STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056372	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Healthcare Center	105 Terracina Blvd. Redlands, CA 92373

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a risk on nutritional deficit care plan upon readmission to the facility for one of 21 sampled residents (Resident 46). This failure had the potential for not meeting nutritional goals, treatments, and services related to resident's medical, physical, mental, and psychosocial needs. Findings: During an observation and concurrent interview with Resident 46, in resident's room, on October 21, 2024, at 11:21 a.m., Resident 46 was noted to be pale and weak. It was also noted that the food on the lunch plate was untouched. Resident 46 stated that lately the food was not appetizing after staying in the hospital for a few days. During an interview with Resident 46's brother, on October 21, 2024, at 11:22 a.m., the brother stated that Resident 46 was on dialysis (process of removing excess water from the blood in people whose kidneys can no longer perform the function naturally) every Tuesday, Thursday, and Saturday. The brother also stated that Resident 46 just had a below the knee amputation (surgical removal of a body part) of his right leg due to gangrene (death of body cells) infection that developed at home. A review of Resident 46's Face Sheet (a document with resident's information), indicated that Resident 46 was readmitted to the facility on [DATE], with diagnoses which included Systemic Lupus Erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs), Dysphagia (difficulty swallowing), End Stage Renal Disease (a condition where the kidneys have permanently failed to function properly), and Dependence on Renal (kidney) Dialysis. A review of Resident 46's current Care Plan (individualized outline of specific care, interventions, and goals for a patient), on October 22, 2024, at 2:58 P.M., noted no care plan was developed to reflect Resident 46's nutritional status. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with Registered Nurse Supervisor (RNS) 1, on October 23, 2024, at 7:31 a.m., RNS 1 stated that Resident 46 had high risk for nutritional deficit due to multiple medical diagnoses that could lead to weight loss. RNS 1 confirmed that Resident 46 had no care plan related to nutritional status. RNS 1 stated that the importance of developing a care plan was to determine an appropriate intervention to prevent resident from weight loss. RNS 1 also stated that a Registered Nurse is responsible in developing a care plan during admission based on resident's needs. During an interview with the Director of Nursing (DON), on October 24, 2024, at 9:55 a.m., the DON stated that a plan of care on risk for nutritional deficit to resident on dialysis was important to implement interventions and to continuously monitor resident's nutritional status. The DON confirmed that Resident 46's care plan on risk for nutritional deficit was not initiated at the time of readmission. A review of the facility's undated policy and procedure titled, Care Plan and Care Plan Revisions, indicated, . PROCEDURES: 1. Care plan will be initiated within 24 hours upon admission . 4. Care plan will be initiated based on identified problem and medical change of condition.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an individualized care plan (a plan showing specific interventions to provide effective and person-centered care to meet the resident's needs) was developed for one of 21 sampled residents (Resident 69) to address the resident's ongoing issue of constipation. This failure had the potential to increase the risk of health complications which can lead to Resident 69's chronic discomfort and reduced quality of life. Findings: A review of Resident 69's face sheet (a document showing a summary of the resident's information) indicated Resident 69 was admitted to the facility on [DATE]. During a review of Resident 69's Minimum Data Set (MDS - a standardized assessment tool used to evaluate a resident's health status) - Version 3.0, dated September 16, 2024, the BIMS score (Brief Interview for Mental Status score - a number that indicates a person's cognitive function) indicated Resident 69 was cognitively intact. A review of Resident 69's Skilled Nursing Facility H&P (History and Physical - a reference document that provides concise information about a resident's history and examination findings at the time of admission), dated September 23, 2024, indicated the physician documented constipation as part of Resident 69's assessments. The plan showed to place Resident 69 on a bowel regimen which included administering routine and as needed medications. The medications included Senna, Colace, Miralax, Dulcolax, and Fleet Enema (medications used to treat constipation). A review of Resident 69's Skilled Nursing Facility - Progress Note, dated October 18, 2024, indicated on . 10/17: patient was seen in his room in bed, denies any new concerns except for ongoing constipation . During an interview with Resident 69 on October 21, 2024 at 10:05 AM, Resident 69 stated he last had a bowel movement three days ago. He took medications, but always had problems with being constipated. During a concurrent interview and record review on October 24, 2024 at 03:26 PM with LVN 2, Resident 69's care plans were reviewed. Resident 69's clinical record indicated the baseline and comprehensive care plans were developed. However, there was no documented evidence showing a care plan problem related to Resident 69's constipation was developed. LVN 2 confirmed Resident 69's constipation issue was present on admission and verified there was no documented evidence a care plan to address Resident 69's constipation was developed. LVN 2 stated any nursing staff could initiate a care plan if they identified a concern. LVN 2 stated the purpose of developing a care plan was to ensure the staff knew the plan of care for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy and procedure titled, Care plan and care plan revision, indicated .This facility will assure the completion of the resident assessment process enabling the development of an individualized comprehensive care plan for the resident . The procedures included .Care plan will be initiated within 24 hours upon admission and completed within 7 days and will monitor after comprehensive assessment .Care plan will be initiated based on identified problem and medical change of condition .Care plan will be reviewed by the team for needed update and/or resolved care plan will be discontinued upon review.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing activity program to meet the needs and interests of one of 21 sampled residents (Resident 83). The facility failed to provide Resident 83 with an individualized activity program which met his identified preferences of listening to music, keeping up with the news, and going outside for fresh air. This failure created the risk of not providing appropriate and individualized care to Resident 83 which can lead to cognitive and emotional decline as well as increased feelings of isolation. Findings: A review of Resident 83's face sheet (a document showing a summary of the resident's information) indicated Resident 83 was admitted to the facility on [DATE]. His primary language was English. During a review of Resident 83's Minimum Data Set (MDS - a standardized assessment tool used to evaluate a resident's health status) - Version 3.0, dated September 25, 2024, the BIMS score (Brief Interview for Mental Status score - a number that indicates a person's cognitive function) indicated Resident 83 had moderate cognitive impairment. Further review of the MDS Section F (a section of the MDS indicating the resident's daily and activity preferences) showed listening to music that he liked, keeping up with the news, and going outside to get fresh air when the weather was good were somewhat important to Resident 83. During a review of Resident 83's care plan (a plan showing specific interventions to provide effective and person-centered care to meet the resident's needs), a care plan problem was developed which indicated Resident benefits from 1:1 activity visit, dependent on others for all activity programming, expresses reluctance to attend group activities, needs transport to and from activity programming, prefers to initiate activities of choice independently, self isolates due to feeling depressed. The Interventions/Tasks showed to . Invite to and encourage activities with a low stimulation environment when available .It is somewhat important to the resident to go outside for fresh air when the weather is good. Resident cannot propel wheelchair independently. Assist outside for fresh air during nature walk .It is somewhat important to the resident to keep up with the news. Prefers to get news from news channel 7. Invite to coffee/news. Activity staff will deliver the daily chronicle every morning during stop by visits .It is somewhat important to the resident to listen to classical music. Invite to music programs. Offer a personal stereo .Provide 1:1 program to support in-room activities with supplies, conversation, and comfort . During an observation on October 21, 2024 at 09:37 AM, October 21, 2024 at 12:15 PM, October 21, 2024 at 12:51 PM, October 22, 2024 at 09:09 AM, October 22, 2024 at 10:08 AM, October 22, 2024 at 11:10 AM, and October 22, 2024 at 11:55 AM, Resident 83 was observed awake, lying in bed, and staring at the TV. However, the TV was off. There was no stereo, nor any in-room sensory stimulation observed. During a concurrent observation and interview with Resident 83 on October 23, 2024 at 08:07 AM, the TV was on; however, the program was set to a Spanish channel. When asked about activities, Resident 83 stated he liked to stay in his room but would like to go out sometimes. When asked if he liked listening to music, Resident 83 nodded. