STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056475	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VISTA POST ACUTE	3269 D STREET HAYWARD, CA 94541

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to to cover the urinary drainage bag (a bag for urine collection and storage outside the body, collected by a tube inserted through the urethra, into the urinary bladder) for one of 20 residents (Resident 14) from public view. This failure had the potential for Resident 14 to feel emtional distress. Findings: During a review of Resident 14's Admission Record, printed 3/5/20, the Record indicated Resident 14 was admitted with an included [DIAGNOSES REDACTED]. During an observation on 3/2/20, at 10:03 a.m., in Resident 14's room, Resident 14 lay in bed with a urinary drainage bag not covered and visible to both room occupants, and passers-by in the common hallway. During an interview on 3/3/20, at 1:35 p.m., with certified nursing assistant (CNA) 6, CNA 6 stated Resident 14's catheter bag was always uncovered.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on observation, interview, and record review, the facility failed to ensure two of 20 residents (Resident 30 and Resident 33) had access to their call lights. This failure had the potential to prevent the residents from calling for assistance for routine or emergent care needs. Findings: During an observation on 3/3/20, at 1:15 p.m., in Resident 33's room, Resident 33 lay in bed positioned so she faced away from her nightstand. Her call light was on top of the nightstand, on the side furthest away from Resident 33. During an interview on 3/3/20, at 1:20 p.m., in Resident 33's room, with Certified Nursing Assistant 5 (CNA 5), During an observation and interview on 3/3/20 at 1:22 p.m., with Resident 30, in Resident 30's room, Resident 30 lay in bed with her call light on top of her nightstand, on the side furthest from Resident 30. Resident 30 stated she could not reach her call light at this time. During an observation and interview on 3/3/20 at 1:24 p.m., in Resident 30's room, with CNA 5, CNA 5 stated she was assigned to Resident 30, and Resident 30 was unable to reach the call light in its current placement on top of the far side of the nightstand.
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of three sampled residents who were receiving Medicare Part A services (Resident 44), the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC) was issued at the required time. This failure had the potential to result in Resident 44 missing the opportunity to appeal the right to continue Medicare services. Findings: During a review of Resident 44's Admission Record (AR), printed 3/9/2020, the Record indicated Resident 44 was admitted [DATE], for a broken leg and weakness. During a concurrent interview and review of Resident 44's NOMNC on 3/4/2020, at 10:11 a.m., with the Social Service Director (SSD), the SSD stated the NOMNC indicated, Skilled Nursing Services will end 12/18/19, and was signed by Resident 44's responsible party (RP) on 1/20/2020. The SSD stated the RP should have been informed three days prior to the end of Resident 44's medicare service coverage. During a review of the undated facility policy and procedure (P & P) titled, Form Instructions for the Notice of Medicare Non Coverage (NOMNC), the P & P indicated, The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. Medicare providers are responsible for the delivery of the NOMNC.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** Based on interview, and record review, the facility did not ensure 3 of 20 residents (Resident 32, Resident 36, and Resident 66) promptly received mail. This failure resulted in delayed receipt of residents' written communications. Findings: During a Resident Council interview on 3/3/20, at 10:04 a.m., Resident 32, Resident 36, and Resident 66, stated they had not received mail regularly, especially on weekends. Resident 66 stated that the facility collected the mail until there was a pile, then delivered the mail to residents. Resident 66 further stated there was no Saturday mail delivery at all. During an interview on 3/5/20, at 10:53 a.m., with Social Services Director (SSD), SSD stated she passed out the mail when it was placed in her mailbox, but that the mail was not always placed in her mailbox. SSD stated the activities assistant usually passed out the mail to residents. During an interview on 3/5/20, at 10:56 a.m., with the Activities Assistant (AA), AA stated she had only distributed resident mail on one occasion. AA stated she did not know the routine process for resident mail distribution. During an interview on 3/5/20, at 11:00 a.m., with Director of Nurses (DON), DON stated the SSD received the mail, and usually passed it out. DON stated, SSD does not work the weekends; any mail received on Saturday would not be distributed until Monday, when SSD returned to work.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services to maintain a clean, homelike environment for three (Residents 54, 55, 32) of 19 sampled residents when: 1. The curtains in the shared room of Resident 55 and Resident 54 were stained, and hung in an irregular pattern due to missing hooks used to suspend the curtains. Resident 55's window curtain was re-inforced with a piece of blue cloth that partially covered the window. The ceiling directly above Resident 54's bed and the wall on his right side were covered with splatters of a black, dry substance. 2. The window curtain in Resident 32's room was stained, and too small to cover the window completely. The windowsill was coated in dark, dusty substances, with multiple black spots. These failures resulted in an uncomfortable, and unclean environment for the residents. Findings: 1. During an observation and concurrent interview on 3/2/2020, at 10:00 a.m., in the room shared by Resident 55 and Resident 54, with Resident 55 and Resident 54, the window curtains were stained, and hung in an irregular pattern due to missing hooks used to suspend the curtains. A piece of blue cloth was placed over part of the curtain. Resident 55 stated, It does not look good. The ceiling directly above Resident 54's bed, and the wall on his right side were covered with splatters of black, dry matter. Resident 54 stated I don't know what those are. During an interview on 3/2/2020, at 10:15 a.m. with Janitor 1, Janitor 1 confirmed there was black matter on the ceiling and wall by Resident 54's bed, and the room's curtains were stained and missing hooks.

