| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 055417 | A. Building<br>B. Wing | 05/08/2025 |

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| Saylor Lane Healthcare Center | 3500 Folsom Boulevard<br>Sacramento, CA 95816 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, interview, and record review, the facility failed to ensure professional standards were followed when nursing staff failed to label the flush bag (used to provide hydration) with the date and time attached to the Gastrostomy Tube (a tube inserted into the stomach through the abdomen to provide nutrition, fluids, and medication) for Resident 25, document pain assessment before and after administration of pain medication to Resident 19, verify or recheck vitals taken by Certified Nursing Assistants (CNAs) prior to withholding blood pressure medications, and wear appropriate personal protective equipment (PPE) while handling hazardous medication (medications that can cause serious effects including cancer, organ toxicity, fertility problems, genetic damage, and birth defects if not handled appropriately).<br><br>These failures had the potential to result in worsening resident health conditions and unwanted exposure to hazardous medications leading to health complications.<br><br>Findings:<br><br>A review of Resident 25's admission Record indicated, Resident 25 was admitted to the facility in 2024 with diagnoses that included Dysphagia (difficulty swallowing) following Cerebral Infarction (occurs when blood supply to part of the brain is interrupted causing brain damage or death).<br><br>A review of Resident 25's, Order Summary dated 4/22/25, indicated an order for water flushes of 150 milliliters (ML, unit of measurement) every four hours via the Gastrostomy Tube (GT).<br><br>A review of Resident 25's, Minimum Data Set (MDS - an assessment tool used to guide care) Cognitive (having full understanding) Patterns, dated 2/8/25, indicated Resident 25 had a Brief Interview for Mental Status (a tool to assess a person's full understanding) score of 99 which indicated Resident 25 did not have full understanding and thus, not interviewable.<br><br>During an observation on 5/7/25 at 1:25 p.m., Resident 25's flush bag label had no date or time it was hung.<br><br>During an interview with Licensed Nurse 1 (LN 1) on 5/7/25 at 1:39 p.m., LN 1 verified Resident 25's flush bag label had no date or time. LN 1 stated, The flush bag should be labeled with the date and time.<br><br>During an interview with the Nurse Consultant (NC) on 5/8/25 at 10:34 a.m., the NC stated, The facility expectation is for the tube feeding flush bag to be labeled with the date and time.<br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility policy titled, Enteral Feedings - Safety Precautions dated 2018 indicated, Document date and time .<br><br>During a medication pass observation on 5/6/25 at approximately 7:30 a.m. with LN 1, LN 1 was observed preparing twelve medications for Resident 19, including hydrocodone/APAP (a narcotic medication to treat pain) 5/325 milligrams (mg, a unit of measurement), 1 tablet.<br><br>A review of Resident 19's medical record indicated physician's orders for the following:<br><br>- Hydrocodone/APAP 5/325 mg: give 1 tablet by mouth two times a day for moderate to severe pain, ordered 4/21/25<br><br>- Metoprolol tartarate (a medication to lower high blood pressure 25 mg: give 0.5 tablet by mouth two times a day for HTN (hypertension, high blood pressure) hold for SBP (systolic blood pressure, the pressure in your arteries when your heart beats and pumps blood out) below 110, HR (heart rate) below 60, ordered 4/9/25<br><br>During an interview on 5/6/25 at 10:47 a.m. with LN 1, LN 1 confirmed he did not administer Resident 19's metoprolol because his blood pressure was 94/68 and his heart rate was 62. LN 1 stated resident vitals were taken by Certified Nursing Assistants (CNAs). He stated Resident 19's hydrocodone/APAP was a scheduled medication for arthritis pain but he still assessed the resident's pain level before and after. He stated he had not documented the resident's pain score before administering the hydrocodone/APAP and still had not reassessed Resident 19's pain level after administering the medication 3 hours prior.<br><br>During an interview on 5/6/25 at 3:58 p.m. with Director of Nursing (DON), DON stated nursing staff were expected to complete and document pain assessments on a resident before administering pain medication to make sure the medication was effective, and pain was properly managed. She stated she would expect to see a follow up assessment completed after administering the pain medication.<br><br>During a medication pass observation on 5/6/25 at 7:50 a.m. with LN 2, LN 2 was observed preparing 11 medications for Resident 18, including bicalutamide (a hormone-based chemotherapeutic medication to treat prostate cancer) 50 milligrams (mg, a unit of measurement), 1 tablet. The pharmacy label affixed to the bubble pack indicated the medication was hazardous. LN 2 prepared the medications without wearing gloves or any other personal protective equipment. LN 2 stated she would not administer Resident 18's carvedilol (a medication to treat high blood pressure) because the CNA's had measured the resident's vitals and his SBP was less than 100. She stated the CNA's took Resident 18's blood pressure at 7:08 a.m. that morning that they were the ones to take the first set of vitals.<br><br>A review of Resident 18's medical record indicated the following physician's orders:<br><br>- Bicalutamide 50 mg: give 1 tablet by mouth in the morning for prostate cancer, ordered 2/5/25<br><br>- Carvedilol 6.25 mg: give 1 tablet by mouth two times a day for CHF (congestive heart failure, a disease where the heart does not pump as well as it should leading to fluid buildup in the body) hold for SBP less than 100 or HR less than 60, ordered 2/6/25<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/6/25 at 10:18 a.m. with LN 2, LN 2 confirmed Resident 18 received bicalutamide to treat prostate cancer and stated she did not know and was not aware of any special handling requirements. She stated she would expect to see directions in the physician's order to wear gloves if it was a hazardous medication but did not see that in Resident 18's order.<br><br>During an interview on 5/6/25 at 10:23 a.m. with LN 2, LN 2 stated some residents had low blood pressure upon waking up and that it would go up after breakfast. She stated Resident 18's blood pressure was 100/67 after breakfast. She stated the morning vitals obtained by CNAs were what was used to determine if a blood pressure medication was given or held based off any parameters in the physician's order. LN 2 stated if the resident's blood pressure was out of their baseline, only then would nursing staff recheck the vitals. She stated it was difficult to recheck vitals because breakfast often collided with morning med pass so it was not ideal to retake until the resident finished eating.<br><br>During an interview on 5/6/25 at 3:49 p.m. with DON, DON stated nursing staff were made aware that a medication was hazardous and required special handling under special instructions in the computer system. She stated whichever staff inputted the order into the system had to put in special handling instructions. DON confirmed special handling instructions were not put in for Resident 18's bicalutamide. She stated if nursing staff were unfamiliar with a medication, they were expected to call the pharmacy about what type of special precautions they would need to take for that medication.<br><br>A review of OSHA's current recommendations for addressing the health and safety hazards faced by healthcare workers titled, Controlled Occupational Exposure to Hazardous Drugs, dated XXX, indicated, IV. Work Areas . A. Administration of Drugs to Patients: Administration of HDs to patients is generally performed by nurses or physicians. The potential for occupational exposure exists for every route of drug administration . Drug Administration: HDs [hazardous drugs] are administered through many different routes, in several types of settings, and for numerous disease states, Safe handling is required for all HDs no matter how they are used . (https://www.osha.gov/hazardous-drugs/controlling-occex; accessed 5/13/25)<br><br>During a medication pass observation on 5/6/25 at 8:15 a.m. with LN 2, LN 2 was observed preparing six medications for Resident 7, including oxycodone (a narcotic medication to treat pain) 10 mg, 1 tablet. LN 2 stated vitals were obtained by a CNA at 7:12 a.m. that morning and she would not administer metoprolol to Resident 7 since the heart rate was 58.<br><br>A review of Resident 7's medical record indicated the following physician's orders:<br><br>- Oxycodone 10 mg: give 1 tablet by mouth every 6 hours as needed for pain, ordered 4/25/25<br><br>- Metoprolol tartarate 25 mg: give 1 tablet by mouth two times a day for HTN Hold if SBP less than 100 or HR less than 60, ordered 3/29/25<br><br>During an interview on 5/6/25 at 3:55 p.m. with DON, DON stated vitals should be obtained within 30 minutes of medication administration. She stated if the vitals obtained were from more than 30 minutes prior to the medication pass, nursing staff were expected to obtain a new assessment. She stated it was acceptable for nursing staff to use vitals obtained by CNAs as long as it was within the 30 minute window and did not expect them to verify the vitals. DON stated for pain medications ordered as needed without a pain scale, nursing staff were expected to get clarification on the order to indicate when it was appropriate to administer the medication.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated, Policy heading: Medications are administered in a safe and timely manner . Policy Interpretation and Implementation . 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facilities medical director to discuss the concerns . 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary . 22. As required or indicated for a medication, the individual administering the medication records in the resident's medication record . e. any results achieved and when those results were observed . |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on observation, interview, and record review, the facility failed to ensure one out of 14 sampled residents (Resident 8) was provided with appropriate care and services with enteral feeding (also referred to as tube feeding/ feeding tube- the delivery of food and nutrients through a feeding tube directly into the stomach or part of the intestines) when Resident 8's percutaneous endoscopic gastrostomy tube (PEG tube- a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) placement was not checked before enteral feeding.