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nurse Assistant (CNA) 2 on October 23, 2024 at 08:40 AM, CNA 2 stated Resident 83 was in his room most of the time and ate in there. CNA 2 stated Resident 83 just looked at the ceiling and did not go to activities. Activity staff came in to talk to the resident sometimes, but he would stay in his room. CNA 2 also stated she had not seen the resident listening to music or going outside. During a review of Resident 83's daily activity log for October 2024, the log showed one-on-one activity was only offered three times during the month of October on October 3, 2024, October 14, 2024, and October 23, 2024. The log showed music was offered on October 14, 2024. However, there was no other documented evidence showing Resident 83's preferences of listening to music, keeping up with the news, and going outside were offered during the one-on-one room visits in October. During a concurrent interview and record review with the Activity Director (AD) on October 24, 2024 at 12:28 PM, the daily activity log for October was reviewed. The AD was asked about Resident 83's activities. The AD stated they offered activity materials and invited Resident 83 to group activities. Resident 83 liked to keep to himself, talked about his family, and expressed his worries. The activity staff mostly conversed with him. Resident 83 did not like to do much, so one-to-one room visits were provided. When asked about documentation regarding Resident 83's activities, the AD stated they documented the activities that were provided daily. They would visit Resident 83 throughout the day; however, they did not document every time they visited the resident. The AD verified the activities provided in the log did not reflect Resident 83's preferences. The AD stated they offered activities based on Resident 83's preferences, but the resident would sometimes refuse. The AD verified there was no documentation of the resident's refusal in the log. During a review of the facility's undated policy and procedure titled Activities Program, the document indicated, It is the policy of this facility to implement an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being, and independence. The procedures included 1. Activities are planned according to the residents' preferences, needs, and abilities. Every resident will be interviewed for preferences .9. Some activities can be adapted to accommodate the resident's change in functioning due to physical or cognitive limitations .e. Cognitive impairment (i.e., task segmentation, settings that recreate past experiences, smaller groups without interruption, one-to-one, etc .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure coordination and collaboration were practiced with contracted hospice agency when one of one resident admitted for hospice had no hospice plan of care available to facility staff. These failures had the potential to cause delay in treatment, miscommunication, and uncoordinated care for Resident 10. Findings: 1.During an initial tour observation on October 21, 2024, at 10:53 AM, inside resident's room, Resident 10 was lying on her low air loss mattress (LALM- a special bed to help prevent skin breakdown) with eyes closed. Resident 10 was receiving oxygen via nasal cannula (a thin, flexible tubing which delivers oxygen in small amounts through the nostrils)) connected to an oxygen concentrator (a medical device that provides a supply of oxygen to help people breathe easier). Resident 10's oxygen concentrator was set at 2.5 LPM (Liters Per Minute- unit of measure or dose). A review of Resident 10's face sheet (document which contains demographic and medical information) indicated she was admitted to the facility on [DATE], with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke), aphasia (language disorder that affects a person's ability to communicate), and chronic embolism (circulating blood clot) and thrombosis (blood clot) of unspecified deep veins of right lower extremity (leg). A review of Resident 10's physician's order dated October 23, 2024, indicated, Admit to [name of hospice agency] effective 10/18/2024. During a concurrent interview and record review with the Licensed Vocational Nurse (LVN) 6, on October 24, 2024, at 2:05 PM, LVN 6 reviewed Resident 10's hospice binder and verified that the Plan of Care/IDT (Interdisciplinary Team) Note section was empty. During a concurrent interview and record review with Minimum Data Set Nurse (MDSN), on October 24, 2024, at 2:57 PM, MDSN reviewed Resident 10's hospice binder and confirmed that there was no hospice plan of care. MDSN stated that the hospice agency should have a plan of care available to facility staff. During a concurrent interview and record review with the Social Service Director (SSD), on October 24, 2024, at 3:27 PM, the SSD showed the Hospice Plan of Care to the surveyor and stated she just received this document via email today around 3:07 PM and will put in the hospice binder. SSD also stated that the expectations were the care plans should have been secured in the hospice binder and available to the facility staff. SSD further stated it was important to have the hospice plan of care readily available because it was a means of communication between the hospice agency and the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Hospice Director of Patient Care Services (HDPCS), on October 25, 2024, at 8:18 AM, the HDPCS stated that the Hospice Plan of Care should have been secured in the hospice binder within 48-72 hours from admission to hospice or around last Monday (October 21, 2024). The HDPCS also acknowledged that it was missed and that was not acceptable. The HDPCS stated it was important that the hospice plan of care was available to facility staff as it was a form of communication between the hospice and facility. During an interview with the Director of Nursing (DON), on October 25, 2024, at 10:23 AM, the DON stated that her expectations were for hospice agency to provide the plan of care within 72 hours and for the facility to follow-up as needed. The DON also stated the hospice plan of care was important for the facility staff to know what kind of care and services were needed to ensure continuity of care. A review of the facility's Registered Nurse's Job Description, indicated, Our expectation is that you will perform your job in a manner consistent with our Core Values .ACCOUNTABILITY .OWNERSHIP . ESSENTIAL DUTIES AND RESPONSIBILITIES .Administer services within the applicable scope of nursing practice, which may include: .care of the dead/dying, .as appropriate and in accordance with applicable standard . Ensure that assigned CNAs [Certified Nursing Assistants] are aware of the resident care plan. Ensure that the CNAs refer to the resident's care plan prior to administering daily care to the resident . A review of the facility's Social Worker's Job Description, indicated, Duties and Responsibilities. Administrative Functions. Assists in planning, developing, organizing, implementing, evaluating, and directing the social service programs of this facility. Assist in the development, administering, and coordinating of department policies and procedures . Care Plan and Assessment Functions .Ensure that all social services personnel are aware of the care plan and that care plans are used in providing daily social services to the resident . Develop and maintain a good rapport with all services involved with the care plan to ensure that a team effort is achieved . A review of the facility's undated policy and procedure (P&P) titled, Section: Quality of Care; Administration. Subject: End of Life; Hospice indicated, POLICY: .Through continuing interdisciplinary assessment, individualized plans will be developed and implemented .PROCEDURES: .4. Hospice services will be offered as appropriate and as ordered by the physician. These services will be integrated into the overall individualized, interdisciplinary care plan. 5 .the facility will continue: a. To provide necessary care and services to assist the resident to achieve his or her highest practicable well-being .c. To update and implement an individualized, interdisciplinary plan of care. A review of the hospice agency's policy and procedure (P&P) titled, ENTRIES INTO THE CLINICAL RECORD revised April 2023, indicated, POLICY .Documentation in the clinical record will be timely, detailed, accurate, and reflect the care or services provided .PROCEDURE .1. A clinical record will be initiated and maintained for each patient receiving care or services, according to organization policies found in this manual, and will include at a minimum: .D. Initial plan of care, updated plans of care .E. Dates, times, and types of interventions, assessments, and coordination of care .18. For patients receiving services in a facility, clinical records to include, but not limited to plan of care, medication profile, calendar, CTI (Certification of Terminal Illness), Hospice Aide Care Plan/Instructions .must be provided to the facility within 72 hours .19. For patients receiving services in a facility, plan of care is completed within 5 days of start of care in collaboration with the Facility representatives, patient/family representative and hospice representative . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 10's Hospice Services Agreement, dated October 14, 2024, indicated, HOSPICE Plan of Care .must reflect the HOSPICE Patient and family goals and interventions based on the problems identified in the HOSPICE Patient assessments. The HOSPICE Plan of Care should reflect the participation of the HOSPICE, FACILITY, and the HOSPICE Patient and such patient's family .which includes: .(iii) measurable outcomes anticipated from implementing and coordinating the HOSPICE Plan of Care .2.2 HOSPICE Plan of Care. HOSPICE shall develop and maintain a written HOSPICE Plan of Care and retains responsibility for determining the appropriate HOSPICE plan of care. The HOSPICE Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the HOSPICE Plan of Care .2.3 Communication. HOSPICE and FACILITY shall communicate with one another regularly and as needed for each HOSPICE patient .2.4 HOSPICE Standards. Services provided by HOSPICE shall be provided in a timely manner and shall meet applicable professional standards and principles .2.14 Providing Information. HOSPICE shall promote open and frequent communication with FACILITY. HOSPICE shall provide the following information to FACILITY for each HOSPICE Patient: (a) HOSPICE Plan of Care .