and every resident should have one especially for personal care. During an interview with the MSDA on 7/13/22 at 11:45 A.M., the MSDA stated that he was in charge of room maintenance and equipment, but deep cleaning of rooms and curtains were a task for the facility's Environmental Services or housekeeping department. The MSDA stated it was important to have privacy curtains for every resident for privacy issues. During a concurrent observation and interview on 7/13/22, at 12:00 P.M. with the EVSD, in Resident 122's room, the EVSD stated that the privacy curtain for 122 was not present. The EVSD stated privacy curtain should have been provided to ensure privacy. During a concurrent interview and record review on 7/13/22 at 12:10 P.M., with EVSD, the facility's Monthly Housekeeping Cleaning Schedule, dated July 2022, was reviewed. The EVSD stated Resident 122's room was deep cleaned on 7/4/22 and the privacy curtain should have been put back up after the deep cleaning was completed. The EVSD stated each resident was required to have a privacy curtain to ensure privacy and dignity. Per the facility's policy titled, Quality of life, .Dignity 10. Staff shall promote, maintain and protect resident privacy including bodily privacy