<br><br>This failure had the potential for Resident 8 to experience complications of enteral feeding such as regurgitation (digestive fluids and undigested contents in the stomach rise into the mouth) and/or accidental aspiration (accidental inhalation) of feeding formula into the lungs.<br><br>Findings:<br><br>A review of Resident 8's clinical record indicated Resident 8 was admitted January of 2025 and had diagnoses that included diabetes mellitus (a chronic condition causing too much sugar in the blood), gastroesophageal reflux disease (GERD- a condition where stomach contents flow back up into the food pipe, causing heartburn and other symptoms), and encounter for attention to gastrostomy.<br><br>A review of Resident 8's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 4/30/25, indicated Resident 8 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 10 out of 15 which indicated Resident 8 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 8's MDS Swallowing/Nutritional Status, dated 4/30/25, indicated Resident 8 had feeding tube on admission and while a resident in the facility.<br><br>A review of Resident 8's care plan, revised 2/13/25, indicated, [Resident 8] requires tube feeding. On supplemental enteral feeding. A review of Resident 8's care plan intervention, dated 9/11/24, indicated, The resident is dependent with tube feeding and water flushes. See MD [medical doctor] orders for current feeding orders.<br><br>A review of Resident 8's active physician's order, dated 3/24/25, indicated, PEG TUBE FEEDING: [feeding formula] 1.2 via BOLUS FEEDING [formula is delivered in large doses through a syringe or gravity drip over a short period] of 330 mL [milliliters- unit of measurement] after LUNCH and after DINNER. two times a day for Supplement.<br><br>A review of Resident 8's active physician's order, dated 3/24/25, indicated, Check placement and residual [quantity of feeding formula remaining in the stomach] .every shift.<br><br>During an observation on 5/6/25 at 12:59 p.m. with Licensed Nurse (LN) 2, in Resident 8's room, LN 2 was observed doing Resident 8's bolus feeding. LN 2 positioned Resident 8 properly and checked Resident 8 for the presence of active bowel sounds and feeding residual amount but did not check for PEG tube placement prior to starting the enteral feeding. Resident 8 was observed to have intermittent coughing all throughout the formula feeding.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a subsequent interview on 5/6/25 at 1:20 p.m. with LN 2, LN 2 confirmed that she did not check Resident 8's PEG tube placement prior to starting the enteral feeding. LN 2 stated the PEG tube placement should be checked before enteral feeding to know that the tube was in the stomach, and it was safe to proceed with the enteral feeding. LN 2 further stated that the risk of not checking the PEG tube placement before enteral feeding was possible aspiration of feeding formula into the lungs.<br><br>During an interview on 5/7/25 at 11:28 a.m. with the Director of Staff Development (DSD), the DSD stated that the standard of practice before enteral feeding was to check for the placement of the PEG tube by injecting air into the tube and listening using a stethoscope (a medical instrument used to amplify sounds) to confirm that the end of the PEG tube was in the stomach. The DSD further stated that if the PEG tube was displaced, the feeding formula could go into the other organs, like the lungs, which could cause aspiration pneumonia (a lung infection that occurs when foreign material, like food or liquid, is inhaled into the lungs instead of being swallowed).<br><br>During an interview on 5/7/25 at 2:49 p.m. with the Director of Nursing (DON), the DON stated she would expect staff to always check PEG tube placement before enteral feeding to make sure the feeding formula would go in the stomach. The DON further stated that the resident would be the risk for possible aspiration pneumonia or regurgitation of feeding formula if the PEG tube placement was not checked before enteral feeding.<br><br>A review of the facility's policy and procedures titled, Enteral Tube Feeding via Syringe (Bolus), revised 11/2018, indicated, Steps in the Procedure .7. Verify placement of tube. 8. If anything suggests improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician. 9. When correct tube placement has been verified, flush tubing with at least 30 mL warm water (or prescribed amount) . |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, and record review, the facility failed to ensure safe and proper delivery of respiratory care consistent with the facility's policy and procedures (P&P) for one out of 14 sampled residents (Resident 3) when:<br><br>1. Resident 3's physician's order for oxygen therapy was not followed; and,<br><br>2. Resident 3's oxygen nasal cannula (NC- a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils) was not changed every seven days.<br><br>These failures had the potential to result in unsafe and unsanitary delivery of oxygen to Resident 3 and to not achieve her highest practicable well-being.<br><br>Findings:<br><br>1. A review of Resident 3's clinical record indicated Resident 3 was admitted April of 2025 and had diagnoses that included congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), chronic obstructive pulmonary disease (COPD- a group of diseases that causes airflow blockage and breathing-related problems), pleural effusion (a condition where excessive fluid accumulates in the area between the lungs and the chest wall), and malignant neoplasm (cancer) of pleura (a membrane surrounding the lungs).<br><br>A review of Resident 3's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 4/18/25, indicated Resident 3 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 3 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 3's MDS Health Conditions, dated 4/18/25, indicated Resident 3 experienced shortness of breath or trouble breathing when lying flat. A review of Resident 3's MDS Special Treatments, Procedures, and Programs, dated 4/18/25, indicated Resident 3 had received oxygen therapy on admission and while she was a resident in the facility.<br><br>A review of Resident 3's care plan, revised 4/22/25, indicated, The resident has oxygen therapy r/t [related to] COPD. A review of Resident 3's care plan intervention, dated 4/13/25, indicated, OXYGEN SETTINGS: O2 [oxygen] via NC per MD [medical doctor] orders.<br><br>A review of Resident 3's physician's order, dated 4/16/25, indicated, OXYGEN: Administer continuous oxygen at 3 LPM (liters per minute- unit of measurement for oxygen administration flow rate)(may titrate [measure and adjust] O2 to maintain saturation [percentage of oxygen carried in the blood] above 92% [percent- measurement of one part in every hundred]) via NASAL CANNULA at all times for COPD. every shift Document LPM and O2 saturation.<br><br>During a concurrent observation and interview on 5/5/25 at 10:14 a.m. with Resident 3, in Resident 3's room, Resident 3 was lying on bed, awake, and was on oxygen via nasal cannula with the oxygen concentrator (machine) set at 4.5 lpm. Resident 3 stated she uses oxygen all the time and the nurses adjust the settings of it.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 5/5/25 at 10:45 a.m. with Licensed Nurse (LN) 3, in Resident 3's room, LN 3 confirmed that Resident 3's oxygen was set at 4.5 lpm.<br><br>A review of Resident 3's clinical record did not indicate that Resident 3's oxygen was being titrated.<br><br>During another concurrent observation and interview on 5/6/25 at 8:59 a.m. with Resident 3, in Resident 3's room, Resident 3 was lying on bed, awake, and was on oxygen via nasal cannula with the oxygen concentrator set at 4.5 lpm.<br><br>During a concurrent observation and interview on 5/6/25 at 9:50 a.m. with LN 2, in Resident 3's room, LN 2 confirmed that Resident 3's oxygen was set at 4.5 lpm. LN 2 then confirmed that the order for Resident 3 was only at 3 lpm with an order for titration. LN 2 also confirmed that Resident 3's oxygen was not being titrated. LN 2 stated Resident 3's oxygen setting should be at 3 lpm per the doctor's order. LN 2 also stated that if Resident 3's oxygen setting is being titrated, it should be documented in the resident's chart and the doctor should be notified.<br><br>2. A review of Resident 3's physician's order, dated 4/18/25, indicated, OXYGEN: Change .oxygen tubing and nasal cannula once a week. Label accordingly (use orange label sticker with LN initials and date). every night shift every Fri [Friday].<br><br>During a concurrent observation and interview on 5/5/25 at 10:14 a.m. with Resident 3, in Resident 3's room, Resident 3 was lying on bed, awake, and was on oxygen via nasal cannula which was labelled 4/19/25.<br><br>During a concurrent observation and interview on 5/5/25 at 10:45 a.m. with LN 3, in Resident 3's room, LN 3 confirmed that Resident 3's oxygen nasal cannula was labelled 4/19/25 which was already more than 2 weeks. LN 3 stated the nasal cannula should be changed every week for infection control.<br><br>During an interview on 5/7/25 at 11:28 a.m. with the Director of Staff Development (DSD), the DSD stated oxygen orders should be followed as prescribed, and that there should always be documentation that the oxygen is being titrated, and the doctor should be notified of titration. The DSD also stated the resident would be at risk for oxygen toxicity (lung damage that happens from breathing in too much extra supplemental oxygen) if the physician's order is not followed. The DSD further stated that oxygen tubing should be changed every seven days, and that the resident would be at risk of infection if the nasal cannula was not changed every seven days.<br><br>During an interview on 5/7/25 at 2:49 p.m. with the Director of Nursing (DON), the DON stated she would expect nurses to follow doctors order for oxygen administration and if the oxygen is being titrated, she would expect documentation of the titration and communication to the doctor. The DON further stated she would expect nasal cannula to be changed every seven days for infection control.