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care and services in accordance with professional standards of practice and the resident's plan of care when two of 21 sampled residents (Resident 10 and 36) oxygen therapies were not followed as prescribed by his physician. These failures had the potential to cause changes in Resident 10 and 36's respiratory status and affect their overall health and well-being. Findings: 1.During an initial tour observation on October 21, 2024, at 10:53 AM, inside resident's room, Resident 10 was lying on her bed with eyes closed. Resident 10 was receiving oxygen via nasal cannula (a thin, flexible tubing which delivers oxygen in small amounts through the nostrils) connected to an oxygen concentrator (a medical device that provides a supply of oxygen to help people breathe easier). Resident 10's oxygen concentrator was set at 2.5 LPM (Liters Per Minute- unit of measure or dose). A review of Resident 10's face sheet (document which contains demographic and medical information) indicated she was admitted to the facility on [DATE], with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke), aphasia (language disorder that affects a person's ability to communicate), and chronic embolism and thrombosis (blood clot) of unspecified deep veins of right lower extremity (leg). A review of Resident 10's History and Physical dated January 27, 2024, indicated, PHYSICAL EXAM . Neurological: Opens eyes to voice. Does not follow command at this time .CAPACITY: This resident does NOT have the capacity to understand and make decisions . During a subsequent observation on October 22, 2024, at 11:12 AM, inside resident's room, Resident 10 was lying on her bed asleep and turned towards her left side, with supporting pillows to her right. Resident 10 was receiving oxygen via nasal cannula attached to an oxygen concentrator at a rate of 2.5 LPM. During an observation on October 23, 2024, at 6:48 AM, inside resident's room, Resident 10 was lying on her bed asleep and turned towards her right side, with supporting pillows to her left. Resident 10 was receiving oxygen via nasal cannula attached to an oxygen concentrator at a rate of 2.5 LPM. A review of Resident 10's Physician's Order via PCC (Point Click Care - electronic health record) on October 22, 2024, at 7:10 AM, indicated, Resident 10 had the following order: Admit to [name of hospice agency] effective 10/18/2024 .Apply oxygen via NC [nasal cannula] at 3 LPM continuous to keep saturation at or above 90% every shift for low O2 (Oxygen) saturation . During a concurrent observation and interview with the Licensed Vocational Nurse (LVN) 1, on October 23, 2024, at 8:05 AM, LVN 1 checked Resident's 10's oxygen concentrator and stated it was set between 2.5-3.0 LPM. LVN 1 adjusted the oxygen concentrator regulator to deliver 3 LPM of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the LVN 1, on October 23, 2024, at 8:10 AM, LVN 1 reviewed Resident 10's physician's orders, and stated Resident 10's oxygen therapy order was 3 LPM via nasal cannula. LVN 1 stated that the oxygen therapy order was not followed. LVN 1 also stated that it was important to follow the doctor's order so as not to compromise resident's respiratory status. In a concurrent interview and record review with the Registered Nurse Supervisor (RNS) 1 on October 23, 2024, at 8:28 AM, the RNS 1 reviewed Resident 10's electronic health records and verified that oxygen therapy order was 3 LPM. RNS 1 stated that nurses were expected to follow the doctor's order for patient safety. During an interview with the Director of Nursing (DON) on October 23, 2024, at 12:56 PM, the DON stated that it was her expectations for nurses to follow the doctor's order. The DON also stated that it was important to follow the doctor's oxygen therapy order for resident to not have any respiratory distress. A review of Resident 10's Individual Care Plan, indicated, Has Oxygen Therapy r/t [related to] Ineffective gas exchange .Interventions .Apply oxygen via NC at 3 LPM continuous to keep saturation [amount of oxygen in the blood] at or above 90% . A review of the facility's Licensed Vocational Nurse's Job Description, indicated, Our expectation is that you will perform your job in a manner consistent with our Core Values .ACCOUNTABILITY .OWNERSHIP . POSITION SUMMARY: The primary purpose of your job position is to provide primary care to specific residents under the medical direction and supervision of the resident's attending physician's .ESSENTIAL DUTIES AND RESPONSIBILITIES .Implement and maintain established policies, procedures, .safety . Administer services within the applicable scope of nursing practice .as appropriate and in accordance with applicable standards, .Prepare and administer medications as ordered by the physician . A review of the facility's policy and procedure (P&P) titled, Resident Care . Subject: Oxygen, Use of, with a revised date of July 2022, indicated, POLICY: It is the policy of this facility to promote resident safety in administering oxygen . 2.During an initial tour observation on October 21, 2024, at 10:34 AM, in the resident's room, Resident 36 was awake, comfortably lying on her bed covered with a blanket. Resident 36 was receiving oxygen via nasal cannula (a thin, flexible tubing which delivers oxygen in small amounts through the nostrils) connected to an oxygen concentrator (a medical device that provides a supply of oxygen to help people breathe easier). Resident 36's oxygen concentrator was set at 2.5 LPM (Liters Per Minute- unit of measure or dose). A review of Resident 36's face sheet (document which contains demographic and medical information) indicated she was initially admitted to the facility on [DATE], with diagnoses that included essential hypertension (elevated blood pressure), atherosclerosis (build-up of fats and other substances in and on the artery walls) and non-[NAME] lymphoma (blood cancer). A review of Resident 36's History and Physical dated September 08, 2024, indicated, PHYSICAL EXAM . Respiratory: CTAB [lungs clear to auscultation bilaterally], bases diminished, On nasal cannula .OTHER: PLAN: Wean patient off oxygen as she was not any prior to hospitalization . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 36's Physician's Order via PCC (Point Click Care- electronic health record) on October 22, 2024, at 10:03 AM, indicated, Resident 36 had the following order: may have 2L [liters] of oxygen via nasal cannula to maintain oxygen above 90% . During a subsequent observation on October 22, 2024, at 11:09 AM, inside resident's room, Resident 36 was lying on her bed asleep and receiving oxygen via nasal cannula at a rate of 2.5 LPM. During a concurrent observation and interview with the Licensed Vocational Nurse (LVN) 1, on October 23, 2024, at 7:57 AM, LVN 1 stated that the morning shift started at 7 :00 AM. LVN 1 also stated that during change of shift rounds, nurses were expected to check the rate of oxygen delivered to residents as ordered by the doctor. LVN 1 checked Resident's 36's oxygen concentrator and stated it was set 2.5 LPM. LVN 1 adjusted the oxygen concentrator regulator to deliver 2 LPM of oxygen and stated it should be at 2 LPM. During a concurrent interview and record review with the LVN 1, on October 23, 2024, at 8:12 AM, LVN 1 reviewed Resident 36's physician's orders, and stated Resident 36's oxygen therapy order was 2 LPM via nasal cannula. LVN 1 stated that the oxygen therapy order was not followed. LVN 1 also stated that it was important to follow the doctor's order so as not to compromise resident's respiratory status. In a concurrent interview and record review with the Registered Nurse Supervisor (RNS) 1 on October 23, 2024, at 8:29 AM, the RNS 1 reviewed Resident 36's electronic health records and verified that oxygen therapy order was 2 LPM. RNS1 stated that nurses were expected to follow the doctor's order for patient safety. During an interview with the Director of Nursing (DON) on October 23, 2024, at 12:56 PM, the DON stated that it was her expectations for nurses to follow the doctor's order. The DON also stated that it was important to follow the doctor's oxygen therapy order for resident to not have any respiratory distress. A review of Resident 36's Individual Care Plan, indicated, Resident has altered cardiovascular status r/t [related to] hypertension, hyperlipidemia [high cholesterol level], CAD [Coronary Artery Disease- disease of the heart's major blood vessels], . At risk for cardiac distress . Interventions .Give oxygen as ordered by the physician . A review of the facility's Licensed Vocational Nurse's Job Description, indicated, Our expectation is that you will perform your job in a manner consistent with our Core Values .ACCOUNTABILITY .OWNERSHIP . POSITION SUMMARY: The primary purpose of your job position is to provide primary care to specific residents under the medical direction and supervision of the resident's attending physician's .ESSENTIAL DUTIES AND RESPONSIBILITIES .Implement and maintain established policies, procedures, .safety . Administer services within the applicable scope of nursing practice .as appropriate and in accordance with applicable standards, .Prepare and administer medications as ordered by the physician . A review of the facility's policy and procedure (P&P) titled, Resident Care . Subject: Oxygen, Use of, with a revised date of July 2022, indicated, POLICY: It is the policy of this facility to promote resident safety in administering oxygen .