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

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

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 2. During an interview on 3/3/20, at 10:04 a.m., Resident 32 stated, I have mold in my room. During an observation on 3/4/20, at 1:30 p.m., in Resident 32's room, the windowsill was coated in dark, dusty substances, with multiple black spots. The window curtain was stained, and too small to cover the window completely.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to complete a Significant Change Minimum Data Set (MDS, a clinical assessment tool used to guide care) for one (Resident 43) of 16 sampled residents. This failure had the potential to result in unmet care needs for Resident 43. Findings: During a review of Resident 43's Admission Record, printed 3/4/20, the Record indicated Resident 43 was admitted to the facility in 2018 with included [DIAGNOSES REDACTED]. During a review of the nursing progress notes dated 12/4/2019, the note indicated Resident 43 had gone to the acute care hospital for evaluation after he experienced a [MEDICAL CONDITION] ([MEDICAL CONDITION] are the result of abnormal electrical impulses in the brain, and can result in convulsive uncontrollable shaking.) in the facility. Resident 43 returned 12/4/19, from the acute care hospital, with new orders for an anti-[MEDICAL CONDITION] medication. During a review of the nursing progress notes dated 12/9/2019, the note indicated Resident 43 had gained weight during the last six months for a total of a 13% increase. During an interview on 3/4/20, at 12:40 P.M., with MDS Coordinator, MDS Coordinator stated a Significant Change MDS should have been completed within fourteen days after Resident 43 had a change in his diagnosis/medication and significant weight change. The facility's RAI (Resident assessment Instrument) Manual version 3.0 dated July 2010 indicated, A significant change is a decline or improvement in resident's status that .impacts more than one area of the resident's health status.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate coding of the Minimum Data Set (MDS, an assessment tool used to direct care) for five of 19 sampled residents (Resident 14, 45, 50, 54 and 55) when: 1. Residents 45, 50, and 54's MDS were inaccurately coded as receiving anticoagulants (medications used to thin and prevent blood clots). 2. Resident 55's MDS did not indicate Resident 55 was receiving anticoagulant medication. 3. Resident 14's MDS was coded inaccurately for pressure ulcers. These failures posed the risk of the residents not receiving appropriate care interventions due to inaccurate coding of the residents' assessments and care screenings. Findings: 1. During a review of Resident 45's Quarterly MDS (Section N), dated 1/28/2020, the MDS indicated Resident 45 received anticoagulant medication in the past seven days. During a review of Resident 45's March 2020 Order Summary Report, the physician orders [REDACTED]. During a review of Resident 50's Quarterly MDS (Section N), dated 1/23/2020, the MDS indicated Resident 50 received anticoagulant medication in the past seven days. During a review of Resident 50's March 2020 Order Summary Report, the physician orders [REDACTED]. During a review of Resident 54's Quarterly MDS (Section N), dated 1/30/2020, indicated Resident 54 received anticoagulant medication in the past seven days. During a review of Resident 54's March 2020 Order Summary Report, the physician orders [REDACTED]. During an interview on 3/3/2020, at 9:10 a.m., with the MDS Coordinator (MDSC), the MDSC stated Residents 45, 50, and 54 were taking aspirin for clot prevention, which did not qualify as anticoagulant use for the MDS. 2. During a review of Resident 55's March 2020 Order Summary Report, the physician orders [REDACTED]. During a review of Resident 55's Quarterly MDS (Section N), dated 1/28/2020, the MDS indicated Resident 55 had not received any anti-coagulant medications in the past seven days. During a concurrent record review and interview on 3/3/2020, at 9:15 a.m., with the MDSC, the MDSC reviewed Resident 55's March Order Summary, and Quarterly MDS, dated [DATE]. The MDSC stated rivaroxaban qualified as an anticoagulant, and the MDS should have reflected Resident 55's anticoagulant use. 3. During a review of Resident 14's Admission Record, printed 3/5/2020, the Record indicated Resident 14 was admitted with an included [DIAGNOSES REDACTED]. During a review of Resident 14's MDS, dated [DATE], Section I, Active Diagnoses, the MDS indicated Resident 14 had two pressure ulcers; Section M, Skin Conditions, indicated Resident 14 had no pressure ulcers. During an interview on 3/4/20, at 10:01a.m., with the Treatment Nurse (TN), the TN stated Resident 14 had been admitted to the facility on with pressure ulcers, but the ulcers had healed and treatment had been discontinued on 10/31/19.