<br><br>A review of the facility's P&P titled, Oxygen Administration, revised 10/2010, indicated, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's P&P titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised 11/2011, indicated, Infection Control Considerations Related to Oxygen Administration .5. Change the oxygen cannula and tubing every seven (7) days, or as needed. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview and record review, the facility failed to ensure:<br><br>1. Controlled substance medications (medication with a high potential for abuse and addiction) were accurately accounted for on the medication administration record (MAR) and the Controlled Drug Record (CDR, an accountability record) for one of six randomly selected residents (Residents 288);<br><br>2. Controlled drug shift-to-shift count records (a record used to reconcile inventory of controlled medications in the medication cart by the off-going and on-coming nurse during a shift change) were routinely signed by the off-going and on-coming nursing shifts;<br><br>3. The narcotic emergency kit (e-kit; a kit/box containing medications and supplies for immediate use or during a medical emergency) was replaced according to facility policy and procedure (P&P) after use;<br><br>4. Routine medication for one of 14 sampled residents (Resident 3) was available for administration.<br><br>These failures resulted in the facility not having accurate accountability of controlled medications, potential for abuse or misuse of these medications, the potential for emergency medications to be unavailable when needed, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions.<br><br>Findings:<br><br>1. Resident 288 had a physician's order for tramadol (a narcotic medication to treat pain) 50 milligrams (mg, a unit of measurement), give 0.5 tablet by mouth every 8 hours as needed for moderate (4-6) to severe (7-10) pain, dated 5/4/25. The CDR indicated tramadol was removed from the medication cart on the following dates and times, but their respective administrations were not documented on the MAR: 0.5 tablet on 4/25/25 at 7:45 p.m. and 0.5 tablet on 4/29/25 at 7:42 p.m. The MAR indicated 0.5 tablet was administered to Resident 288 on 4/30/25 at 7:41 p.m. but the removal of the medication from the cart was not documented on the CDR.<br><br>During an interview on 5/5/25 at 10:03 a.m. with Licensed Nurse 1 (LN 1), LN 1 stated whenever a controlled drug was administered to a resident, nursing staff were expected to document the resident's pain level and location then sign out the medication on the CDR and MAR. He stated it was expected to document on both the CDR and MAR to ensure accuracy of controlled medication inventory.<br><br>During a concurrent interview and record review on 5/6/25 at 4:11 p.m. with Director of Nursing (DON), Resident 288's CDR and MAR dated April 2025 were reviewed. DON confirmed the identified discrepancies and stated every tablet removed from the medication cart should have been documented on the CDR. She stated the administration should have been documented on the MAR as well. DON stated not documenting on both the CDR and the MAR could place a resident at risk for not having adequate pain management.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Controlled Medications, dated March 2018, the P&P indicated, Procedures . D. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1. Date and time of administration. 2. Amount administered. 3. Signature of the nurse administering the dose, completed after the medication is actually administered.<br><br>2. During a concurrent interview and record review on 5/6/25 at 10:37 a.m. with LN 2, the controlled drug shift-to shift count records for the Back Hall dated May 2025 were reviewed. LN 2 confirmed there were missing signatures for the on-coming and off-going nursing shifts. She stated nurses were expected to sign the record to indicate the controlled medication count was completed between shift change, everything was in order, and no discrepancies were identified. She stated nurses should have been mindful to sign at beginning and end of their shift with the other nurse.<br><br>During a concurrent interview and record review on 5/6/25 at 4:08 p.m. with DON, the controlled drug shift-to-shift count records dated May 2025 for Front and Back Hall Medication Carts were reviewed. The Back Hall record indicated three missing signatures, and the Front Hall record indicated one missing signature by the off-going and on-coming nurse for various shifts. DON acknowledged and confirmed the finding and stated nursing staff were expected to sign before and after their shift to confirm all controlled medications were accounted for.<br><br>During a review of the facility's P&P titled, Controlled Medications, dated March 2018, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility .<br><br>During a review of the facility's document titled, Controlled Drug Count Record, used to ensure controlled drug accountability from shift to shift, the document indicated at the top, Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of medication counted is in agreement with the quantity stated on the controlled drug administration record.<br><br>3. During a concurrent interview and inspection on 5/5/25 at 10:04 a.m. of Medication Cart 1 with LN 1, a narcotic e-kit with a red plastic tie (indicating it had been opened) was identified. Inside the e-kit were two logs, indicating medication had been removed from the e-kit twice. LN 1 confirmed the finding and stated e-kits were to be reordered from the pharmacy as soon as they were opened but it had not.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Emergency Pharmacy Service and Emergency Kits, dated 3/2018, the P&P indicated, Procedures . E. The emergency supply is maintained at a designated area, along with a list of supply contents as follows . 4) Emergency Schedule 2 controlled substances are kept at designated nursing stations or the medication room, as determined by the facility, under double lock in a sealed, portable container. This kit is optional. The kit is examined at the time of the shift count. The off-going nurse is responsible for reordering the kit, and reports such to the on-coming nurse if the kit is found to have been opened at the time of the shift count . G. As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the kit by transmitting the entire order for the resident and indicating that the first dose was used from the kit . K. If exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening. If replacing used medications, the replacement doses are added to the kit within 72 hours of opening.<br><br>4. A review of Resident 3's medical record indicated the following physician's orders for Ozempic (a medication used to treat diabetes):<br><br>- Ozempic 2 mg/dose subcutaneous (under the skin) pen injector 8 mg/3 ml: inject 2 mg subcutaneously (under the skin) one time a day every Mon for DM2 (Diabetes type 2, a type of diabetes where the body does not respond properly to insulin), ordered 4/18/25 to 5/5/25<br><br>- Ozempic 2 mg/dose subcutaneous pen injector 8 mg/3 ml: Inject 2 mg subcutaneously one time a day every Fri for DM2, ordered 5/5/25, start 5/9/25<br><br>A review of Resident 3's MAR dated April 2025 indicated she received her weekly doses on 4/21/25 and 4/27/25 (every Monday).<br><br>A review of Resident 3's MAR dated May 2025 indicated she was due for her weekly dose on 5/5/25 but the nurse documented an administration note and the medication was not administered to the resident as was scheduled.<br><br>A review of the administration note dated 5/5/25 at 10:01 indicated, Pending for pharmacy delivery.<br><br>During a concurrent interview and record review on 5/7/25 at 12:01 p.m. with LN 2, Resident 3's May 2025 MAR and notes were reviewed. LN 2 confirmed Resident 3 was not administered her scheduled dose of Ozempic on 5/5/25 because the medication was pending delivery from the pharmacy. She then stated she recalled that the medication was supplied by the family and that communication should have been made with them to ensure the resident did not miss a dose. LN 2 reviewed Resident 3's record but was unable to find documentation that the family had been contacted to supply the medication. LN 2 stated she needed to follow up on it.<br><br>During a concurrent interview and record review on 5/7/25 at 12:51 p.m. with the DON, Resident 3's May MAR and notes were reviewed. DON stated the notes indicated the medication was pending pharmacy delivery. She stated when the last dose was administered, the facility asked her son if he could bring the medication. She stated the expectation was that before the last dose is administered, when the last dose is administered and before the next dose is due that it would be communicated with the family that the medication needs to be brought to the facility. She stated she expected nursing staff to document the communications with the family in the resident's record. DON reviewed the record and stated she did not see any communication made with the family.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy, dated 3/2018, the P&P indicated, Procedures . 2 . a. Reorder medication three to four days in advance of need to assure an adequate supply is on hand .<br><br>During a review of the facility's P&P titled, Establishing Pharmacy Services, dated 3/2018, the P&P indicated, Policy: Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications . |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 14 sampled residents (Resident 3) was free from unnecessary medication when Resident 3 received insulin glargine (a type of long-acting insulin to treat diabetes) without adequate monitoring. This failure had the potential to result in the worsening clinical conditions of Resident 3.<br><br>Findings:<br><br>A review of Resident 3's medical record indicated she was admitted to the facility on [DATE] with diagnoses including urinary tract infections, congestive heart failure (a condition where the heart cannot pump effectively to meet the body's needs), glaucoma (increased pressure in the eye leading to vision loss or blindness) and diabetes type 2 (a chronic condition that affects how your body uses sugar for energy).