STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555861	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Oaks Care	897 North M Street Tulare, CA 93274

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51434 Based on observation, interview and record review, the facility failed to ensure five of 18 sampled residents (Resident 33, Resident 50, Resident 64, Resident 67, and Resident 63) call lights were within reach. This failure had the potential for residents unable to call for assistance and potential for delaying care. Findings: During a concurrent observation and interview on 10/7/24 at 10:03 a.m. with Certified Nursing Assistant (CNA) 3, in Resident 33's room, Resident 33's call light was on the floor out of Resident 33's reach. CNA 3 stated the call light must have fallen on the floor, the call light should have been clipped to Resident 33's blanket and within Resident 33's reach. During a review of Resident 33's Minimum Data Set (MDS - an assessment tool), dated 8/9/24, the MDS indicated, Brief Interview for Mental Status (BIMS-cognition screening) score was 4 (score of 0-7 indicates severe cognitive impairment). The MDS indicated, under Functional Abilities and Goals, Resident 33 required maximal assistance for upper body dressing and rolling left to right indicating impairment with upper extremities. During a review of Resident 33's Care Plan (CP) dated 2/11/22, the CP indicated, Physical Functioning Deficit related to: ROM [range of motion] limitations, intervention: Call bell within reach. 44134 During a concurrent observation and interview on 10/7/24 at 10:46 a.m. with Restorative Nurse Assistant (RNA) 1, in Resident 50's room, Resident 50 was asleep on the bed with the call light on the floor. RNA 1 stated Resident 50 should have had the call light placed within Resident 50's reach. 50409 During a concurrent observation and interview on 10/7/24 at 10:07 a.m. with CNA 9 in Resident 64's room, Resident 64 was asleep on the bed with the call light on the floor. CNA 9 stated Resident 64 should have had the call light placed within Resident 64 's reach. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 64's MDS, dated [DATE], the MDS indicated, Resident 64 required substantial/maximal assistance (helper does more than half the effort) to total assistance with self-care and mobility. During a concurrent observation and interview on 10/7/24 at 10:07 a.m. with CNA 9, in Resident 67's room, Resident 67 was asleep on the bed with the call light on the floor. CNA 9 stated Resident 67 should have had the call light placed within Resident 67's reach. During a review of Resident 67's MDS, dated [DATE], the MDS indicated, Resident 67 required substantial/maximal assistance to total assistance with self-care and mobility. During a concurrent observation and interview on 10/7/24 at 10:10 a.m. with Resident 63, in Resident 63's room, Resident 63 was lying on the bed with the call light on the floor. Resident 63 stated she could not find the call light. During a concurrent observation and interview on 10/7/24 at 10:12 a.m. with Graduate Vocational Nurse (GVN, unlicensed nurse) 1, in Resident 63's room, Resident 63's call light was on the floor. GVN 1 stated Resident 63 should have had the call light placed within Resident 63's reach. During a review of Resident 63's MDS, dated [DATE], the MDS indicated, Resident 63 had a BIMS score of 11 (score of 8 to 12 indicates moderate cognitive impairment). The MDS indicated, Resident 63 required set up to substantial/maximal assistance with self-care and mobility. During a review of Resident 63's CP, dated 10/31/22, the CP indicated, Physical functioning deficit. Interventions Call bell within reach. During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, dated 2023, the P&P indicated, Staff will ensure the call light is within reach of resident and secured, the call system will be accessible to residents while in their bed or other sleeping accommodation within the resident's room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 44134 Based on interview and record review, the facility failed to ensure an Advance Directive (AD-health care preferences, including decisions for end-of-life care) acknowledgement form was completed for ten of 20 sampled residents (Resident 443, Resident 40, Resident 20, Resident 6, Resident 37, Resident 51, Resident 18, Resident 43, Resident 54, and Resident 87). This failure had the potential to result in the residents' wishes or health choices not being honored. Findings: During a concurrent interview and record review on 10/10/24 at 8:42 a.m. with Admission Coordinator (AC), Resident 443's Advanced Directive Acknowledgement (ADA), dated 9/25/24 was reviewed. The ADA indicated, Resident 443 had not completed an AD. AC stated the ADA form was incomplete. AC stated she was unable to provide documentation that Resident 443 was offered/or received information on the right to formulate an AD. During a concurrent interview and record review on 10/10/24 at 8:44 a.m. with AC, Resident 40's ADA, dated 7/17/24 was reviewed. The ADA indicated, Resident 40 had not completed an AD. AC stated the ADA form was incomplete. AC stated she was unable to provide documentation that Resident 40 was offered/or received information on the right to formulate an AD. During a concurrent interview and record review on 10/10/24 at 8:45 a.m. with AC, Resident 20's ADA, dated 6/20/23 was reviewed. The ADA indicated, Resident 20 had not completed an AD. AC stated the ADA form was incomplete. AC stated she was unable to provide documentation that Resident 20 was offered/or received information on the right to formulate an AD. 51434 During a concurrent interview and record review on 10/10/24 at 8:46 a.m. with AC, Resident 6's ADA, dated 10/8/24 was reviewed. The ADA indicated, Resident 6 had not completed an AD. AC stated the ADA form was incomplete. AC stated she was unable to provide documentation that Resident 20 was offered/or received information on the right to formulate an AD. 51320 During a concurrent interview and record review on 10/10/24 at 8:47 a.m. with AC, Resident 37's ADA, dated 4/24/23 was reviewed. The ADA indicated, Resident 37 had not completed an AD. AC stated the ADA form was incomplete. AC stated she was unable to provide documentation that Resident 37 was offered/or received information on the right to formulate an AD. During a concurrent interview and record review on 10/10/24 at 8:48 a.m. with AC, Resident 341's ADA, dated 10/8/24 was reviewed. The ADA indicated, Resident 341 had not completed an AD. AC stated the ADA form was incomplete. AC stated she was unable to