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, one of five Licensed Vocational Nurses (LVN 7) failed to demonstrate competency in medication administration for one of nineteen sampled residents (Resident 62). LVN 7 did not follow facility procedure when administering medication through the Gastrostomy tube (G-tube- a tube inserted into the stomach for the purpose of providing nutrition) for Resident 62. This failure had the potential to cause G-tube complications for Resident 62. Findings: During a review of Resident 62's admission Record (AR), dated October 25, 2024, the AR indicated Resident 62 was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty in swallowing) and Gastrostomy status (presence of a G-tube), among others. During an observation on October 23, 2024, at 5:48 AM, during medication pass, LVN 7 was observed pouring water mixed with the contents of a medication packet labeled Pantoprazole (medication that reduces acid in the stomach) 40 milligrams (mg- unit of measure) into a syringe. LVN 7 administered the medication through Resident 62's G-tube by pushing the plunger of the syringe. During an interview on October 23, 2024, at 6:05 AM, with LVN 7, LVN 7 stated the Pantoprazole should have been administered to Resident 62 by gravity and should not have been pushed into the G-tube with the syringe. During a concurrent interview and record review on October 25, 2024, at 9:22 AM, with the Director of Nursing (DON), Resident 62's Order Summary Report (OSR), dated October 25, 2024, was reviewed. The OSR indicated, Pantoprazole Sodium Oral Packet .give 40 mg via [by] G-tube in the morning . The DON stated Pantoprazole was not supposed to be pushed and should have been administered via flow of gravity. During a concurrent interview and record review on October 25, 2024, at 9:22 AM, with the DON, the facility's undated policy and procedure (P&P) titled, Specific Medication Administration Procedures was reviewed. The P&P indicated, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices .Enteral [food or drug administration via the human gastrointestinal tract] Tube Medication Administration Procedures . Oral medication(s) are administered through an enteral tube in a safe and accurate manner . Allow medication to flow down the tube via gravity . Do not push medications through the tube . The DON stated LVN 7 did not demonstrate competency in administering medication through the G-tube when she pushed the Pantoprazole and did not allow the medication to flow by gravity.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on interview and medical record review, the facility failed to ensure the Social Services Department followed up on a physician's order for a hospice evaluation for one of 21 sampled residents (Resident 30). This failure had the potential to delay hospice services for Resident 30. Findings: A review of Resident 30's Facesheet indicated an admission date of October 12, 2022. A review of Resident 30's Progress Note dated September 23, 2024, indicated diagnoses including dementia (progressive state of decline in mental abilities), history of stroke (damage to the brain caused by interrupted blood flow), aphasia (disorder that makes it difficult to speak), and major depressive disorder. The Progress Note further indicated Resident 30 did not have the capacity to understand and make decisions. A review of Resident 30's Order Summary Report dated August 28, 2024, indicated a hospice evaluation was ordered on July 8, 2024. A review of Resident 30's Progress Notes dated July 8, 2024, to October 23, 2024, indicated on July 8, 2024, Resident 30's family were aware of the resident's declining condition and agreeable to the physician's recommendation for a hospice evaluation. The Progress Notes did not indicate Social Services followed up with a hospice company or Resident 30's family regarding the evaluation for hospice services. During a concurrent interview and record review on October 24, 2024, at 10:08 AM, with the Case Manager (CM) and Social Services Director (SSD), Resident 30's medical record was reviewed. The SSD and CM verified there were no Progress Notes indicating Social Services followed up with a hospice company or family regarding the plan for hospice services. During an interview on October 25, 2024, at 8:53 AM, with the Director of Nursing (DON), the DON stated Social Services should have communicated with the family and hospice company for follow up on Resident 30's hospice order. A review of the job description for the Social Worker, revised date November 28, 2016, indicated the Social Worker Duties and Responsibilities included to refer resident/families to appropriate social service agencies when the facility does not provide the services or needs of the resident.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from unnecessary drugs when: 1. The adverse reactions for antibiotic medication were not monitored for one of 21 sampled residents (Resident 46). 2. Indication for an antibiotic medication was not clear and clarified with the doctor for one of 21 sampled residents (Resident 46). These failures had the potential to put the resident at risk of receiving unnecessary medications that could result in serious harm. Findings: 1. A review of Resident 46's Order Summary Report (a document with list of active physician's orders) for October 2024, indicated a medication order of Amoxicillin-Pot Clavulanate (a generic name of antibiotic medication) Tablet 500-125 MG (milligram - unit of measurement) Give 1 tablet by mouth every 12 hours for bacterial infection for 7 days, with a start date of October 20, 2024. During an interview with the Infection Preventionist (IP), on October 23, 2024, at 12:59 p.m., the IP stated that each resident on antibiotic therapy should be monitored for any adverse reactions for three days. The IP also stated that three-day monitoring should be documented every shift by a licensed nurse. During an interview and concurrent record review with the IP, on October 23, 2024, at 1:11 p.m., the IP was not able to locate the documentation of antibiotic monitoring in Resident 46's chart. The IP verified that antibiotic monitoring was not implemented by any of the licensed nurses. During an interview and concurrent record review with the Director of Nursing (DON), on October 23, 2024, at 1:19 p.m., the DON confirmed and verified that Resident 46 was not being monitored for antibiotic therapy. The DON stated that monitoring a resident on antibiotic was very important to determine any adverse reactions or allergies to medications. During an interview and concurrent record review with the IP, on October 24, 2024, at 3:48 p.m., the IP stated that at the beginning of antibiotic therapy, an infection surveillance (close monitoring) should also be initiated in addition to three-day monitoring to identify signs and symptoms of infections, and to determine the appropriate antibiotic treatment. The IP confirmed that based on Resident 46's medical records, infection surveillance was not initiated. A review of Resident 46's Face Sheet (document with resident's information), indicated Resident 46 was re-admitted to the facility on [DATE], with diagnoses which included Systemic Lupus Erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs), Dysphagia (difficulty swallowing), End Stage Renal Disease (a condition where the kidneys have permanently failed to function properly), and Dependence on Renal (kidney) Dialysis. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Antibiotic Stewardship, revised in January 2022, indicated, Procedure . 1. Leadership . b.Incorporate monitoring of antibiotic use, including the frequency of monitoring/review . 5. Tracking a. IP or designee will be responsible for infection surveillance and MDRO training. 2. During an interview with Resident 46's brother, on October 21, 2024, at 11:22 a.m., the brother stated that Resident 46 was on dialysis (process of removing excess water from the blood in people whose kidneys can no longer perform the function naturally) every Tuesday, Thursday, and Saturday. The brother also stated that Resident 46 just had a below the knee amputation (surgical removal of a body part) of his right leg due to gangrene (death of body cells) infection that developed at home. A review of Resident 46's Face Sheet (document with resident's information), indicated Resident 46 was re-admitted to the facility on [DATE], with diagnoses which included Systemic Lupus Erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs), Dysphagia (difficulty swallowing), End Stage Renal Disease (a condition where the kidneys have permanently failed to function properly), and Dependence on Renal (kidney) Dialysis. A review of Resident 46's Order Summary Report (a document with list of active physician's orders) for October 2024, indicated a medication order of Amoxicillin-Pot Clavulanate (a generic name of antibiotic medication) Tablet 500-125 MG (milligram - unit of measurement) Give 1 tablet by mouth every 12 hours for bacterial infection for 7 days, with a start date of October 20, 2024. The order did not indicate the site of bacterial infection. A review of Resident 46's Infection Surveillance (a document utilizing an infection control program that identifies resident's needs, infection control measures to help in preventing an outbreak) dated October 24, 2024, indicated that Resident 46 was on infection surveillance for skin, soft tissue (may be fat, muscles, nerves, or blood vessels), and mucosal (moist inner lining of some body organs) infections with antibiotic therapy. The Infection Surveillance also indicated that a pus (yellowish - white fluid matter containing dead blood cells due to bacterial infection) was present at a wound, skin, or soft tissue site. A review of Resident 46's Physician Discharge Summary (a document that communicates resident's care plan to the post-hospital care team) dated October 20, 2024, indicated that Resident 46 underwent below the knee amputation of his right leg, and was postoperatively managed and treated with intravenous (administered into veins) antibiotic. The Physician Discharge Summary further indicated that Resident 46 had a chest x-ray (test that creates images of structures inside your chest) and computed tomography (CT) scan (test that shows three-dimensional detailed images of the inside of the body), on October 20, 2024, which indicates a bilateral loculated pleural effusion (a medical condition when there is an abnormal accumulation of fluids on both lungs that may be caused by bacterial infection), recommending a seven-day course of Augmentin (a brand name of antibiotic medication) and follow-up with chest x-ray in four weeks. During an interview and concurrent record review with the Director of Nursing (DON), on October 25, 2024, at 10:50 a.m., the DON verified that based on physician's discharge summary and physician's order, Resident 46's antibiotic medication order should have the right indication of use. The DON further stated, We need to clarify the order with the doctor and should indicate that her antibiotic is for respiratory bacterial infection. The DON verified that the infection surveillance had incorrect information, and that the indication for antibiotic therapy was not clear and complete. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Infection Preventionist (IP), on October 25, 2024, at 10:59 a.m., the IP stated that antibiotic medication order should indicate the site of infection. A review of the facility's policy and procedure titled, Antibiotic Stewardship, revised in January 2022, indicated, Procedure . 1. Leadership . b.Incorporate monitoring of antibiotic use, including the frequency of monitoring/review . 5. Tracking a. IP or designee will be responsible for infection surveillance and MDRO training.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain professional standards for food service safety when: 1. Food crumbs, black grime, and trash were found on the floor under the steam table. 2. Food crumbs and thickener powder residue were present in the food preparation area. 3. Six wet scoops (dishers) were found stored inside the plastic container box. These failures had the potential to expose 78 of 84 highly susceptible residents who receives food from the kitchen to foodborne illnesses (illness caused by ingestion of contaminated food or beverages) due to cross-contamination (the transfer of harmful substances or disease- causing microorganisms to food). FINDINGS: 1. During an initial observation tour of the kitchen and interview with the Dietary Services Director (DSD), on October 21, 2024, at 7:50 AM, food crumbs, black grime and trash were found on the floor under the steam table. The DSD stated areas in the kitchen should be kept clean and free of crumbs, trash, and dirt. The DSD also stated the dietary staff did not do the regular cleaning. A concurrent interview and record review with the DSD on October 24, 2024, at 9:20 AM, the DSD reviewed and acknowledged the facility's undated policy and procedure (P&P), titled, General Cleaning of Food & Nutrition Services Department, indicated, Floors and Floor Mats .must be scheduled for routine cleaning and maintained in good condition .1. Floors must be mopped at least once per day . During a phone interview with the Registered Dietitian (RD), on October 24, 2024, at 9:45 AM, the RD stated that kitchen floors and under kitchen tables should always be kept clean. The RD further stated that the area under the steam table should be swept up regularly. A review of the FDA Federal Food Code 2022, 4-601.11 titled Equipment, Food- Contact Surfaces, Nonfood-Contact Surfaces and Utensils, indicated, .(C) Nonfood- contact surfaces of equipment shall be kept free of accumulation of dust, dirt, food residue and other debris. In addition, 4-602.13, indicated The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. 2. During an initial observation tour of the kitchen, and interview with the Dietary Services Director, on October 21, 2024, at 8:00 AM, food crumbs and thickener powder residue were present in the cook preparation area. The DSD stated that preparation areas should be kept clean and free of crumbs and powder residues. The DSD also stated the dietary staff did not do the regular cleaning. A concurrent interview and record review with the DSD on October 24, 2024, at 9:20 AM, the DSD reviewed and acknowledged the facility's undated policy and procedure (P&P), titled, Sanitation, indicated, .11. All utensils, counters, shelves, and equipment shall be kept clean . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a phone interview with the Registered Dietitian (RD), on October 24, 2024, at 9:45 AM, the RD acknowledged the cook preparation area should be kept clean. A review of the FDA Federal Food Code 2022, 4-601.11 titled Equipment, Food- Contact Surfaces, Nonfood-Contact Surfaces and Utensils, indicated, .(C) Nonfood- contact surfaces of equipment shall be kept free of accumulation of dust, dirt, food residue and other debris. In addition, 4-602.13, indicated The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. 3. During an initial observation tour of the kitchen and interview with the DSD, on October 21, 2024, at 8:15 AM, six wet scoops were found stored inside the plastic container box. The DSD stated kitchen utensils should be air dried before storing since moisture may produce bacteria. The DSD further stated the dietary staff did not air dry the large scoops before putting them back in the container. During a concurrent interview and record review with the DSD on October 24, 2024, at 9:20 AM, the DSD reviewed and acknowledged the facility's undated policy and procedure (P&P), titled, Sanitation, indicated, . 11. All utensils, counters, shelves, and equipment shall be kept clean .All items are air-dried, which means no water droplets are present . During a phone interview with the Registered Dietitian (RD), on October 24, 2024, at 9:45 AM, the RD stated utensils should not be sitting wet inside the containers since moisture harbors bacteria. All utensils should be cleaned and air dried prior to securing it to its container. The RD further stated the expectation is that dietary staff should follow infection control precautions for food safety. A review of the FDA Federal Food Code 2022, 4-901.11 indicated, Equipment and Utensils, Air-Drying Required .After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD; and (B) May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry. In addition, a review of the FDA Federal Food Code 2022, 4-903.11 indicated, (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide services in compliance with state requirements when Physician 1 did not complete a history and physical exam (H&P- a formal assessment of a resident done by a physician that includes a medical history, physical exam, and a summary of any tests) within the timeframe specified in the facility's policy for one of three sampled residents (Resident 341). This failure had the potential to prevent Resident 341 from receiving appropriate and timely care and services. Findings: A review of Resident 341's admission Record, dated October 25, 2024, indicated Resident 341 was admitted to the facility on [DATE] under the services of Physician 1, with diagnoses that included multiple fractures (a break or crack in a bone) of ribs on the left side, with interstitial pulmonary disease(a large group of diseases that cause scarring of the lungs), and depression (a mental health condition that causes a persistent low mood and loss of interest in activities), among others. A review of Resident 341's Skilled Nursing Facility H&P, dated October 8, 2024, indicated Physician 1 performed a history and physical examination for Resident 341 on October 8, 2024, six days after admission to the facility. During an interview on October 25, 2024, at 9:12 AM with the Director of Nursing (DON), the DON stated a resident's comprehensive medical condition, including their capacity to understand and make decisions, was determined through a physician's assessment documented in the resident's H&P. The DON stated physicians should complete an H&P for their residents within three days of admission. During a concurrent interview and record review on October 25, 2024, at 9:15 AM with the DON, the facility's undated policy and procedure (P&P) titled, Physician Services was reviewed. The P&P indicated, . Procedures .2. Physician services include, but are not limited to: A. A written report of a physical examination conducted within five (5) days prior to the admission or within seventy-two (72) hours following the admission . The DON stated Physician 1's H&P for Resident 341 should have been completed on October 5, 2024, and not October 8, 2024. The DON stated a delay in the physician's assessment could prevent Resident 341 from receiving appropriate care and services. A review of Barclays California Code of Regulations Title 22. Division 5. Chapter 3. Article 3. 72303, undated, indicated (b) Physician services shall mean those services provided by physicians responsible for the care of individual patients in the facility. Physician services shall include but are not limited to: (1) Patient evaluation including a written report of a physical examination within 5 days prior to admission or within 72 hours following admission.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure complete, accurate and consistent documentations in residents clinical records when: 1. One of 21 sampled residents (Resident 36's) Treatment Administration Record (TAR-a document that tracks the time and type of treatments administered to a patient) had multiple gaps/ missed documentations. 2. The POLST (Physician Orders for Life-Sustaining Treatment) Form for three of 21 sampled residents (Resident 10, 36, and 82) had missing information. These failures had the potential for residents to receive inconsistent care coordination and unmet care needs. Findings: During an observation on October 22, 2024, at 8:28 AM, in the resident's room, Resident 36 was awake, comfortably lying on her bed covered with a blanket. Resident was observed with indwelling foley catheter (IFC- a thin, flexible tube inserted into the bladder to drain urine) attached to a urine bag with yellow urine output noted. A review of Resident 36's face sheet (document which contains demographic and medical information) indicated she was initially admitted to the facility on [DATE], with diagnoses that included essential hypertension (elevated blood pressure), polyneuropathy (damage to nerves) and non-[NAME] lymphoma (blood cancer). A review of Resident 36's Physician's Order via PCC (Point Click Care- electronic health record) on October 23, 2024, at 1:22 PM, indicated, Resident 36 had the following orders: 1. CATHETER CARE: CLEANSE WITH SOAP and WATER and PAT DRY every shift. 2. MONITOR PROPER PLACEMENT OF CATHETER - NO KINKING OR COMPRESSION THAT COULD OBSTRUCT URINE FLOW TO GRAVITY BAG [BELOW BLADDER LEVEL] DURING CATHETER CARE every shift. 3. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MONITOR S/SX [Signs and Symptoms] OF INFECTION D/T [Due To] INDWELLING CATHETER USE: HEMATURIA, INCREASE IN URINE SEDIMENTS IN THE URINE, TEMP, FOUL ODOR, CLOUDY APPEARANCE IN THE URINE QSHIFT [every shift] AND NOTIFY MD [Medical Doctor] IF S/SX ARE PRESENT every shift. During a concurrent interview and record review with the Registered Nurse Supervisor (RNS) 2, on October 25, 2024, at 9:56 AM, The RNS 2 reviewed Resident 36's October 2024 Treatment Administration Record printed on October 23, 2024, at 1:56 PM and acknowledged there were gaps or missing documentations on the following treatments, dates and shifts: 1. CATHETER CARE: CLEANSE WITH SOAP and WATER and PAT DRY every shift. a. Day shift on October 15, 2024 b. PM shift on October 11, 12, 13, 14, 17, 19, and 22, 2024 c. Night shift on October 6, 13, 18, and 19, 2024 2. MONITOR PROPER PLACEMENT OF CATHETER- NO KINKING OR COMPRESSION THAT COULD OBSTRUCT URINE FLOW TO GRAVITY BAG DURING CATHETER CARE every shift. a. Day shift on October 15, 2024 b. PM shift on October 11, 12, 13, 14, 17, 19, and 22, 2024 c. Night shift on October 6, 13, 18, and 19, and 22, 2024 3. MONITOR S/SX OF INFECTION D/T INDWELLING CATHETER USE: HEMATURIA, INCREASE IN URINE SEDIMENTS IN THE URINE, TEMP, FOUL ODOR, CLOUDY APPEARANCE IN THE URINE QSHIFT AND NOTIFY MD IF S/SX ARE PRESENT every shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Day shift on October 15, 2024 b. PM shift on October 11, 12, 13, 14, 17, 19, and 22, 2024 c. Night shift on October 6, 13, 18, and 19, and 22, 2024 During an interview with the RNS 2 on October 25, 2024, at 9:58 AM, the RNS 2 stated that it was her expectations that after the care was provided, nurses should document immediately that the treatment was provided. RNS 2 also stated that it was not acceptable to have missing documentations in the client records and documentation was important because it meant that staff have completed and carried out the doctor's order. During an interview with the Director of Nursing (DON) on October 25, 2024, at 10:29 AM, the DON stated that it was her expectations for staff to complete their documentation. The DON also stated that this was important because if it was not documented it meant it was done. A review of the facility's Licensed Vocational Nurse's Job Description, dated 12/17/2021, indicated, Our expectation is that you will perform your job in a manner consistent with our Core Values . ACCOUNTABILITY .OWNERSHIP . POSITION SUMMARY: The primary purpose of your job position is to provide primary care to specific residents under the medical direction and supervision of the resident's attending physician's .ESSENTIAL DUTIES AND RESPONSIBILITIES .Chart nurses' notes in professional and appropriate manner that timely, accurately and thoroughly reflects the care provided to the resident . Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures and applicable state and federal regulations. A review of the facility's undated policy and procedure (P&P) titled, Catheter Care- Section: Resident Care: Subject: Catheter Care; Indwelling Urinary, indicated, POLICY: It is the policy of this facility that each resident with an indwelling urinary catheter will receive the necessary care and services related to minimizing the risk and promoting the highest practicable wellbeing . A review of the facility's undated policy and procedure (P&P) titled, Subject: Documentation and Charting, indicated, POLICY: It is the policy of this facility to provide: 1. An account of the resident's care, treatment, response to the care, signs and symptoms, etc., as well as the progress of the resident's care. 5. Assistant in the development of a Plan of Care for each resident. 6. A legal record that protects the resident, physician, nurse and the facility . 2. A review of Resident 10's face sheet (document which contains demographic and medical information) indicated she was admitted to the facility on [DATE], with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke), aphasia (language disorder that affects a person's ability to communicate), and chronic embolism (circulating blood clot) and thrombosis (blood clot) of unspecified deep veins of right lower extremity (leg). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 36's face sheet (document which contains demographic and medical information) indicated she was initially admitted to the facility on [DATE], with diagnoses that included essential hypertension (elevated blood pressure), polyneuropathy (damage to nerves) and non-[NAME] lymphoma (blood cancer). A review of Resident 82's face sheet (document which contains demographic and medical information) indicated she was initially admitted to the facility on [DATE], with diagnoses that included hypertensive heart disease (elevated blood pressure), malignant neoplasm of the ovaries (ovarian cancer) and type 2 diabetes mellitus (disease that occurs when the body can't produce or use insulin, resulting in high blood sugar levels). During a concurrent interview and record review with the Licensed Vocational Nurse (LVN) 5, on October 21, 2024, at 3:42 PM, LVN 5 reviewed Resident 10, 36, and 82's POLST and verified that the following information were missing or left blank: a. Resident 10 - Date Form Prepared:; Patient date of birth :; Section D INFORMATION AND SIGNATURES: Print Physician/NP [Nurse Practitioner]/ PA [Physician Assistant]:, Physician/NP/PA Phone #:; Physician/PA License #, NP Cert #:; Physician/NP/PA Signature: [required]:; and Date: . b. Resident 36- Section D INFORMATION AND SIGNATURES: Discussed with: .; Advance Directive Information .; Print Physician/NP/ PA:, Physician/NP/PA Phone #:; and Date: . c. Resident 82- Section D INFORMATION AND SIGNATURES: Print Physician/NP/PA:, Physician/NP/PA Phone #:; and Date:; Signature of Patient or Legally Recognized Decisionmaker .Print Name:; Relationship:; Date:; Mailing Address:; and Phone Number: During a subsequent interview with LVN 5, on October 21, 2024, at 3:47 PM, at the south nursing station, LVN 5 stated that the expectations were for the Registered Nurse Supervisor (RNS) or the admitting nurse to completely fill out the POLST form during admission because it was the resident's wish. During a concurrent interview and record review with the Registered Nurse Supervisor (RNS) 1, on October 23, 2024, at 11:41 AM, at the north nursing station, RNS 1 reviewed Resident 10, 36, and 82's POLST and stated he would not know who and when the doctor signed the POLST for Resident 36 as it was left blank. RNS 1 also stated he would not know if there was any advance directive for Resident 36 as this item was also left blank on the POLST form. RNS 1 also stated he would not know who and when the doctor signed the POLST form for Resident 82. RNS 1 stated that it was not acceptable to leave some of the items blank and that the expectations were for the form to be filled out completely. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Social Service Director (SSD), on October 23, 2024, at 12:06 PM, the SSD stated that nursing initiates the completion of POLST form on admission and the social services department confirm the information with the resident or representative the following day. SSD also stated that the expectations were that the POLST form be filled out because it is a means of communication and if information were missing it may cause a delay in treatment or miscommunication. During a subsequent interview with the SSD, on October 23, 2024, at 12:16 PM, the SSD stated that she reviewed residents POLST forms last week but only focused on the doctor's signature and missed the other information. During an interview with the Director of Nursing (DON) on October 23, 2024, at 12:42 PM, the DON stated that it was her expectations for admission nurse to complete the POLST form. DON also stated that it is facility's responsibility to check the form for completeness of information. A review of the facility's Registered Nurse's Job Description, dated 12/17/2021, indicated, Our expectation is that you will perform your job in a manner consistent with our Core Values .ACCOUNTABILITY . OWNERSHIP . POSITION SUMMARY: The primary purpose of your job position is to provide primary care to specific residents under the medical direction and supervision of the resident's attending physician's . ESSENTIAL DUTIES AND RESPONSIBILITIES .Perform administrative duties .such as completing medical forms .Chart nurses' notes in professional and appropriate manner that timely, accurately and thoroughly reflects the care provided to the resident .Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures and applicable state and federal regulations. A review of the facility's Social Worker's Job Description, indicated, Duties and Responsibilities. Administrative Functions. Assists in planning, developing, organizing, implementing, evaluating, and directing the social service programs of this facility .Perform administrative requirements, such as completing necessary forms, reports, etc .Miscellaneous .Make weekly inspections of all social service functions to assure that quality control measures are continually maintained . A review of the facility's undated policy and procedure (P&P) titled, Section: Nursing. Subject: Physician Orders for Life Sustaining Treatment (POLST) indicated, SKILLED NURSING FACILITY PROCEDURES .1. The admitting nurse will note the existence of the POLST form on the admission assessment and review the form for completeness .9. To be valid, a POLST form must be signed by (1) physician, or by a nurse practitioner or a physician assistant .