<br><br>A review of Resident 3's physician's orders indicated the following:<br><br>- Insulin glargine 100 units/milliliter (u/ml, a unit of measurement): Inject 8 unit subcutaneously at bedtime for DM2 (diabetes type 2) hold for FSBS (fingerstick blood sugar) <100. Notify MD/NP if FSBS<100 or >300, ordered from 4/12/25 to 4/21/25<br><br>- Insulin glargine 100 units/ml: inject 15 units SQ (subcutaneous, under the skin) at bedtime for DM, hold for FSBS<110 notify MD/NP if FBS<100 or >300, ordered 4/21/25<br><br>During a concurrent interview and record review on 5/7/25 at 12:57 p.m. with Director of Nursing (DON), Resident 3's progress notes and Medication Administration Records (MARs) dated April 2025 and May 2025 were reviewed. DON confirmed Resident 3's MARs indicated her blood sugar readings taken at 2100 (9 p.m. , when insulin glargine was scheduled to be administered) were above 300 milligrams/deciliter (mg/dl, a unit of measurement) on the following dates: 310 mg/dl on 4/27/25, 341 mg/dl on 5/1/25, 311 mg/dl on 5/2/25, and 329 mg/dl on 5/5/25. DON stated she would expect nursing staff to have notified the physician or nurse practitioner as indicated in the order on those dates. DON reviewed Resident 3's medical record for documentation that they were notified of high blood sugar readings and stated, No I don't see any.<br><br>During a concurrent interview and record review on 5/7/25 at 1:07 p.m. with DON, Resident 3's orders for monitoring of high and low blood sugar were reviewed. DON stated there should have been monitoring parameters in place to monitor Resident 3 for signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). DON reviewed Resident 3's orders and stated she only saw an order to monitor for signs and symptoms of hypoglycemia and not hyperglycemia.<br><br>During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated, Policy heading: Medications are administered in a safe and timely manner, and as prescribed .<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Obtaining a Fingerstick Glucose Level, revised 10/2011, the P&P indicated, Documentation: The person performing this procedure should record the following information in the resident's medical record . 6. The blood sugar results. Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on sliding scale coverage, and/or physician intervention is needed to adjust insulin or oral medication dosages), etc . Reporting: 1. Report results promptly to the supervisor and the attending physician . 3. Report other information in accordance with the facility policy and professional standards of practice. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview, and record review, the facility had a 5.56% error rate when two medication errors out of 36 opportunities were observed during a medication pass for two of nine Residents (Residents 1 and 12). This failure resulted in medications not given in accordance with the manufacturer's specifications and potential to affect the residents' clinical conditions.<br><br>Findings:<br><br>During a medication pass observation on 5/5/25 at 11:32 a.m. with Licensed Nurse 1 (LN 1), LN 1 was observed preparing insulin lispro (a fast-acting insulin to treat diabetes) pen for Resident 12. LN 1 removed the cap from the pen, twisted the needle on, then dialed the dose knob to 1 unit. LN 1 did not prime (a process to ensure the pen measures and delivers the correct dose) the insulin pen before he dialed the dose.<br><br>During a second medication pass observation on 5/5/24 at 11:37 a.m. with LN 1, LN 1 was observed preparing insulin lispro for Resident 1. LN 1 removed the cap from the pen, twisted the needle on, then dialed the dose knob to 8 units. LN 1 did not prime the pen before he dialed the dose.<br><br>During an interview on 5/5/25 at 1:58 p.m. with LN 1, LN 1 stated the process for preparing the insulin pens was to twist off the cap, put the needle on, then dial the correct dose. He confirmed he did not prime the insulin pens prior to dialing the dose and was not aware that it was a necessary step in preparing the medication.<br><br>During an interview on 5/6/25 at 3:47 p.m. with Director of Nursing (DON), DON stated nursing staff were expected to prime insulin pens with 2 units before dialing the dose.<br><br>A review of the manufacturer's labeling for insulin lispro pen, revised 5/2012, indicated, Follow these instructions for each injection . 2. Priming Humalog KwikPen (brand for insulin lispro). Caution: If you do not prime before each injection, you may get too much or too little insulin. A. Pull of Outer Needle Shield. Do not throw away. Pull off Inner Needle Shield and throw away. B. Dial 2 units by turning the Dose Knob C. Point Pen up. Tap cartridge Holder to collect air at top. D. With needle pointing up, push Dose Knob in until it stops and 0 is seen in the Dose Window. Hold Dose Knob in and count to 5 slowly. Priming is complete when a stream of insulin appears from the needle tip and you have counted to 5 slowly. If a stream of insulin does not appear, repeat priming steps 2 B-D up to four times. If the Pen still does not prime, change the needle and repeat the priming steps above. Note: If you do not see a stream of insulin from the tip of the needle and the Dose Knob becomes hard to push, then change the needle and prime the Pen.<br><br>During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated, Policy heading: Medications are administered in a safe and timely manner, and as prescribed . |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation and interview, the facility failed to ensure refrigerated medications and biologicals were stored at temperatures in accordance with facility policy and procedure (P&P). This failure had the potential for residents to receive dangerous or inadequate treatment for their medical conditions, leading to further health complications.<br><br>Findings:<br><br>During an inspection of the Medication Storage Room refrigerator on 5/7/25 at 11:40 a.m. with the Director of Nursing (DON), the temperature was observed on the thermometer at 28°F. Inside the refrigerator were various types of insulin (medication to treat diabetes), and Afluria Quadrivalent (flu vaccine). DON confirmed the temperature was 28°F, in the freezing range indicated by the thermometer. She stated the medications in the refrigerator were to be stored at 36°F to 46°F.<br><br>A review of an article by ConsumerMedSafety.org (a nationally recognized medication safety organization) indicated, Safety Tips for Storing Insulin . Do not keep insulin in places that freeze. Never store insulin products in a freezer. If insulin is frozen, do not use even after thawing. Freezing temperatures will breakdown the insulin and then it will not work well to lower your blood sugar. (https://www.consumermedsafety.org/insulin-safety-center/insulin-basics/storage-of-insulin; accessed 5/13/25)<br><br>A review of the manufacturer's labeling for Afluria Quadrivalent (undated) indicated, 16.2 Storage and Handling: Store refrigerated at 2-8°C (36-46°F). Do not freeze. Discard if product has been frozen.<br><br>During a review of the facility's P&P titled, Medication Storage in the Facility, dated 3/2018, the P&P indicated, Procedures . K. Medications requiring 'refrigeration' or 'temperatures between 2°C (36°F) and 8°C (46°F)' are kept in a refrigerator with a thermometer to allow temperature monitoring . N. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. O. Medication storage conditions are monitored by facility staff on a monthly basis and corrective action taken if problems are identified. |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>Based on observation, interview and record review, the facility failed to ensure Dietary Aide (DA) 1 and DA 2 had the appropriate skill set to safely perform the daily operations of the food and nutrition services department when:<br><br>1. DA 1 and DA 2 were unable to verbalize the proper procedure of manual dishwashing by the 2-Compartment sink (cross refer to F812, #6), and<br><br>2. DA 2 was unable to verbalize and demonstrate the proper testing and correct concentration of the sanitizer of dishwashing with the machine (cross refer to F812, #7).<br><br>These failures had the potential to place 31 out of 33 highly susceptible residents who consumed food from the facility kitchen at risk for food borne illness.<br><br>Findings:<br><br>1. An interview with DA 1 and Dietary Manager (DM) regarding manual dishwashing by using the 2-compartment sink on 5/5/25 at 10:14 a.m. was conducted. DA 1 stated the steps for the 2-compartment sink manual dishwashing were rinse, wash, and sanitize. DA 1 was not sure of the water temperature of the wash and rinse steps, the immersion time for the dishes in the sanitizer, and the correct concentration of the sanitizer. DM prompted DA 1 for the answers by using the posted instructions on the wall. Confirmed with DM and he agreed the staff, especially the dishwasher, needed to have good knowledge about the procedure for manual dishwashing.<br><br>During an interview with DA 2 on 5/6/25 at 9:26 a.m., DA 2 stated the process of 2-compartment sink manual dishwashing involved washing, rinsing, and sanitizing. DA 2 stated the water temperatures for the wash and rinse steps were 120 degrees Fahrenheit (F). She stated the immersion time for the dishes in the sanitizer was 20 seconds, and the concentration of the sanitizer was 50 ppm.<br><br>During an interview with RD on 5/6/25 at 3:29 p.m., RD stated the staff should have a good knowledge about manual dishwashing because the procedure replaced the dishwashing machine if not working in case of emergency.<br><br>A review of facility P&P titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, indicated the process involved washing, rinsing, sanitizing, and air-dried, and .sanitizer solution .must read 200 ppm . immerse all washed items (in the sanitizer solution) for at least 60 seconds .<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. An observation and concurrent interview with DA 2 on 5/6/25 at 9:20 a.m. for the process of dishwashing by the machine was conducted. DA 2 stated the washing and rinsing water temperatures should be 120-140 degrees F. She demonstrated the process with the machine and the final temperature for the washing cycle was 125 degrees F, and the rinsing cycle was 127 degrees F. DA 2 was not able to state the method to show the effectiveness of the sanitizer of the dishwashing. DA 2 stated using the test strip to test the concentration of the sanitizer with prompt. She was not able to answer the correct concentration of the sanitizer. DA 2 demonstrated using the test strip to test the concentration level. She dipped the test strip in the sanitizer during the washing cycle, and the test strip did not register any color (the change of color shows the levels of concentration of the sanitizer). Then she used the same test strip to test three times until the color was changed. By prompt, she used the new test strip to test again after the washing and rinsing cycles were completed. The test strip showed the concentration was 50 ppm (parts per million - a measurement unit for the concentration of the sanitizer), but she stated the concentration should be 200 ppm.