provide documentation that Resident 341 was offered/or received information on the right to formulate an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50409 During an interview on 10/8/24 at 8:07 a.m. with Resident 18, Resident 18 stated she did not remember being provided information on AD and would like further information on formulating an AD. During a review of Resident 18's Minimum Data Set (MDS - an assessment tool), dated 8/16/24, the MDS indicated Resident 18 had a BIMS (Brief Interview for Mental Status) score of 12 (score of 8 to 12 indicates moderate cognitive impairment). During a concurrent interview and record review on 10/8/24 at 1:18 p.m. with Social Services Supervisor (SSS), Resident 18's ADA, dated 8/13/24 was reviewed. The ADA indicated Resident 18 had not completed an AD. SSS stated she was unable to provide documentation that Resident 18 was offered/or received information on the right to formulate an AD. During an interview on 10/8/24 at 2:57 p.m. with Family Member (FM) 1, FM 1 stated neither he nor Resident 18 were provided information on the right to formulate an AD. During a concurrent interview and record review on 10/10/24 at 8:37 a.m. with AC, Resident 51's ADA, dated 10/8/24 was reviewed. The ADA indicated Resident 51 had not completed an AD. AC stated the ADA was incomplete. AC stated she was unable to provide documentation that Resident 51 was offered/or received information on the right to formulate an AD. 46958 During a concurrent interview and record review on 10/10/24 at 8:50 a.m. with AC, Resident 43's ADA, dated 10/8/24 was reviewed. The ADA indicated Resident 43 had not completed an AD. AC stated the ADA was incomplete. AC stated she was unable to provide documentation that Resident 43 was offered/or received information on the right to formulate an AD. During a concurrent interview and record review on 10/10/24 at 8:52 a.m. with AC, Resident 54's ADA, dated 10/8/24 was reviewed. The ADA indicated Resident 54 had not completed an AD. AC stated the ADA was incomplete. AC stated she was unable to provide documentation that Resident 54 was offered/or received information on the right to formulate an AD. During a concurrent interview and record review on 10/10/24 at 8:55 a.m. with AC, Resident 87's ADA, dated 10/8/24 was reviewed. The ADA indicated Resident 87 had not completed an AD. AC stated the ADA was incomplete. AC stated she was unable to provide documentation that Resident 87 was offered/or received information on the right to formulate an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated September 2022, the P&P indicated, The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46958 Based on observation, interview, and record review the facility failed to ensure one of 37 sampled residents' (Resident 87) room was maintained with a homelike environment. This failure resulted in Resident 87 feeling uncomfortable and not able to use his personal belongings. Findings: During a concurrent observation and interview on 10/7/24 at 10:30 a.m. with Resident 87, in Resident 87's room, a breathing excercise device, hung on the wall. The breathing exercise device was labeled with another resident's (Resident 87) initials. Resident 87 stated there were items in his room that did not belong to him. Resident 87 stated he was not sure who the items belonged to. During an interview on 10/7/24 at 2:31 p.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated when a resident moved or discharged , Social Services would tell staff to pack up the residents' belongings and where to move them. CNA 8 stated she worked last Thursday and Resident 77 had already moved to a different room. CNA 8 stated the belongings in Resident 87's room belonged to Resident 77. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated February 2021, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: d. personalized furniture and room arrangements.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34510 Based on interview and record review, the facility failed to ensure the Long Term Care Ombudsman (representatives who assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) was notified of transfer and discharge for two of three sampled residents (Resident 89 and Resident 90). This failure had the potential for unsafe resident transfer and discharge. Findings: During a review of Resident 89's Transfer or Discharge Fax Cover Sheet Ombudsman Program (TDFCSO), dated 8/2/24, the TDFCSO indicated Resident 89 was discharged on [DATE]. The TDFCSO indicated, Faxed 8/2/24 at 9 a.m. There was no fax confirmation the ombudsman received the notice. During an interview on 10/9/24 at 2:40 p.m. with Social Services Supervisor (SSS), SSS stated she was not sure if ombudsman received the notification of Resident 89's discharge. SSS stated, There was no fax confirmation. 46958 During a review of Resident 90's TDFCSO, dated 9/2/24, the TDFCSO indicated Resident 90 was discharged on [DATE]. There was no fax confirmation the ombudsman received the notice. During an interview on 10/9/24 at 2:47 p.m. with SSS, SSS stated the discharge notification to the ombudsman should have been completed within 30 days of discharge. SSS stated there was no fax confirmation to indicate that fax was sent to ombudsman. During a review of the facility's policy and procedure (P&P) titled, Transfer and Discharge (including AMA), dated 2024, the P&P indicated, The notice must be provided at least 30 days prior to a facility-initiated transfer or discharge of the resident.7. The facility will maintain evidence that the notice was sent to the Ombudsman.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 47734 Based on interview and record review, the facility failed to ensure: 1) A Licensed Nurse did not share her Electronic Protected health information (EPHI-resident clinical record) access code) and leave Graduate Vocational Nurse (GVN, unlicensed nursing staff) 1 unsupervised while administering narcotics (addictive pain medications) for three of three sampled residents (Resident 51, Resident 63, and Resident 18). This failure resulted in unauthorized access to residents' protected health information, falsification of residents' medical record and the potential for medication errors. 