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 8. A review of Resident 83's face sheet (a document showing a summary of the resident's information) indicated Resident 83 was admitted to the facility on [DATE]. During a review of Resident 83's Minimum Data Set (MDS - a standardized assessment tool used to evaluate a resident's health status) - Version 3.0, dated 9/25/24, the BIMS score (Brief Interview for Mental Status score - a number that indicates a person's cognitive function) indicated Resident 83 had moderate cognitive impairment. Further review of the MDS Section GG (a section of the MDS indicating the resident's admission and discharge self-care and mobility performance) showed Resident 83 required supervision or touching assistance when eating. The MDS coding definition for supervision or touching assistance indicated the Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. A review of Resident 83's Order Summary Report, dated as of October 1, 2024, indicated to place Resident 83 on a regular diet and Enhanced Barrier Precaution every shift due to an indwelling catheter (a catheter inserted through the urethra into the bladder to drain urine). During a review of Resident 83's care plan (a plan showing specific interventions to provide effective and person-centered care to meet the resident's needs), a care plan problem was developed for the resident's indwelling catheter. The Interventions/Tasks included to use Enhanced Barrier Precaution. During an observation on October 21, 2024, at 1:06 PM, CNA 2 performed hand hygiene prior to bringing Resident 83's meal tray inside the resident's room. There was an Enhanced Barrier Precaution sign posted outside of the room. After setting the meal tray on the bedside table, CNA 2 assisted Resident 83 by elevating the head of the bed using the hand controller. CNA 2 then picked up the bread from Resident 83's plate with her bare hands and fed the resident. There was no hand hygiene performed after touching the bed's hand controller and prior to picking up the bread to feed the resident. CNA 2 was also not wearing any PPEs while assisting Resident 83 during feeding. During another observation on October 23, 2024, at 08:07 AM, CNA 3 brought Resident 83's meal tray into the room. CNA 3 was not wearing any PPEs except for a face mask. CNA 3 then assisted the resident by elevating the head of the bed and tucked a napkin in the resident's shirt. CNA 3 was about to feed the resident when another staff came in to prompt her to wear PPEs. CNA 3 then donned a gown and continued to feed the resident. However, CNA 3 did not wear gloves. During an interview with CNA 3 on October 23, 2024, at 08:30 AM, CNA 3 was asked about the facility's policy regarding PPE use when residents were placed on Enhanced Barrier Precautions. CNA 3 stated if a resident was placed on Enhanced Barrier Precaution, the staff needed to wear gown, mask, and gloves while assisting the resident. CNA 3 was then informed of the observation of her not wearing gloves while feeding the resident. CNA 3 stated she did not wear gloves because she was taught not to wear one due to it being a dignity issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with CNA 2 on October 23, 2024, at 08:40 AM, CNA 2 stated Resident 83 was on Enhanced Barrier Precaution because he had an indwelling catheter. When residents were on Enhanced Barrier Precaution, the staff needed to wear PPEs when touching and assisting the resident. They also needed to wear PPEs including gown and gloves when feeding the resident, and wash hands prior to and after feeding. CNA 2 was then informed of the observation when she was feeding the resident. CNA 2 verified the information and stated she forgot. During an interview with LVN 3 on October 24, 2024, at 08:55 AM, LVN 3 stated the staff needed to wear PPEs if they were doing direct care such as changing, feeding, turning, and assisting the resident. When staff needed to touch the resident, they needed to wear PPEs including gown and gloves. When feeding the residents, the staff needed to wear gloves as well. The purpose of wearing PPEs was to protect the resident from infection. A review of the facility's policy and procedures titled IPCP (Infection Prevention and Control Plan) Standard and Transmission-Based Precautions, revised October 2022, indicated .1. Standard Precautions are infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. They are based on the principle that all blood, body fluids, secretions, and excretions (except sweat) may contain transmissible infectious agents .Standard Precautions include: .a. Proper selection and use of PPE, such as gowns, gloves, facemasks, respirators, and eye protection .i. Use and type of PPE is based on the predicted staff interaction with residents and the potential exposure to blood, body fluids, or pathogens (e.g. gloves are worn when contact with blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated surfaces or equipment are anticipated .b. Hand hygiene . The policy also indicated .3. Enhanced Barrier Protection (EBP): expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs (multi-drug resistant organisms) to staff hands and clothing then indirectly transferred to residents or from resident-to-resident (e.g. residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs) .C. Example of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: i. Dressing, ii. Bathing/showering, iii. Transferring, iv. Providing hygiene, v. Changing linens, vi. Changing briefs or assisting with toileting, vii. Device care or use: central vascular line (including hemodialysis catheters), indwelling urinary catheter, feeding tube, tracheostomy/ventilator .viii. Wound care .ix. In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions . Based on observation, interview, and record review, the facility failed to implement infection control and prevention measures when: 1. Resident 58's oxygen tubing was not changed in accordance with facility policy. 2. A Licensed Vocational Nurse (LVN) 5 presenting with Covid-19 (an illness that spread from person to person when an infected person coughs, sneezes, or talks) symptoms (fever or chills, cough, shortness of breath, sore throat, runny nose) was not tested upon return to work and prior to providing care to residents. 3. LVN 4 did not perform hand hygiene after checking the vital signs and before administering medications to Resident 76. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. A Certified Nursing Assistant (CNA) 1 did not perform hand hygiene before entering and after leaving a room on Enhanced Barrier Precaution (EBP - an infection control practice that involves wearing gloves and gowns during high-contact patient care activities) and before and after using gloves. 5. Medical Records (MR) did not perform hand hygiene when entering and exiting a resident room on enhanced barrier precautions. 6. Restorative Nurse Assistant (RNA) 1 did not perform hand hygiene when moving between care activities for different residents. 7. CNA 4 handled soiled linens wearing a glove on one hand only, touched the soiled linen bin with the ungloved hand, and did not perform hand hygiene after. 8. CNAs 2 and 3 did not wear the appropriate PPEs (personal protective equipment such as gowns and gloves) and perform hand hygiene while feeding Resident 83 who was on an Enhanced Barrier Precaution. These failures had the potential for cross contamination and spread of infection which can adversely affect the health and wellbeing of 84 medically compromised residents, staff, and visitors. Findings: 1. During an initial tour observation, on October 21, 2024, at 9:48 a.m., in Resident 58's room, Resident 58 was sitting in bed, receiving oxygen at two liters (unit of volume) per minute via nasal cannula (a thin, flexible tubing to which delivers oxygen in small amounts through the nostrils) attached to an oxygen concentrator (a medical device that provides a supply of oxygen to help people breathe easier). The oxygen tubing had a label which indicates Change Sunday and the date it was last changed, which was on October 13, 2024. During an observation and concurrent interview with LVN 4, on October 21, 2024, at 10:18 a.m., LVN 4 confirmed that oxygen tubing should have been changed on Sunday, October 20, 2024. LVN 4 stated that changing oxygen tubing once a week was important to prevent accumulating of odor and dirt. During an interview with the Infection Preventionist (IP), on October 22, 2024, at 9:43 a.m., the IP stated that oxygen tubing should be changed once a week per facility policy for infection control purposes. A review of Resident 58's Minimum Data Set (MDS - a standardized assessment tool used to evaluate the health of residents in nursing homes), indicated that Resident 58 was admitted to the facility on [DATE], with diagnoses which included Hypertension (a medical condition with elevated blood pressure) and Anemia (a medical condition with low healthy red blood cells). A review of the facility's undated policy and procedure titled, Oxygen Therapy, indicated, POLICY: It is the policy of this facility to administer oxygen in a safe manner. PROCEDURES: Equipment: . Oxygen tubing to be replaced every week. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an observation, on October 24, 2024, at 8:41 a.m., in Resident 54's room, LVN 5 was noted administering medications to Resident 54. LVN 5 was having a hard time talking, had a low, hoarse voice, and was holding the throat while talking. Resident 54 asked LVN 5, You have colds?. LVN 5 responded, I have sore throat, don't worry I am wearing a mask. During an interview with the Infection Preventionist (IP), on October 24, 2024, at 9:07 a.m., the IP stated that staff with Covid-19 symptoms should inform the facility IP and should get tested for Covid-19 before coming to work. The IP was aware that LVN 5 had a sore throat. The IP stated that LVN 5 was tested last October 22, 2024, in the facility, and the result was negative. The IP was not able to provide the test result and stated, Oh I threw away the results because it's negative. The IP added, I didn't document it because it's negative anyway and I have everything in my mind. I will test her again today and if she gets positive, then I will start documenting it and keep track of close contacts. The IP verified that Covid-19 test results should be recorded and that the onset of symptoms should be documented to keep track of close contact to prevent spread of infection. During an interview with LVN 5, on October 24, 2024, at 9:15 a.m., LVN 5 stated that a symptom of sore throat started on October 21, 2024, after work, then got tested at home but the result was negative. The next day, LVN 5 was still feeling sick and did not come to work. LVN 5 further stated that facility never conducted a Covid-19 test upon returning to work. LVN 5 added that the IP did not ask for a copy of the test result. During an interview and concurrent record review with the Director of Nursing (DON), on October 24, 2024, at 10:01 a.m., the DON stated, The staff should know if they have symptoms to take a test before coming to work. The staff with symptoms should inform the IP and send a copy of their test results and the IP should keep a copy of the results regardless of positive or negative result for line listing (a table that summarizes information about persons who may be associated with an outbreak) to track the onset of symptoms. The DON further stated that LVN 5 provided the facility a copy of doctor's note from the urgent care, dated October 22, 2024, which indicates, Patient off work and may return on 10/24/2024. The doctor's note did not state anything about Covid-19 test results. During a subsequent interview with the DON, on October 24, 2024, at 10:05 a.m., the DON stated that the expectations from the IP was to test LVN 5 before coming back to work for monitoring and to prevent the spread of infection in the event of a future Covid-19 outbreak. A review of Resident 54's Face Sheet (a document with resident's information), indicated that Resident 54 was admitted to the facility on [DATE], with diagnoses which included Hypertension (a medical condition with elevated blood pressure), Benign Prostatic Hyperplasia (enlargement of the prostate), and Depression. A review of facility's COVID-19 MITIGATION PLAN, revised on June 1, 2024, indicated, COVID-19 MITIGATION PLAN REQUIREMENTS . 7. LABORATORY SERVICES AND TESTING SERVICES . Staff with symptoms or signs of COVID-19 must be tested and restricted from the facility pending results, . 3. During an observation in the hallway, on October 22, 2024, at 9:33 a.m., LVN 4 was noted inside resident's room checking Resident 76's blood pressure. LVN 4 was noted to administer Resident 76's medications immediately after. LVN 4 did not perform hand hygiene in between checking the blood pressure and administering medications. (continued on next page)