<br><br>During an interview with RD on 5/6/25 at 3:29 p.m., RD acknowledged the issue above and stated the staff, especially dishwashers, should be able to know the dishwashing procedure which the dishes would be washed and sanitized properly to avoid food borne illness.<br><br>A review of facility P&P titled, Dishwashing, dated 2023, indicated, .the Chlorine (sanitizer for dishwashing machine) should read 50-100 ppm on dish surface in final rinse (after the wash and rinse cycles). The proper chorine level is crucial in sanitizing the dishes .<br><br>A review of the test strip vial with instruction, it stated, .to remove strip of paper from vial, dip strip into solution to be tested, without agitation and compare immediately with color chart on label. This color indicates approximate strength of the solution in parts per million (ppm) available chlorine. Time for test 1 second . There were four different colors that indicated different levels of concentration with 10 ppm, 50 ppm, 100 ppm, and 200 ppm.<br><br>A review of job description of dietary aides, dated 6/2020, it indicated dietary aides should .perform dishwashing/cleaning procedures .prepare food, etc., in accordance with sanitary regulations as well as with our established policies and procedures .ensure that the department is maintained in a clean and safe manner .<br><br>A review of DA 1's employee file with his date of hire (DOH) was on 1/9/25 for the dietary aide position. The document titled, Verification of Job Competency Demonstration - Dietary Aides, completed for the year of 2025 by DM, indicated DA 1 was competent on the category, Emergency dish washing procedure and when to use it. An interview with DM on 5/7/25 at 10:06 a.m., DM confirmed and stated DA 1 was competent on the emergency dish washing procedure.<br><br>A review of DA 2's employee file with her DOH was on 4/21/20 for the dietary aide position. The document titled, Verification of Job Competency Demonstration - Dietary Aides, completed for the year of 2025 by DM, indicated DA 2 was competent on the categories of Sanitation method used in dish machine and proper concentration and Emergency dish washing procedure and when to use it. It indicated DA 2 was competent for both categories with verbal and demonstration methods.<br><br>A review of departmental document titled, Food and Nutrition Services In-Service, Topic: 3-compartment sink, completed on 3/3/2025, given by DM, indicated DA 1 and DA 2 attended.<br><br>(continued on next page) |

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| | 055417 | A. Building<br>B. Wing | 05/08/2025 |

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| Saylor Lane Healthcare Center | 3500 Folsom Boulevard<br>Sacramento, CA 95816 |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of departmental document titled, Food and Nutrition Service In-Service, Topic: Dishwashing Machine, completed on 2/17/25, given by DM, indicated DA 2 attended.<br><br>A review of job description of dietary manager, dated 6/2020, it indicated the DM should, .shall oversee facility .assist in the development of an participate in the planning, conducting, .in-service training classes that provide instructions on how to do the job, and that ensure a well-educated food services department . monitor food services service personnel to assure that they are following established safety regulations in the use of equipment and supplies .ensure that all food services service personnel follow established departmental policies and procedures . |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>Based on observation, interview and record review, the facility failed to ensure the menu was followed for the therapeutic diet during lunch on 5/6/25 when:<br><br>1. Five residents (Resident 1, 8, 10, 19 and 139) with mechanical soft (MS) texture diets (a diet consisting of soft, moist foods for people who have chewing and/or swallowing difficulties) received a smaller portion of mechanical soft meatballs.<br><br>2. Resident 16 with fortified diets (added calories and/or protein) did not get fortified foods with Resident 16's meal.<br><br>These failures had the potential to result in compromising the medical and nutrition status of 6 out of 31 residents who received meals from the facility kitchen.<br><br>Findings:<br><br>During the lunch meal distribution on 5/6/25 beginning at 12:05 p.m., it was noted as follows:<br><br>1. During an interview with [NAME] (CK) on 5/6/25 at 9:37 a.m. before meal distribution started, CK stated the fortified foods for lunch on 5/6/25 were to give extra one ounce (oz.) of gravy on the meat and extra ½ oz. of melted margarine on the vegetables.<br><br>Resident 16 with fortified diet did not receive extra one oz. of gravy on the meatballs and extra ½ oz. of melted margarine on the vegetables.<br><br>2. Five residents (1, 8, 10, 19 and 139) with MS texture diets received two oz. (#16 scoop<br><br>of MS meatballs.<br><br>During an interview with CK on 5/6/25 at 12:34 p.m., CK confirmed and stated he used #16 scoop (two oz.) to serve the MS meatballs for the residents with MS texture diets. A concurrent review of facility spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) titled, Spring Cycle Menus, Week 2 Tuesday, indicated that MS texture diet should receive #10 scoop (three oz.) of MS meatballs.<br><br>During an interview with Registered Dietitian (RD) on 5/6/25 at 3:29 p.m., RD acknowledged the issues found above during the meal distribution. She stated the staff, or CK should follow the fortification as indicated in the spreadsheet. She further explained the fortified food provided extra calories to the residents who needed the extra nutrition. If the fortified foods were not provided, those who needed them may lead to at risk of weight loss.<br><br>RD stated the CK needed to follow the spreadsheet to provide the correct portion (scoop) size for the food to the residents. RD further stated providing the wrong portion size of the meat may affect wound healing and/or limit the protein for the residents to meet their protein need.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility policy and procedures titled, Menu Planning, dated 2023, indicated, .The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician's orders .<br><br>A review of the facility document titled, Dietary Supervisor - Job Duties and Responsibilities, dated 6/2020, indicated the therapeutic and regular diets and menus should be followed per the physician's orders.<br><br>A review of facility document titled, Job Description: Cook, dated 9/1/23, indicated, .Essential job functions . follow recipes and prepares foods that correspond to menu cycles and recipes .Inspect trays following meal service to monitor and record resident acceptance of menu items .able to understand and to follow written and verbal directions including menus, tray tickets .<br><br>A review of facility document titled, Dietary Aide-Job Duties and Responsibilities, dated 1/10/2025, indicated, . Food services .served food in accordance with established portion control procedures .assist in checking diet trays before distribution . |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food safety when:<br><br>1. The ice machine was not clean per manufacturer's guidance,<br><br>2. The reach-in freezer was not clean,<br><br>3. The blade of the can opener was not well maintained,<br><br>4. The cutting boards had deep grooves,<br><br>5. Several metal pans were stacked wet and stored in the clean and ready-to-use storage areas,<br><br>6. Dietary Aide (DA) 1 and DA 2 were unable to verbalize the proper procedure of manual dishwashing with the 2-compartment sink,<br><br>7. DA 2 was unable to verbalize and demonstrate the proper testing and correct concentration of the sanitizer for the dishwashing with the dishwashing machine and<br><br>8. DA 3 was noted with long artificial nails with gem décor.<br><br>These failures had the potential to cause food contamination which could cause food borne illnesses for 31 out of 31 medically vulnerable residents who consumed food from the facility kitchen.<br><br>Findings:<br><br>1. During an observation and concurrent interview with Maintenance Supervisor (MS) on 5/6/25 at 11 a.m., MS stated he was responsible for doing deep cleaning (cleaning and sanitizing the machinery parts on the top section of the ice machine and ice storage bin on the bottom section of the machine with chemical solutions designed to remove lime scale and mineral deposits and to remove algae and slime, then sanitize with chemical agent) of the ice machine monthly. He stated the last deep cleaning was completed on 4/17/25. He further stated the water filter was changed every six months.<br><br>MS dissembled the top (machinery) part of the ice machine; it was noted there were black substances on the inside of the water curtain (a plastic cover rest on the ice making panel to redirect the ice to the ice storage bin), and the substances could be removed when wiping with paper towel. The water trough (a plastic tray under the evaporator unit) was detached and observed there were pink substances on the side and could be removed when wiping the paper towel. There were significant black substances found on the bottom of the evaporator unit (a unit where to make ice). The black substances were hard to remove by wiping with paper towel and were rough to touch. MS confirmed the findings and agreed the ice machine was dirty.<br><br>MS explained the deep cleaning steps of the ice machine as followed:<br><br>1.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Discard the ice from the ice storage bin,<br><br>2.<br><br>Dissemble the removable components (water curtain and water trough) to clean with descaler (cleaner) solution and then sanitize them with sanitizer (MS stated the water level probe and the ice thickness probe could not be removed, therefore, he did not dissemble them to clean and sanitize.),<br><br>3.<br><br>Use the descaler and sanitizer to clean and sanitize the components, wall and ice storage bin,<br><br>4.<br><br>Assemble the parts (water curtain and water trough) together,<br><br>5.