2) Physician Orders were followed when licensed nurse did not document wound care treatment for three of three residents (Resident 51, Resident 63, and Resident 18). This failure had the potential for worsening of Resident 51, Resident 63 and Resident 18's wounds. Findings: 50409 1. During an observation on 10/7/2024 at 11:38 a.m. in the 400 hallway, GVN 1 was administering medications to residents without licensed nurse supervision. During a concurrent interview and record review on 10/10/24 at 11:53 a.m. with ADON, the following documents were reviewed: Resident 71's Medication Count Sheet (MCS), dated October 2024 Resident 37's MAR, dated 10/7/24, Resident 5's MAR, dated 10/7/24 Resident 5's Controlled Drug Record (CDR), dated 10/7/24 Resident 71's Medication Count Sheet (MCS), dated October 2024 indicated GVN 1 dispensed and signed off Resident 71's Morphine Sulfate (controlled medication used for pain management) on 10/7/24 at 10 a.m. without a supervising licensed nurse. ADON stated GVN 1 was not supposed to dispense controlled medications and sign off on the controlled medication sheet by herself. Resident 37's MAR, dated 10/7/24, indicated the initials of the ADON was used by GVN 1 when GVN 1 administered medications. ADON stated she was not with GVN 1 during medication administration. Resident 5's MAR, dated 10/7/24, indicated, Oxycodone HCL [narcotic pain medication] 5 mg [milligram]. The MAR indicated the initials of the ADON was used by GVN 1 when the GVN administered a controlled medication without supervision. ADON stated she was not with GVN 1 during medication administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 5's Controlled Drug Record (CDR), dated 10/7/24, indicated a signature of the GVN 1 was signed to administer the controlled drug without a witness and a licensed nurse to co-sign on 10/7/24 at 7:30 a.m. ADON stated GVN 1 was not supposed to dispense controlled medications and sign off on the controlled medication sheet by herself. ADON stated, The GVN [1] is using my sign in [access to EPHI]. ADON stated she does not know how the medications were administered under her initials 'CC'. ADON stated, I was not physically passing medications this week. I only have to be there if [GVN 1] needs direction, [but] narcotics and insulin I am there for [GVN 1]. ADON stated, It's a narcotic, that is [GVN 1's] signature, I was not with her. That is a narcotic, yes I should've been there. ADON stated, No, I am not there to give every dose of insulin. During an interview on 10/10/24 at 3:44 p.m. with DON, DON stated the GVN did not have an EPHI access because they were not licensed. DON stated the expectation was for GVNs to be supervised while using a licensed nurse's EPHI access. DON stated it was unacceptable for a GVN to document under another licensed nurse's credentials when the GVN was not being directly supervised. During a review of the facility's P&P titled, Informed Access Management, dated August 2024, the P&P indicated, The level of access will be based on requirements necessary for the employees or business associates to complete their necessary functions. During a review of the facility's job description (JD) for Graduate Vocational Nurse, dated 2020, the JD indicated, Prepares and administers medications under the supervision of Licensed Nurse as per physicians' orders and observes for adverse effects. During a review of the facility's P&P titled, Controlled Substances, dated November 2022, the P&P indicated, Only authorized licensed nursing and/or pharmacy personnel have access to Schedule II controlled substances maintained on premises. 2) During a concurrent interview and record review on 10/9/24 at 2:02 p.m. with DON, Resident 51, Resident 63, and Resident 18's Treatment Administration Record (TAR), dated October 2024 were reviewed. The TAR indicated missing licensed nurse initials for the following residents: a. Resident 51's TAR indicated on 10/4/24 day shift was missing licensed nurse initials for Cleanse (R [Right]) inner elbow with normal saline, pat dry and apply moisture barrier cream and leave open to air. b. Resident 63's TAR indicated on 10/4/24 pm shift, 10/5/24 day shift, and 10/6/24 day and pm shift were missing licensed nurse initials for Cleanse with soap and water, pat dry, apply moisture barrier cream. c. Resident 18's TAR indicated on 10/4/24 day and evening shift, and 10/6/24 evening shift were missing licensed nurse initials for Cleanse and irrigate wound to Left Lateral ankle with NS [Normal Saline - cleaning solution], pat dry. d. Resident 6's TAR indicated on 10/4/24 PM shift, 10/5/24 day shift, 10/6/24 day shift & PM shift were missing licensed nurse initials for Cleanse w/ [with] NS pat dry and apply Zinc Oxide [medicated cream for skin protection] and leave open to air. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated the missing licensed nurse initials meant the treatments were not done. During a review of the facility's P&P titled, Wound Treatment Management, dated May 2022, the P&P indicated, Treatments will be documented on the Treatment Administration Record or in the electronic health record. 51320

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50409 Based on observation, interview, and record review, the facility failed to ensure interventions to prevent skin breakdown were implemented for one of one sampled residents (Resident 51). This failure had the potential for Resident 51 to develop skin breakdown and worsening skin injury. Findings: During a concurrent observation and interview on 10/9/24 at 8:45 a.m. with Licensed Vocational Nurse (LVN) 4 in Resident 51's room, Resident 51's heels were not elevated and were touching the bed. Resident 51 had non blanchable redness (discoloration of the skin that does not turn white when pressed which can indicate a pressure ulcer) on her left heel. LVN 4 stated Resident 51's heels were supposed to be elevated to prevent skin breakdown. During a review of Resident 51's Order Summary Report (OSR), dated 10/8/24, the OSR indicated, Heels up device, monitor for proper placement every shift for hx [history] of blanchable redness. During a review of Resident 51's Braden Scale for Predicting Pressure Sore Risk (BSP), dated 9/26/24, the BSP indicated, Resident 51 had a score of 12 (high risk for developing skin breakdown). During a review of Resident 51's Care plan (CP), dated 11/28/23, the CP indicated, Potential impairment to skin integrity, [Resident 51] needs heels up device to protect the skin (heels) while in bed. During a review of Resident 51's Minimum Data Set (MDS - an assessment tool), dated 8/9/24, the MDS indicated, Resident 51 had limited range of motion on both lower extremities and required total assistance with bed mobility. During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated April 2018, the P&P indicated, The nurse shall describe and document/report the following. Current treatments, including support surfaces.