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	056372	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Healthcare Center	105 Terracina Blvd. Redlands, CA 92373

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with LVN 4, on October 22, 2024, at 9:38 a.m., LVN 4 acknowledged that hand hygiene in between tasks was not performed. LVN 4 stated that hand hygiene was important to prevent staff from infecting the residents, and residents from infecting the staff. During an interview with the IP, on October 23, 2024, at 12:55 p.m., the IP stated that staff should perform hand washing in between tasks. The IP also stated that staff should perform hand hygiene before administering medications even if resident was on standard precautions (minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered). A review of Resident 76's Minimum Data Set (MDS - a standardized assessment tool used to evaluate the health of residents in nursing homes), indicated that Resident 76 was admitted to the facility on [DATE], with diagnoses which included Hypertension (a medical condition with elevated blood pressure), Benign Prostatic Hyperplasia (enlargement of the prostate), and Respiratory Failure (a serious condition that happens when your lungs cannot get enough oxygen into your blood). A review of facility's policies and procedures titled, Hand Hygiene, revised in October 2022, indicated, Purpose . All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infection to other personnel, residents, and visitors . Procedure . 2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . c. Before preparing or handling medications; . 4. During an initial tour observation on October 21, 2024, at 12:03 PM, Resident 295's room had a sign posted next to the entry door that indicated, STOP BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room . During a subsequent observation in the hallway outside Resident 295's room, on October 21, 2024, at 1:03 PM, CNA 1 entered the room without performing hand hygiene. CNA 1 donned (put on) a pair of gloves and set-up the lunch tray for Resident 295. She later removed her gloves, discarded into the trash can and left the room. CNA 1 did not perform hand hygiene before and after using gloves. CNA 1 also left the room without performing any hand hygiene. A review of Resident 295's face sheet (document which contains demographic and medical information) indicated she was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breath), muscle weakness and malignant neoplasm of the mandible (cancer of the jaw). During an interview with CNA 1, on October 21, 2024, at 1:04 PM, CNA 1 acknowledged these findings and stated she should have performed hand hygiene before and after using gloves and when entering and leaving the resident's room. CNA 1 also stated these were important to prevent spread of germs and cross contamination. During an interview with the IP, on October 24, 2024, at 3:47 PM, the IP stated staff were expected to follow the EBP and perform hand hygiene before and after using gloves. IP also stated that following these guidelines and practices were important to prevent the transmission of infection or illnesses. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy and procedure (P&P) titled, Hand Hygiene with a revised date of October 2022, indicated, Policy: It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on acceptable standards. Purpose .All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors .Procedure .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .e. Before donning sterile gloves; .l. After contact with objects .in the immediate vicinity of the resident; m. After removing gloves; o. Before and after eating or handling food; p. Before and after assisting a resident with meals; .r. After removing and disposing of personal protective equipment . 6. During an observation on October 21, 2024, at 7:58 AM, along the South Station hallway, Restorative Nurse Assistant 1 (RNA 1) was observed assisting residents inside a resident's room (Room A), moving from one bed to the next. RNA 1 stepped out of Room A, went directly inside another resident's room (Room B), and started assisting a resident with the meal tray. RNA 1 did not perform handwashing or hand hygiene in between moving from Room A to Room B. During an interview on October 21, 2024, at 8:05 AM, with RNA 1, RNA 1 stated she was cleaning up, making the beds, and attending to the needs of the residents inside Room A. RNA 1 stated she went inside Room B to assist with a resident's meal tray. RNA 1 stated she was supposed to sanitize her hands when moving from one room to another and between care activities for different residents, but she did not do so. During a concurrent interview and record review on October 25, 2024, at 10:20 AM, with the Infection Preventionist (IP), the facility's policy and procedure (P&P) titled, Hand Hygiene, review date October 2022 was reviewed. The P&P indicated, Policy . it is the policy of this facility to provide the necessary supplies, education, and oversight to ensure health care workers perform hand hygiene based on accepted standards . 2. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations . l. after contact with object (e.g., medical equipment) in the immediate vicinity of the resident . p. Before and after assisting a resident with meals . The IP stated RNA 1 should have performed hand hygiene after providing care in Room A and before providing care in Room B. 7. During an observation on October 21, 2024, at 9:46 AM, along the South Station hallway, Certified Nurse Assistant 4 (CNA 4) was observed wearing a glove on her right hand only. CNA 4 went inside a resident's room (Room C) and picked up towels hanging on a shower chair by the doorway. CNA 4 opened the soiled linen bin cover with her ungloved left hand and threw the towels inside the bin with the gloved right hand. CNA 4 walked out of the room without performing hand hygiene. During an interview on October 21, 2024, at 9:50 AM, with CNA 4, CNA 4 stated she opened the soiled linen bin with her ungloved left hand. CNA 4 stated she should have worn gloves on both hands when she handled the used towels and should have washed her hands or performed hand hygiene after handling the soiled linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on October 25, 2024, at 10:20 AM, with the Infection Preventionist (IP), the facility's policy and procedure (P&P) titled, IPCP [Infection Prevention and Control Practices] Standard and Transmission-Based Precautions, review date October 2022 was reviewed. The P&P indicated, .Policy . It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . 1 .Standard Precautions include . a. Proper selection and use of PPE, such as gowns, gloves, facemasks, respirators, and eye protection . i. Use and type of PPE is based on the predicted staff interaction with residents and the potential exposure to blood, body fluids, or pathogens (e.g., gloves are worn when contact with blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated surfaces or equipment are anticipated . b. Hand hygiene . 8. Linens: Contaminated linens should be handled appropriately whether their source was an isolation room or a non-isolation room. All linens should be handled as if it were highly infectious . The IP stated CNA 4 should have worn gloves on both hands when she handled the used towels and should have performed hand hygiene afterward. 5. During a concurrent observation and interview with the MR, on October 23, 2024 at 10:35 AM, the MR entered the resident's room, where an Enhanced Barrier Precaution (EBP) sign was visibly hanging outside of the room. The MR failed to wash or sanitize hands prior to entry and exit of the resident's room. The MR was asked if personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) was required prior to entry of the room. MR stated, No, I don't have to use a gown because I am just taking papers into the room. MR verified the room and resident required EBP prior to entry and staff must clean their hands prior to entry and exit. MR verified she did not perform hand hygiene (practice of cleaning your hands with soap and water or alcohol-based sanitizer to prevent the spread of disease) prior to entry and exit of the resident's room. During a concurrent interview and record review on October 25, 2024 at 9:06 AM. with the Infection Preventionist (IP), the facility's policy and procedure (P&P) titled, IPCP Standard and Transmission-Based Precautions, revised 3/2024 was reviewed. The P&P indicated that hand hygiene should be completed as part of standard precautions (work practices required to achieve a basic level of infection prevention and control) for all residents including those on EBP. The IP verified hand hygiene must be performed by all staff, prior to the entry and exit of rooms, regardless of if direct care was provided to the resident or not.