<br><br>Pour the descaler solution in the water reservoir and run the cleaning cycle (MS confirmed and stated he only used the descaler to run the cleaning cycle, and he stated No, when asked if he used any other solution to run different kind of cycle.) and<br><br>6.<br><br>After the cleaning cycle is done, turn on ice mode to start making ice. Discard the first batch of ice, and the second batch would be ready to use.<br><br>During an interview with Registered Dietitian (RD) on 5/6/25 at 3:29 p.m., RD stated the ice machine needed to be cleaned to prevent bacteria or other dirt getting into the ice that may possibly cause food borne illness.<br><br>A review of [Manufacturer's Name] Ice Machines Installation, Operation and Maintenance Manual, dated 2/2020, indicated, .Ice machine cleaner/descaler is used to remove lime scale and mineral deposits .sanitizer disinfects and removes algae and slime .Parts removal for detailed descaling and sanitizing .remove the water curtain .remove the ice thickness probe .remove water trough .remove the water level probe .remove the water distribution tube(s) . It further indicated when cleaning and sanitizing needed to pay attention to the following areas: side walls, base (area above water trough), evaporator plastic parts (including top, bottom and sides), and the ice storage bin. The ice machine needed to run the cleaning cycle with descaler solution and then run the sanitizing cycle with sanitizer solution after the components put back together.<br><br>A review of facility policy and procedure (P&P) titled, Ice Machine Cleaning Procedures, dated 2023, indicated, .the ice machine needs to be cleaned and sanitized monthly .the internal components cleaned monthly .Information about the operation, cleaning and care of the ice machine can be obtained from owner's manual .<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | According to 2022 FDA (Food and Drug Administration) Food Code, on section 4-602.11 Equipment Food-Contact Surface and Utensils, it stated equipment like ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms (a living thing that is so small it must be viewed with a microscope, such as bacteria or algae).<br><br>In addition, on Section 4-202.11 Food-Contact Surfaces, it stated, .The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food-contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts . and .Multiuse Food-Contact Surfaces shall be: 1. Smooth; 2. Free of breaks, open seams, cracks, chips, inclusions, pits .<br><br>2. During an observation of the reach-in freezer on 5/5/25 at 9:13 a.m., it was noted there were brown liquid spills on the top of the freezer, the top shelf, on the card board boxes on the middle shelf, on the bottom of the freezer, and the spill splashed on the freezer door. The liquid spills were sticky when touched and able to remove by wiping using paper towel.<br><br>During an interview with [NAME] (CK) on 5/5/25 at 9:25 a.m., CK confirmed and stated the spills and splashes were from the explosion of the soda can. He further stated the staff usually would clean up spills immediately and the staff checked the cleanliness every morning and evening.<br><br>During an interview with RD on 5/6/25 at 3:29 p.m., RD stated the freezer should be clean with no spills. She further stated the staff should clean up the spills immediately.<br><br>A review of facility P&P titled, Refrigerator and Freezer, dated 2023, indicated, .Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods .wipe up spills immediately .<br><br>3. During the kitchen observation and a concurrent interview with CK on 5/5/25 at 9:41 a.m., it was noted that the blade of the can opener had discoloration and the blade surface metal part worn off. CK confirmed and stated the blade was old and needed to be replaced. He further stated the metal worn off could potentially lead to physical contamination and that the piece of metal may fall into the food.<br><br>A review of facility P&P titled, Can Opener and Base, dated 2023, indicated, Proper sanitation and maintenance of the can opener .is important to sanitary food preparation. Metal shavings and shredding can result from a dull cutting blade or worn out cogwheel .Replace blade on can opener, as needed .<br><br>4. During the kitchen observation and a concurrent interview with CK on 5/5/25 at 9:30 a.m., it was noted two cutting boards (red and brown color coded) with significant deep grooves on the surfaces. CK confirmed and stated the cutting boards were old and should be replaced.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview with RD on 5/6/25 at 3:29 p.m., RD stated the boards with deep grooves needed to be replaced. She further stated the deep grooves made the boards hard to clean and may trap food or bacteria that cause contamination.<br><br>A review of undated facility P&P titled, Cutting Board Maintenance Policy and Procedure, indicated, . Inspection and Replacement .cutting boards must be inspected for deep grooves, stains, warping, or cracking .boards that cannot be fully cleaned or have significant surface damage must be removed from service and replaced immediately .<br><br>5. During the kitchen inspection and a concurrent interview with CK on 5/5/25 at 9:38 a.m., it was noted there were six full sheet metal pans that were stacked wet and stored in the clean and ready-to-use storage areas. CK confirmed and stated the pans and dishes needed to be completely air-dried before stored away.<br><br>During an interview with RD on 5/6/25 at 3:29 p.m., RD stated the dishes and pans need to be air-dried before stored away to prevent bacteria growth.<br><br>A review of facility P&P titled, Dishwashing, dated 2023, indicated, .Dishes are to be air dried in racks before stacking and storing .<br><br>6. DA 1 and DA 2 were unable to verbalize the proper procedure of manual dishwashing by the 2-compartment sink when:<br><br>a. During an interview with DA 1 and Dietary Manager (DM) on 5/5/25 at 10:14 a.m., DA 1 stated if the dishwashing machine was not working, he would switch to manual dishwashing with the 2-Compartment sink. DA 1 stated first he would soak the dishes, then the following steps were rinse, wash and sanitize, he repeated the same steps three times when asked for confirmation. DA 1 was not sure of the water temperature for the wash and rinse steps. DM cued DA 1 with the posted manual dishwashing instruction on the wall and DA 1 stated the temperature should be at least 110 degrees Fahrenheit (F). DA 1 could not answer the immersion time for the dishes in the sanitizer. DM cued DA 1 again with the posted instruction and DA 1 stated the immersion time should be 60 seconds. DA 1 did not know the correct concentration of the sanitizer until DM 1 cued him to read the poster and DA 1 stated 200 ppm (parts per million - a measurement unit for the sanitizer solution).<br><br>Confirmed with DM and he agreed the staff, especially the dishwasher, needed to have good knowledge about the procedure for manual dishwashing.<br><br>b. During an interview with DA 2 on 5/6/25 at 9:26 a.m., DA 2 stated she would start to use the 2-Compartment sink for dishwashing when the dishwashing machine was not working. DA 2 stated the steps were to wash, rinse and sanitize. She stated the water temperatures for the wash and rinse steps were 120 degrees F. DA 2 stated she used a big tub served as the third compartment for the sanitizer solution for the sanitizing step and the immersion time of the dishes was 20 seconds. She stated by using the test strip to check the concentration of the sanitizer and the correct concentration should be 50 ppm.<br><br>During an interview with RD on 5/6/25 at 3:29 p.m., RD stated the staff should have a good knowledge about manual dishwashing because the procedure replaced the dishwashing machine if not working in case of emergency.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A review of facility P&P titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, indicated the process involved washing, rinsing, sanitizing, and air-dried, and .sanitizer solution .must read 200 ppm . immerse all washed items (in the sanitizer solution) for at least 60 seconds .<br><br>7. During an observation and concurrent interview with DA 2 on 5/6/25 at 9:20 a.m., DA 2 verbalized and demonstrated the process of dishwashing by the machine. DA 2 stated the temperatures for the washing and rinsing cycles in the dishwashing machine were 120-140 degrees F. She demonstrated the process with the machine and the final temperature for the washing cycle was 125 degrees F and the rinsing cycle was 127 degrees F.<br><br>DA 2 could not answer when asked how she ensured if the sanitizer was effective during dishwashing with the machine. She stated that by using the test strip to test the concentration of the sanitizer with prompt. She could not answer the correct concentration of the sanitizer for testing by using the test strip. DA 2 demonstrated using the test strip to test the concentration level. She used the test strip to test the concentration during the washing cycle and the test strip did not register any color (the change of color shows the levels of concentration of the sanitizer). Then she used the same test strip to test three times until the color was changed. Then she used the new strip by cueing to test again after the washing and rinsing cycles were completed. The test strip showed the concentration was 50 ppm, but DA 2 stated the concentration should be 200 ppm.<br><br>During an interview with RD on 5/6/25 at 3:29 p.m., RD acknowledged the issue above and stated the staff, especially dishwashers, should be able to know the dishwashing procedure which the dishes would be washed and sanitized properly to avoid food borne illness.<br><br>A review of facility P&P titled, Dishwashing, dated 2023, indicated, .the Chlorine (sanitizer for dishwashing machine) should read 50-100 ppm on dish surface in final rinse (after the wash and rinse cycles). The proper chorine level is crucial in sanitizing the dishes .<br><br>A review of the test strip vial with instruction, it stated, .to remove strip of paper from vial, dip strip into solution to be tested, without agitation and compare immediately with color chart on label. This color indicates approximate strength of the solution in parts per million (ppm) available chlorine. Time for test 1 second . There were four different colors indicating different levels of concentration with 10 ppm, 50 ppm, 100 ppm, and 200 ppm.