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47734 Based on observation, interview and record review, the facility failed to ensure three of three sampled residents (Resident 47, Resident 48, and Resident 51), had Restorative Nurse Assistant (RNA - therapy for residents with limited mobility) program orders. This failure had the potential for Resident 47, Resident 48, and Resident 51 to have an avoidable reduction in range of motion. Findings: During a concurrent observation and interview on 10/7/24 at 10:12 a.m. in Resident 47's room, Resident 47 stated he gets changed in his bed. During an observation on 10/7/24 at 10:22 am in Resident 48's room, Resident 48 was watching tv. Resident 48 was non-verbal. During a concurrent interview and record review on 10/9/24 at 11:52 a.m. with the Director of Rehabilitation (DOR), Resident 47 and Resident 48's Order Summary Report (OSR), dated October 2024 was reviewed. DOR stated neither Resident 47 nor Resident 48 had orders for RNA program. During a concurrent interview and record review on 10/9/24 at 3:24 p.m. with Assistant Director of Nursing (ADON), Resident 47 and Resident 48's OSR, dated October 2024 was reviewed. ADON stated there were no RNA orders for both residents. ADON stated both Resident 47 and Resident 48's orders should have been renewed. During a review of Resident 47's Care Plan (CP), dated 10/9/24, the CP indicated, Resident 47 has actual contractures/impaired functional range of motion of BLE [bilateral lower extremities] and right-hand related hemiplegia [inability to move one side of the body] and hemiparesis [weakness on one side of the body] . Restorative Nursing: RNA Program (R)PROM [Right Passive Range of Motion - staff does the effort to move extremities] or prolonged stretching for all three joints in all planes of motion. During a review of Resident 48's CP, dated 7/31/24, the CP indicated, Resident 48 has actual impairment in functional joint mobility related to decreased ability to self-perform ADLs [Activities of Daily Living] independent, inactivity resulting from a medical condition .RNA program (L) AAROM [Left Active Assisted Range of Motion - staff assisted with some resident assist to move extremities] for all three joints in all planes of motion 2 sets of 10. 50409 During an observation on 10/7/24 at 10:15 a.m. in Resident 51's room, Resident 51 was on the bed and had contractures on both hands. Neither contracted hands had palm protectors. During a review of Resident 51's Minimum Data Set (MDS - an assessment tool), dated 8/9/24, the MDS indicated, Resident 51 had functional limitation in range of motion on both upper extremities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 51's CP, dated 7/30/24, the CP indicated, Actual impairment in functional joint mobility. Interventions. RNA to apply devices [palm protectors] to affected joints as ordered. During a concurrent interview and record review on 10/9/24 at 9:32 a.m. with DOR, Resident 51's Order Listing Report (OLR), dated 10/9/24 was reviewed. The OLR indicated, Resident 51 had an RNA order for palm protectors for 90 days. The OLR indicated, the RNA order was ordered on 5/3/24. DOR stated the RNA order was completed in August 2024. DOR stated, It [RNA order] is something that should have been renewed to protect the integrity of the skin because of her contracted digits [fingers] and nail length we don't want any pressure wounds on the palm also to decrease infection and wound. During a review of the facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion, dated July 2017, the P&P indicated, 3. Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44134 Based on interview and record review, the facility failed to complete performance evaluations for three of eight sampled employees (Certified Nursing Assistant [CNA] 3, CNA 5 and Licensed Vocational Nurse [LVN] 1. This failure had the potential for employees not meeting performance standards providing care for residents. Findings: During a concurrent interview and record review on 10/9/24 at 11:53 a.m. with Director of Staff Development (DSD), CNA 3's employee personnel record (EPR), undated was reviewed. The EPR indicated, CNA 3's date of hire was on 8/1/24. DSD stated she was unable to find CNA 3's competency checklist. DSD stated CNA 3 should have had a competency checklist completed prior to working on the floor alone. During a concurrent interview and record review on 10/9/24 at 12:06 p.m. with DSD, CNA 5's EPR, undated was reviewed. The EPR indicated, CNA 5's most recent competency checklist was completed on 7/7/23. DSD stated, Yes [CNA 5] is due and should have had her annual review and competency checklist completed last July. During a concurrent Interview and record review on 10/9/24 at 2:47 p.m. with DSD, LVN 1's EPR, undated was reviewed. The EPR indicated, LVN 1's date of hire was on 7/1/24. DSD stated she was unable to find LVN 1's competency checklist. DSD stated LVN 1 should have had a competency checklist completed prior to working on the floor alone. DSD stated there should be a competency checklist completed on hire, prior to working on the floor alone and annually. During an interview on 10/9/24 at 4:41 p.m. with Assistant Director of Nursing (ADON), ADON stated LVN 1 did not have a competency checklist completed upon hire. ADON stated LVN 1 should have had a competency checklist completed prior to working on the floor. Facility's policy and procedure on staff competency was requested on 10/9/24 at 4:45 p.m. Facility failed to provide requested document.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. 50409 Based on interview and record review, the facility failed to ensure social services assessments (SSA) were completed quarterly (every three months) for nine of 19 sampled residents (Resident 51, Resident 63, Resident 71, Resident 44, Resident 27, Resident 6, Resident 54, Resident 47, and Resident 48). This failure had the potential for the delay in providing medically related social services for the residents affecting their psychosocial needs. Findings: During a concurrent interview and record review on 10/9/24 at 9:41 a.m. with Social Services Supervisor (SSS), Resident 51, Resident 63, Resident 71, Resident 44, Resident 27, Resident 6, Resident 54, Resident 47, and Resident 48's SSAs were reviewed. The SSAs indicated they were not completed every three months for the following residents: a. Resident 51's last SSA was completed on 8/11/23 (11 months overdue). b. Resident 63's last SSA was completed on 4/20/23 (15 months overdue). c. Resident 71's last SSA was completed on 8/25/23 (11months overdue). d. Resident 44's last SSA was completed on 6/2/23 (13 months overdue). e. Resident 27's last SSA was completed on 4/20/23 (15 months overdue). f. Resident 6's last SSA was completed on 6/2/23 (13 months overdue). g. Resident 54's last SSA was completed on 1/8/24 (6 months overdue). h. Resident 47's last SSA was completed on 3/29/23 (16 months overdue). i. Resident 48's last SSA was completed on 3/22/23 (16 months overdue). SSS stated there should have been SSAs done every three months. During a review of the facility's job description (JD) for Social Services, dated 12/5/12, the JD indicated, Completes social and emotional assessments of residents on a quarterly [every three months] basis. During a review of the facility's policy and procedure (P&P) titled, Social Services, dated February 2023, the P&P indicated, The social worker, or social service designee, will complete an initial and quarterly assessment of each resident, identifying any need for medically-related social services of the resident.

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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. 46958 Based on interview and record review, the facility failed follow their policy and procedures titled Medication Reordering and Unavailable Medications when Licensed Nurse did not reorder medications timely, notify physician of unavailable medication and obtain alternate orders for one of one sampled residents (Resident 54). This failure resulted in .Resident 54 not receiving physician ordered diabetic medications (to manage blood sugar level) and had the potential to result in adverse health outcomes. Findings: During a review of Resident 54's Order Summary Report (OSR), dated 10/9/24, the OSR indicated the following orders: Admelog Injection Solution [rapid acting insulin, medication to manage blood sugar level] 100 UNIT/ML (milliliter) Inject 15 unit subcutaneously before meals for DM (diabetes mellitus) hold for BS (blood sugar) < (less than) 100, Jardiance oral tablet (medication to manage blood sugar level) 25 mg [milligrams] Give 1 tablet by mouth one time a day for Diabetes Mellitus, Lasix oral tablet [medication to remove excess water in the body] 40 mg Give 1 tablet by mouth one time a day for CHF (congestive heart failure- heart can't pump enough blood to meet the body's needs) [hold for systolic blood pressure < l00, Diastolic blood pressure <60, Pulse <60] , and Tresiba FlexTouch Subcutaneous Solution (medication to manage blood sugar level) Pen-Injector 100 Unit/ml Inject 15 unit subcutaneously two times a day for DM (hold for BS <70). During a review of Resident 54's Progress Note (PN), dated 10/6/24 at 05:28 (5:28 am), the PN indicated Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 unit/ml . still pending delivery. The PN dated 10/6/24 at 20:33 (8:33pm) indicated Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 unit/ml .not in stock, pending delivery. The PN dated 10/9/2024 at 19:12 (7:12pm) by Director of Nursing (DON), indicated Resident (Resident 54) noted with missed doses of Lasix 40 mg 10/1-10/5. Resident (Resident 54) was also noted with missed doses for Jardiance 10/7-10/8, Admelog 10/6 1630 (4:30pm) and 10/7 0630 (6:30am), 1130 (11:30am), 1630 (4:30pm) dose. All not available from pharmacy. During an interview on 10/9/24 at 3:49 p.m. with DON, DON stated medications should be re-ordered at least 7 days prior to medications running out. DON stated if medications were running low then pharmacist should have been contacted and the licensed nurses should have documented. DON stated the physician should have been notified when doses were missed. DON stated that there was no documentation that Resident 54's physician was notified of missed medications and pharmacy notification. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/24 at 4:08 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she should have called the pharmacy when Resident 54 had three doses of medication remaining, and a progress note should have been done. LVN 1 stated there was no documentation Resident 54's physician was notified of the missed medication. During a review of the facility's policy and procedure (P&P) titled, Unavailable Medications, dated February 2023, the P&P indicated, 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn [as needed] and emergency medications .3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications (See Medication Reordering Policy.) 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold .If a resident misses a scheduled dose of a medication, staff shall follow procedures for medication errors, including physician/family notification, completion of medication error report, and monitoring the resident for adverse reaction to omission of the medication. During a review of the facility's P&P titled, Medication Reordering undated, the P&P indicated, Policy: It is the policy of the facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident .Policy Explanation and Compliance Guidelines .2.Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34510 Based on interview and record review, the facility failed to act on pharmacy recommendations for Medication Regimen Review (MRR- a thorough evaluation of the medication regimen of a resident with a goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) for the month of July 2024. This failure had the potential for residents' adverse health outcomes due to physician was not notified of the pharmacy recommendations. Findings: During a review of the facility's Psychotropic & Sedative/Hypnotic Utilization by Resident (PSHUR), dated 7/1/24 until 7/28/24, the PSHUR indicated, there were 99 pharmacy recommendations the facility did not act on. There were no documentation of notification of the physician. During an interview on 10/9/24 at 11:13 a.m. with Director of Nursing (DON), DON stated the July 2024 pharmacy recommendations were not acted upon. DON stated she did not check if the pharmacy recommendations in July 2024 were completed. During a review of the facility's Consultant Pharmacist's Medication Regimen Review Active Recommendations Lacking a Final Response (CPMRRARLFR), dated 7/1/24 until 7/28/24, the CPMRRARLFR indicated, there were 55 pharmacy recommendations which were not acted on. During an interview on 10/9/24, at 11:14 a.m. with DON, DON stated the Assistant Director of Nursing (ADON) did not complete the CPMRRARLFR in July 2024. DON stated she did not check if the CPMRRARLFR was completed. During a review of the facility policy and procedure (P&P) titled, Medication Regimen Review dated 2024, the P&P indicated, Facility staff shall act upon all recommendations according to the procedures for addressing medication regimen review irregularities.