<br><br>8. During the kitchen inspection on 5/6/25 at 9:17 a.m., it was noted DA 3 had long (approximately one inch) artificial nail with gems décor. Observed DA 3 was using bare hands to touch the food contact surfaces of the pans, clean dishes from the clean side of the dishwashing machine, and the ready-to-use utensils at 10:24 a.m., 11:25 a.m., and 11:35 a.m. respectively.<br><br>During an interview with DM on 5/6/25 at 12:56 p.m., DM acknowledged and stated the long artificial nails were not acceptable and DA 3 should not have artificial nails, and the nails should be trimmed.<br><br>During an interview with RD on 5/6/25 at 3:29 p.m., RD stated she preferred the kitchen staff to keep their fingernails short and trimmed. She further stated the artificial nails, and the gems décor had potential to fall into the food and cause contamination.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A review of facility P&P titled, Dress Code, dated 2023, indicated, .fingernails kept short and well groomed . no nail polish .<br><br>According to Food and Drug Administration (FDA) Food Code 2022, Section 2-302.11 Maintenance, indicated, (A). Food Employees shall keep their fingernails trimmed, filed, and maintained so the edges and surfaces are cleanable and not rough .(B) Unless wearing intact gloves in good repair, a food employee may not wear fingernail polish or artificial fingernails when working with exposed food .<br><br>In addition, on Section 2-301.12 Cleaning Procedure, indicated, .the greatest concentration of microbes exists around and under the fingernails of the hands .The area under the fingernails .by far the largest concentration of microbes on the hand and it is also the most difficult area of the hand to decontaminate . |

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| Saylor Lane Healthcare Center | 3500 Folsom Boulevard<br>Sacramento, CA 95816 |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>Based on observation, interview and record review, the facility failed to provide a clean environment for the residents and visitors when one out of one garbage dumpster, located outside the facility, was not closed securely due to deformed dumpster lids.<br><br>This failure had the potential for an unsafe environment for the residents and visitors due to possible pest infestation and spread of diseases in the facility.<br><br>Findings:<br><br>During a concurrent observation and interview with [NAME] (CK) on 5/5/25 at 9:44 a.m., observed one out of one dumpster was covered with its two lids. However, the lids were bowed away from the edge of the dumpster and leaving a one- to two-inch gap in between. The deformed lids lacked the integrity to securely cover the bin. There were a few bags of trash with few flies flying around the trash inside the dumpster observed. CK confirmed and stated the lids needed to close tightly and agreed the lids were deformed. He further stated the dumpster should be closed tightly with its lids. CK stated he would call the waste management company to get new replacement.<br><br>During an interview with Registered Dietitian (RD) on 5/6/25 at 3:29 p.m., RD stated the dumpster needed to be closed or sealed tightly with the lids to prevent rodents getting in the dumpster.<br><br>A review of undated facility policy and procedure titled, Trash and Dumpster Management Policy and Procedure, Commercial Kitchen, it indicated, .Dumpster lids must remain closed at all times .Dumpster area inspections should occur weekly and be documented .<br><br>According to the Food and Drug Administration (FDA) Food Code 2022, Section 5-501.15 Outside Receptacle, referenced 7/23/24, (A) Receptacles and waste handling units for refuse .used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 33 residents when:<br><br>1. A staff handled resident's food with bare hands;<br><br>2. Clean linen touched the floor and touched employee's clothes;<br><br>3. Safe infection control practices were not followed for cleaning and disinfecting a shared glucometer (a device used to measure blood sugar) in-between resident care and aseptic technique was not followed during medication preparation;<br><br>4. Nursing staff did not perform hand hygiene when moving from one route of medication administration to another and after handling a contaminated medical device;<br><br>5. A facility staff held Resident 15's 5/5/25 lunch meal with bare hands;<br><br>6. Resident 3's nebulizer (machine that turns liquid medicine into a mist that can be easily inhaled) face mask was not changed every seven days;<br><br>These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure of residents to germs, and may cause infection among residents, staff, and visitors.<br><br>Findings:<br><br>1. A review of Resident 142's admission Record, indicated, Resident 142 was admitted to the facility on [DATE] with diagnosis that included legal blindness (a level of visual impairment that limits the activities performed by individuals without assistance), need for assistance with personal care and difficulty walking.<br><br>A review of Resident 142's MDS Section B - Hearing, Speech, and Vision, indicated, Resident 142 had a score of 4 for vision, which indicated, severely impaired vision.<br><br>During a concurrent observation and interview inside the room of Resident 142 with CNA 1 on 5/5/25 at 1:05 p.m., CNA 1 delivered Resident 142's meal tray and assisted him with his lunch. CNA 1 picked up the taco from Resident 142's plate with her bare hands, placed it in Resident 142's hands, instructed him to eat, and Resident 142 ate his taco. CNA 1 acknowledged she held Resident 142's taco with her bare hands. CNA 1 stated she should not hold Resident 142's food with her bare hands to promote infection control.<br><br>2. During a concurrent observation and interview inside the clean laundry room with Laundry Aide 1 (LA 1) on 5/7/25 at 10:42 p.m., as LA 1 was folding the white clean linen, the clean linen touched her clothes and the floor. LA 1 stated as she clutched the clean linen close to her body, that it was okay for the clean linen to touch her clothes.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with the Housekeeping and Laundry Supervisor (HLS), on 5/7/25 at 9:54 a.m., the HLS stated LA 1's clothes should not touch the clean linen or the floor. The HLS further stated that the floor was contaminated, and LA 1 should wash the linens again.<br><br>During an interview with the DON on 5/7/25 at 3:50 p.m., the DON stated, CNA 1 should not hold Resident 142's food with her bare hands as an infection control protocol. The DON also stated that LA 1 should keep the clean linen away from her clothes and off the floor when folding it to keep it clean. The DON continued, LA 1 should use the laundry basket while folding the clean linens, to keep if off the contaminated/dirty floor.<br><br>A review of the facility's policy and procedure, titled Hand Hygiene for Staff Providing Feeding Assistance, undated, indicated, Purpose: To prevent the transmission of infection and ensure safe and sanitary conditions while assisting residents with feeding, by enforcing strict hand hygiene practices among staff .<br><br>A review of the facility's policy and procedure, titled Departmental (Environmental Services) - Laundry and Linen revised date January 2014, indicated, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen .<br><br>3. During a medication pass observation on 5/5/25 at 11:33 a.m. with Licensed Nurse 1 (LN 1), LN 1 was observed measuring Resident 12's blood sugar level with an Evencare G3 glucometer. LN 1 placed the glucometer into a black plastic tray, went into the resident's room, measured the resident's blood sugar then went to clean the glucometer and tray. LN 1 removed one cleaning and disinfecting wipe from the container, then wiped both the tray and the glucometer. LN 1 then prepared Resident 12's insulin lispro (a fast-acting insulin) pen. LN 1 removed the cap from the pen, then attached a needle onto the rubber seal without first sanitizing and disinfecting it.<br><br>During a second medication pass observation on 5/5/25 at 11:37 a.m. with LN 1, LN 1 was observed measuring Resident 1's blood sugar with the same glucometer. Once the resident's blood sugar was measured, LN 1 removed one sanitizing and disinfecting wipe from the container and used it to clean both the black plastic tray used to carry the glucometer and the device itself. LN 1 then prepared Resident 1's insulin lispro pen. LN 1 removed the cap from the pen, then attached a needle onto the rubber seal without first sanitizing and disinfecting it.<br><br>During a third medication pass observation on 5/5/25 at 11:48 a.m. with LN 1, LN 1 was observed measuring a Resident 17's blood sugar with the same glucometer. Afterwards, LN 1 used one wipe to clean the black plastic tray and the glucometer.<br><br>During an interview on 5/5/25 at 1:58 p.m. with LN 1, LN 1 stated he was not aware of any special steps taken to clean or disinfect the insulin pen rubber seal prior to placing the needle on. He stated it was a simple process; he would twist off the cap, put the needle on, then dialed the dose. He stated he did not ever wipe the pen rubber seal with an alcohol pad prior to placing a needle on. LN 1 stated there had not been any training regarding proper sanitizing and disinfecting of blood glucose monitors. He stated nursing staff were to use their judgement to determine if one wipe was adequate for sanitizing and disinfecting multiple surfaces.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/6/25 at 3:44 p.m. with Director of Nursing (DON), DON stated nursing staff were educated to sanitize and disinfect the glucometers before, after and in-between residents. She stated nursing staff were expected to use a new wipe for each type of surface or device that was cleaned.<br><br>A review of an article published by the Centers for Disease Control and Prevention (CDC) titled, Considerations for Blood Glucose Monitoring and Insulin Administration, the article indicated, Recommend practices in healthcare settings . Blood glucose meters . If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, it should not be shared.<br><br>A review of the operations manual for EvenCare G3's indicated, Cleaning and Disinfecting . Step 1. Wash hands with soap and water. Step 2. Put on single-use medical protective gloves. Step 3. Inspect for blood, debris, dust, or lint anywhere on the meter. Blood and bodily fluids must be thoroughly cleaned from the surface of the meter. Step 4. To clean the meter, use a moist (not wet) lint-free cloth dampened with a mild detergent. Wipe all external areas of the meter including both the front and back surfaces until visibly clean. Avoid wetting the meter test strip port. Step 5. To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes .<br><br>During a review of the manufacturer's labeling for insulin lispro pen, dated 5/2012, the labeling indicated, Follow these instructions for each injection 1. Preparing the Humalog Kwikpen [brand name for insulin lispro pen] A. Pull Pen Cap to remove B. Remove Paper Tab from Outer Needle Shield. C. Push capped needle straight onto the Pen. Screw needle on until secure . Use an alcohol swab to wipe the Rubber Seal on the end of the Cartridge Holder.<br><br>During a review of the facility's policy and procedure (P&P) titled, Obtaining a Fingerstick Glucose Level, revised 10/2011, the P&P indicated, Steps in the Procedure . 18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice.<br><br>4. During a medication pass observation on 5/6/25 at 8:11 a.m. with LN 2, LN 2 observed preparing and administering medications to Resident 18, including bicalutamide (a hazardous chemotherapeutic medication used to treat prostate cancer) 50 milligrams (mg, a unit of measurement), Breyna (an inhaler to treat asthma) 160/4.5 microgram (mcg, a unit of measurement) inhaler, and Refresh Tears (an eye drop used to lubricate dry eyes) 1% eye drops. LN 2 prepared the medications in separate plastic cups and placed the medications in a tray that she carried into the Resident 18's room. LN 2 put on gloves to administer the oral medications first, then administered two puffs from the inhaler to the resident. LN 2 used a tissue to wipe the inhaler then administered the resident's eye drops without changing gloves or performing hand hygiene in-between.<br><br>During an interview on 5/6/25 at 10:29 a.m. with LN 2, LN 2 stated that best practice during the medication pass for Resident 18 would have been to perform hand hygiene and change gloves between administering the oral medications and eye medications.<br><br>During an interview on 5/6/25 at 3:44 p.m. with DON, DON stated she had educated nursing staff to perform hand hygiene between care for different residents and between administration of medication through different routes.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Handwashing/Hand Hygiene, revised 8/2019, the P&P indicated, Policy Interpretation and Implementation . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations . k. After handling used dressings, contaminated equipment, etc.<br><br>During a review of the facility's policy P&P, revised 4/2019, the P&P indicated, Policy Interpretation and Implementation . 24. Staff follows established facility infection control procedures (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.<br><br>5. A review of Resident 15's clinical record indicated Resident 15 was admitted April of 2025 and had diagnoses that included malnutrition (state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly), and need for assistance with personal care.<br><br>A review of Resident 15's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 4/13/25, indicated Resident 15 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 15 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 15's MDS Functional Abilities, dated 4/13/25, indicated Resident 15 needed setup or clean-up assistance with eating.<br><br>During an observation on 5/5/25 at 1:04 p.m. of Resident 15 and Certified Nurse Assistant (CNA) 1, in front of Resident 15's room, CNA 1 was observed assisting Resident 15 with her lunch meal. Resident 15's lunch meal was a vegetarian soft taco. CNA 1 placed the soft tortilla on her bare left hand and proceeded on filling it up with beans and vegetables using a fork. CNA 1 then held the soft taco with two bare hands and placed it on Resident 15's plate. CNA 1 was observed to have a small white dressing on the side of her left pointing finger.<br><br>During a subsequent interview on 5/5/25 at 1:08 p.m. with Resident 15, in front of Resident 15's room, Resident 15 stated she was not comfortable, and she did not like it when staff handled her taco with her bare hands.<br><br>During a subsequent interview on 5/5/25 at 1:12 p.m. with CNA 1, CNA 1 confirmed she held Resident 15's taco meal with her bare hands when she assisted Resident 15 with her meal. CNA 1 also confirmed she had a small white dressing on the side of her left pointing finger and stated she has a cut on her finger. CNA 1 stated it would be a risk for food contamination if resident's meal is handled with bare hands.<br><br>During an interview on 5/7/25 at 11:28 a.m. with the Director of Staff Development (DSD), the DSD stated handling ready-to-eat food such as taco with bare hands would place the resident at risk for infection. The DSD further stated it was okay for CNA 1 to assist residents with their meals as long as her cut was covered.<br><br>During an interview on 5/7/25 at 2:49 p.m. with the Director of Nursing (DON), the DON stated she would expect staff to use utensils and observe infection control properly when assisting residents with their meals.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code, section 3-301.11, titled, Preventing Contamination from Hands, 1/18/23 version, indicated, (B) .FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT.<br><br>A review of the US FDA 2022 Food Code, section 2-401.13, titled, Use of Bandages, Finger Cots, or Finger Stalls, 1/18/23 version, indicated, If used, an impermeable cover such as a bandage .located on the wrist, hand or finger of a FOOD EMPLOYEE working with exposed FOOD shall be covered with a single-use glove.<br><br>6. A review of Resident 3's clinical record indicated Resident 3 was admitted April of 2025 and had diagnoses that included congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), chronic obstructive pulmonary disease (COPD- a group of diseases that causes airflow blockage and breathing-related problems), pleural effusion (a condition where excessive fluid accumulates in the area between the lungs and the chest wall), and malignant neoplasm (cancer) of pleura (a membrane surrounding the lungs).<br><br>A review of Resident 3's MDS Cognitive Patterns, dated 4/18/25, indicated Resident 3 had a BIMS score of 13 out of 15 which indicated Resident 3 had an intact cognition. A review of Resident 3's MDS Health Conditions, dated 4/18/25, indicated Resident 3 experienced shortness of breath or trouble breathing when lying flat.<br><br>A review of Resident 3's physician's order, dated 4/24/25, indicated, Ipratropium-Albuterol Inhalation Solution [a combination medication used to treat COPD] 0.5-2.5 (3) MG [milligrams- unit of measurement] /3ML [milliliters- unit of measurement] .3 ml inhale orally every 6 hours for wheezing/SOB [shortness of breath].<br><br>During a concurrent observation and interview on 5/5/25 at 10:14 a.m. with Resident 3, in Resident 3's room, Resident 3's nebulizer face mask tubing was labelled 4/12/25. Resident 3 stated she last used her nebulizer this morning.<br><br>During a concurrent observation and interview on 5/5/25 at 10:45 a.m. with Licenses Nurse (LN) 3, in Resident 3's room, LN 3 confirmed that Resident 3's nebulizer face mask tubing was labelled 4/12/25 which was already more than 3 weeks. LN 3 stated Resident 3 uses her nebulizer four times a day. LN 3 stated the face mask tubing should be changed every week for infection control.<br><br>During an interview on 5/7/25 at 11:28 a.m. with the DSD, the DSD stated that nebulizer face mask should be changed every seven days because nebulizer is used to deliver medication directly into the lungs. The DSD further stated there would be a risk of infection if the nebulizer face mask was not changed every seven days.<br><br>During an interview on 5/7/25 at 2:49 p.m. with the DON, the DON stated she would expect nebulizer face mask to be changed weekly for infection control.<br><br>A review of the facility's policy and procedures (P&P) titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised 10/2010, indicated, 25. Change equipment and tubing every seven days, or according to facility protocol. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>Based on interview and record review, the facility failed to document and maintain records of COVID -19 (mild to severe, viral, respiratory infections) vaccination status for seven of 80 facility staff, Licensed Nurse 4 (LN 4), LN 5, Laundry Aide 2 (LA 2), Certified Nursing Assistant 6 (CNA 6), [NAME] 2 (CK 2), CNA 4, and CNA 5.<br><br>This deficient practice increased the risk for residents to acquire, transmit, or experience complications from COVID -19 infections, compromising the residents, and the visitor's safety.<br><br>Findings:<br><br>During a concurrent interview and record review with the Director of Staff Development (DSD) and Infection Control Nurse (IC) on 5/8/25/ at 12:11 p.m., the DSD and IC confirmed they did not find vaccination records for COVID -19 for 7 facility staff in their Employee Records. The DSD stated they offered immunizations such as COVID -19 to the newly hired employees during their first day of orientation in the facility. The DSD searched the Employee Records and did not find documentation of COVID -19 vaccination status for the following facility staff:<br><br>1. LN 4, date of hire 9/3/24;<br><br>2. LN 5, date of hire 1/14/25;<br><br>3. LA 2, date of hire 1/24/25;<br><br>4. CNA 6, date of hire 4/17/25;<br><br>5. CK 2, date of hire 4/13/23;<br><br>6. CNA 4, date of hire 4/1/25; and<br><br>7. CNA 5, date of hire 1/4/25.<br><br>During an interview with the Administrator on 5/8/25 at 12:25 p.m., the Administrator stated the facility supported and encouraged employees to get immunized with the COVID -19 vaccine for everyone's safety.<br><br>During an interview with the Nurse Consultant (NC) on 5/8/25 at 12:39 p.m., the NC stated it was recommended for the facility staff to get immunized with COVID -19 to prevent potential risk of respiratory infection.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a review of the facility's policy and procedure titled, Employee Infection and Vaccination Status, Revision Date, January 2024, indicated, Prior to or upon an employee's duty assignment, the facility will assess the status of an employee's vaccination against infectious conditions, screening for tuberculosis, and recent history of communicable diseases . and vaccinations are documented on the Employee Record of Vaccination . 1. Employees will be current with mandated vaccinations prior to performing direct resident care . |