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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. 47734 Based on observation, interview and record review, the facility failed to: 1. Ensure two opened medication bottles in the medication storage room were labeled with an opened date. This failure had the potential for contamination of medications. 2. Dispose of three bottles of medications for Resident 79 in a plastic bag in Medication Cart 2 bottom drawer. This failure had the potential for discontinued or outdated medication to be administered. 3. Ensure approximately 50 Over-The-Counter (OTC) medication bottles were safely and securely stored from unauthorized personnel. This failure had the potential for medication to be accessed by unauthorized staff and patients. 4. Ensure medications Resident 54's medications were safely and securely stored from unauthorized personnel and other residents. This failure had the potential for medication to be accessed by unauthorized staff and residents. Findings: 1. During a concurrent observation and interview on 10/8/24 at 1:18 p.m. with Assistant Director of Nursing (ADON) in the medication storage room, there were opened bottles of Glucosamine sulfate (OTC medication for joint swelling) and B-Complex (OTC medication supplement) with no open date labels. ADON stated the medication bottles should have been sealed and not opened. ADON stated there were no open dates written on the bottles and there should have been. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, The date opened is recorded on the container. 2. During a concurrent observation and interview on 10/9/24 at 8:15 a.m. with Licensed Vocational Nurse (LVN) 1 in the 200 hallway, at Medication Cart 2, in the bottom drawer there was a plastic zip bag with Patient 79's name written on it. Inside the plastic zip bag were three prescription bottles: Baclofen (medication for muscle spasm), Propranolol (medication for blood pressure), and Trazodone (medication for depression). LVN 1 stated she did not use the medications in the bottom drawer because Patient 79's current medications were in another drawer. LVN 1 stated the facility process for medication not being used was to destroy the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/9/24 at 8:18 a.m. with Assistant Director Of Nursing (ADON) in the 200 hallway, at Medication Cart 2, ADON verified Patient 79's prescription bottles of Baclofen, Propranolol, and Trazodone in the plastic zip bag in the bottom drawer. ADON stated the medication bottles probably have been in the cart since Patient 79's re-admission in July 2024, and the medications should not have been in the cart for that long. ADON stated if the medication is something that is from the facility pharmacy, the facility puts the medication into the medication destruction bottle. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised date February 2023, the P&P indicated, Medication Storage 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 3. During a concurrent observation and interview on 10/10/24 at 10:55 a.m. with the Director of Nursing (DON) in the storage room, emergency water supplies, enteral (into the digestive system) tubes, beds, mattresses, hoyer lifts and other supplies still in boxes. In the storage room, a shelf contained approximately 50 OTC medication bottles. DON stated non-nursing staff had access to the storage room. During a review of the facility's P&P titled, Medication Labeling and Storage, dated February 2023, the P&P indicated, Medication Storage. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Medication Labeling. 7. Medication for external use. are clearly marked as such, and are stored separately from other medications. 46958 4. During a concurrent observation and interview on 10/9/24 at 9:24 a.m. with Licensed Vocational Nurse (LVN) 1 in Patient 54's room, Patient 54 had Diclofenac Sodium External Gel 1% (Topical-to relieve pain in joints) on the bed in the basin. LVN 1 stated Patient 54 did not have an order to keep it at bedside, and a self medication evaluation should be done. During a review of patient 54's Order Summary Report (OSR), dated 10/9/24, the OSR indicated, Diclofenac Sodium External Gel 1% Apply to Bilateral Feet topically Four times a day for MILD PAIN Apply 4 grams (g) to the affected skin areas four times a day (a total of 16 g each day). However, the total dose should not exceed 32 g per day over all affected joints. Use the enclosed dosing card to measure the appropriate dose. During a concurrent interview and record review on 10/9/24 at 9:40 a.m. with Director Of Nursing (DON), Patient 54's clinical record was reviewed. DON stated there was no documentation of self-medication administration evaluation and the medication should not have been stored at Patient 54's bedside. During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, dated February 2021, the P&P indicated, Self-administered medications are stored in a safe and secure place, which is not accessible by other patients.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47734 Based on observation, interview and record review, the facility failed to follow the physician order for one of three sampled residents (Resident 47) for nectar thick consistency beverage. This failure had the potential for Resident 47 to have a choking incident. Findings: During a concurrent observation and interview on 10/9/24 at 3:56 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 47's room, Resident 47 had unthickened (thin) juice on his bedside table. CNA 1 stated Resident 47 drinks thin liquids. CNA 1 stated Resident 47 did not like the thick consistency. During a concurrent observation and interview on 10/9/24 at 4:14 p.m. with Certified Dietary Manager (CDM) in Resident 47's room, Resident 47 had cans of soda on his bedside table. CDM stated he was not aware if the soda was getting thickened for Resident 47. During a review of Resident 47's Order Summary Report (OSR), dated October 2024 was reviewed. The OSR indicated, Resident 47's diet order was Regular Diet Puree texture, Nectar Thick Consistency. During an interview on 10/10/24 at 12:15 p.m. with Director of Nursing (DON), The DON stated Resident 47 has soda, the thickener should be at the nurses station. The thickener is inside the nurses station. The DON stated there should be a care plan (CP) for Resident 47 not being compliant with diet order. During an interview on 10/10/24 at 12:24 p.m. with CNA 2 in Resident 47's room, CNA 2 stated when Resident 47 asked for soda, she would open the can, put a straw in the soda can and place the soda can on his tray table. During a review of Resident 47's Care Plan for Risk for Dehydration, dated initiated 12/22/21, the care plan indicated Educate [Resident] about location/availability of the hydration cart. The care plan did not indicate liquids should be nectar thick. During a review of Resident 47's Care Plan for Nutrition status, dated revised 1-9-24, the CP indicated Diet as ordered, Regular diet, Puree texture, Nectar Thick consistency .Facility was unable to provide a CP for Resident 47's noncompliance with diet order. During a review of the facility's policy and procedure (P&P) titled, Thickened Liquids, undated, the P&P indicated, The facility provides commercially-prepared thickened liquids, as prescribed, to residents who require them. The use of thickened liquids will be based on the resident's individual needs as determined by the resident's assessment .Thickened liquids are provided only when ordered by a physician/practitioner or when ordered by a dietitian .a. Do not thicken liquids in the facility, even with products designed for this purpose. Use only pre-thickened, commercially prepared liquids in the desired consistency.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 51320 Based on observation, interview, and record review, the facility failed to honor one of one sampled residents' (Resident 37) food preferences. This failure had the potential for Resident 37 to have unmet nutritional needs. Findings: During a concurrent observation and interview on 10/07/24 at 12:27 p.m. with Resident 37 in Resident's 37 room, Resident 37 was laying in his bed with a food tray in front of him. Resident 37's lunch plate had brussels sprouts, mashed potatoes and gravy, and pot roast. Resident 37 had facial grimace and stated, I don't ever eat brussels sprouts and once they are on my plate I will not eat it. Resident 37 stated he does not remember what he asked for, but he stated he knew he did not order the brussels sprouts. During a review of Resident 37's Minimum Data Set (MDS- assessment tool), dated 8/23/24, the MDS indicated, Resident 37 had a Brief Interview for Mental Status (BIMS, cognition assessment tool, 15-point scale: 0-7 severe impairment, 8-12 moderate impairment, 13-15 cognitively intact) score of 13 (score of 13-15 means cognitively intact). During a record review on 10/9/24 at 4:17 p.m. with Certified Dietary Manager (CDM), Resident 37's meal ticket was reviewed. Resident 37's meal ticket indicated, dislikes vegetables, and only likes corns, peas, green beans. During a review of Resident 37's Nutrition Evaluation (NE), dated August 2023, the NE indicated, Dislikes of vegetable list provided to CDM. During a review of Resident 37's NE, dated May 2024, the NE indicated, To respect resident [37] right to make own health choices. During a review of the facility's policy and procedure (P&P) titled, Food Substitutions or Residents Who Refuse The Meal, dated 2023, the P&P indicated, Residents will be provided a suitable nourishing alternate meal after the planned, served meal has been refused. Nursing personnel will ask any resident who does not eat his meal or food item as to why he is not eating and offer a food substitution in accordance with the resident's diet order.

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	555861	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Oaks Care	897 North M Street Tulare, CA 93274

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 50409 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) on Quality Assurance and Performance Improvement (QAPI - data-driven, proactive approach to improving the quality of care and services in the facility). This failure had the potential for the facility to not recognize, identify, address and correct resident safety, care and outcomes for 37 of 37 sampled residents. Findings: During a concurrent interview and record review on 10/10/24 at 2:35 p.m. with Administrator, the facility's QAPI dated 2024 was reviewed. The last QAPI meeting was 9/2024. During the 1/2024 QAPI meeting completing nursing staff competencies, quality of care, incomplete employee files and nursing documentation audits were identified. Administrator stated there was no measurable data discussed for completing the nursing staff competencies. The QAPI plan was not effective. The Administrator stated the analytical data was not available to put in the Process Improvement Projects (PIPs).The QAPI reports indicated no measurable data that were being monitored and evaluated every month. The Administrator stated the QAPI goals are not measurable for all their QAPI plan. The Administrator stated, I'm not documenting that [analyzing data collected for QAPI]. We're lacking the analytical part of it. The Administrator stated their QAPI plan was not effectively being monitored. During a review of the facility's P&P titled, Quality Assurance and Performance Improvement (QAPI) Program, dated February 2020, the P&P indicated, The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Key component of this process include: a. tracking and measuring performance; b. establishing goals and thresholds for performance measurement. systematically analyzing underlying cause of systemic quality deficiencies. The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan.

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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. 51434 Based on observation, interview, and record review, the facility failed to implement infection prevention and control practices when: 1. One of three sampled clean linen cart covers were not fully covered during transport. 2. Four of ten sampled staff (Certified Nursing Assistant-CNA 3, CNA 4, Hospice CNA, and Nursing Consultant [NC]} did not follow enhanced droplet (used to prevent spread of airborne infectious agents) and contact precautions (used to prevent the spread of infectious agents through direct or indirect contact). 3. One of one sampled Resident's (Resident 77) room was not deep cleaned prior to moving another Resident (Resident 87) into room. 4. One of ten sampled staff (Licensed Vocation Nurse [LVN] 1) did not perform appropriate hand hygiene. These failures had the potential to transmit infectious diseases to Residents, staff, and visitors. Findings: 1. During a concurrent observation and interview on 10/8/24 at 1:41 p.m. with Laundry Personnel (LP) in the hallway outside laundry area, a linen cart cover which contained clean linens was opened approximately five-inches and did not fully cover the linens. LP stated the linen cart should have been entirely covered. During an interview on 10/8/24 at 1:45 p.m. with Infection Preventionist (IP), IP stated the linen cart cover was too small for the linen cart which caused the opening in the linen cover. During a review of the facility's policy and procedure (P&P) titled, Handling Clean Linen, dated 7/2019, the P&P indicated, Clean linen shall be delivered to resident care units on covered linen carts with covers down. 2. During an observation on 10/9/24 at 9:10 a.m. outside of Resident 78 and Resident 26's room, CNA 3 exited Resident 78 and Resident 26's room wearing an N95 mask. CNA 3 entered another Resident's room without removing the N95 mask. During an interview on 10/9/24 at 9:26 a.m. with CNA 3, CNA 3 stated, I only change my N95 mask when I go to lunch. During a concurrent observation and interview on 10/9/24 at 9:35 a.m. with IP, IP stated, Yes the N95 mask should be removed every time someone comes out of the isolation room and a new one should be placed. (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 review of the facility's enhanced droplet and contact precautions sign, the sign indicated Exit Room, Wash or sanitize hands, Remove eye protection, Wash or sanitize hands, Remove respiratory protection, Wash or sanitize hands. During an observation on 10/9/24 at 9:29 a.m. outside Resident 26's room, an enhanced droplet and contact precautions sign was posted on the door. Hospice CNA entered Resident 26's room without putting on gown, face shield or gloves on. CNA 5 stated Hospice CNA was supposed to put on all the PPE (personal protective equipment) before entering the isolation room. During an interview on 10/9/24 at 9:45 a.m. with Hospice CNA, Hospice CNA stated I saw the sign on the door. I was rushing. 50409 During a concurrent observation and interview on 10/7/24 at 11:49 a.m. with NC outside of Resident 7 and Resident 71's room, a sign on the door indicated enhanced droplet and contact precautions. NC entered Resident 7 and Resident 71's room without performing hand hygiene or putting on PPE (personal protective equipment - gown, face shield, and gloves). NC stated he should have performed hand hygiene and put on proper PPE before entering Resident 7 and Resident 71's room. During a review of the facility's P&P titled, Enhanced Droplet and Contact Precautions, undated, the P&P indicated, Before entry. Wash or sanitize hands. Put on gown. Put on eye protection. Put on gloves. Exit room. Remove respiratory protection equipment. 46958 3. During an observation and interview on 10/7/24 at 10:30 a.m. with Resident 87 in Resident 87's room, Resident 87 stated there were items in the room that were not his belongings. Resident 87 stated, There was a mouthpiece [used for breathing exercises] hanging on the wall that had Resident's 77 name on it. During an interview on 10/7/24 at 2:25 p.m. with Housekeeper (HK) 1, HK 1 stated deep cleaning the room included disinfecting the mattress, and everything else in the resident rooms. HK 1 stated CNAs were responsible to remove residents' personal belongings when residents moved out of the room before staff did the deep cleaning. HK 1 stated staff would not deep clean the room if residents' personal belongings were still in the room. During an interview on 10/7/24 at 2:31 p.m. with CNA 8, CNA 8 stated when a resident moved to another room, Social Services would tell staff to pack up the residents' belongings and move them to the Resident's new room. CNA 8 stated she worked last Thursday and Resident 77 had moved to a different room. During an interview on 10/7/24 at 2:37 p.m. with IP, IP stated resident rooms should be deep cleaned before a resident was moved into the room. IP stated deep cleaning included cleaning the bed, floors, call lights, mattress, walls, closets, and picture boards. IP stated the expectation would be for housekeeping to notify their supervisor if a room was not deep cleaned prior to a resident moving in the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47734 4. During an observation on 10/9/24 at 9:53 a.m. in Resident 79's room, LVN 1 removed her gloves and handled supplies in Resident 79's bedside drawer without performing hand hygiene. During an interview on 10/9/24 at 9:58 a.m. with LVN 1, LVN 1 stated she should have performed hand hygiene before she touched the clean supplies in Resident 79's drawer. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated August 2019, the P&P indicated, 7. Use alcohol-based hand rub containing at least 62% alcohol. b. before and after direct contact with residents. l. After contact with objects (e.g. Medical equipment) in the immediate vicinity of the resident.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 51434 Based on observation and interview, the facility failed to store chemical containers off the ground. This failure had the potential for the chemical containers to be knocked over and result in a toxic spill which would put staff and Resident's health and safety at risk. Findings: During a concurrent observation and interview on 10/8/24 at 1:14 p.m. with Laundry Personnel (LP) in the laundry room, on the right side of the washing machine, there were five chemical containers and one bleach bottle on the ground. LP stated the containers are filled with chemicals and should be stored above ground. During an interview on 10/8/24 at 1:58 p.m. with Administrator, Administrator stated there should not be anything on the ground in the laundry room, everything should be four inches off the ground. Facility's policy and procedure on chemical storage was requested on 10/9/24 and 10/10/24 and was not provided.