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to provide dining assistance for one of 20 residents (Resident 33) for 25 minutes after delivery of her breakfast tray. This failure had the potential to result in discomfort from hunger, less enjoyment of her food, due to colder temperature, and emotional distress from waiting to be assisted to eat while her roommates completed their meals. Findings: During a review of Resident 33's Admission Record, printed 3/3/2020, the Record indicated Resident 33 was admitted to the facility in 2015 with included [DIAGNOSES REDACTED]. During a review of Resident 33's Care Plan, dated 11/7/18, the Care Plan indicated Resident 33 had a deficit in ADL (activities of daily living) due to dementia, and staff will provide extensive assistance in bed mobility, transfer, dressing, personal hygiene, eating, and toileting daily. During an observation on 3/05/20, at 7:45 a.m., in Resident 33's shared 3-bed room, Resident 33's food tray was on the bedside tray, with the plate and drinks covered. Resident 33 was in bed, awake. Resident 33's two roommates sat in bed, eating breakfast without assistance. During a continuous observation on 3/05/20, from 7:45 a.m., until 8:08 a.m., no staff entered Resident 33's room. During an observation on 3/05/20, at 8:08 a.m., facility staff removed the completed breakfast trays of both of Resident 33's roommates. During an observation and interview on 3/05/20 at 8:10 a.m., Certified Nursing Assistant 8 (CNA 8) entered Resident 33's room and began assisting Resident 33 with her breakfast, feeding Resident 33 eggs. Resident 33 stated she was hungry and wanted to eat her eggs and pineapple. During an interview on 3/5/20 at 8:28 a.m., with CNA 8, CNA 8 stated Resident 33's breakfast meal was delayed because CNA 8 had first fed a resident who ate faster than Resident 33, who was a slow eater.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide needed assistance with grooming and personal hygiene activities for four (Residents 47, 50, 68, 23) of 19 sampled residents when: 1. Residents 47had untrimmed fingernails with black material beneath the ends of the nails. 2. Resident 50 had untrimmed fingernails with black material beneath the ends of the nails. 3. Residents 68 had facial hair stubble. 4. Resident 23 had untrimmed fingernails with black material beneath the ends of the nails. These failures had the potential to cause low self-esteem and embarrassment to the residents. Findings: 1. During a review of Resident 47's Annual Minimum Data Set (MDS, an assessment tool to direct care), dated 1/22/2020, indicated Resident 47 needed extensive assistance from two or more people, for personal hygiene. During an observation on 3/2/2020 at 8:32 a.m., Residents 47 had untrimmed fingernails,with black material under the ends. 2. During a review of Resident 50's Quarterly MDS dated [DATE], the MDS indicated Resident 50 was dependent on the help of one person for assistance with her personal hygiene. During an observation on 3/2/2020 at 8:32 a.m., Residents 50 had untrimmed fingernails,with black material under the ends. During an interview on 3/2/2020, at 9 a.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated the facility made appointments with an outside agency for the residents nail care. 3. During a review of Resident 68's MDS, dated [DATE], the MDS indicated Resident 68 needed supervision with oversight and one person physical assist with grooming. During an observation and concurrent interview on 3/2/2020, at 1:30 p.m., in the room of Resident 68, Resident 68 had visible facial hair growth. Resident 68 stated, I would like to be shaved. During an interview on 3/2/2020, at 1:35 p.m., with CNA 1, CNA 1 stated residents are shaved during shower days and as needed. CNA 1 stated she had seen Resident 68's facial hair yesterday. During an interview on 3/2/2020, at 9:05 a.m, with the Director of Nursing (DON), the DON stated the CNAs should provide grooming including nail care, and shaving for the residents. During a

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) review of the facility's policy and procedure (P & P) titled, Care of Fingernails/Toenails, revised April 2007, the P & P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. During a review of the facility's policy and procedure (P&P) titled, Shaving the Resident, revised December 2007, the P&P indicated, The purpose of this procedure is to promote cleanliness and to provide skin care. 4. During a review of Resident 23's Weekly Summary Assessment, dated 2/26/20, the Weekly Summary Assessment indicated Resident 23 needed total assistance with personal hygiene. During an observation and interview on 3/2/20, at 9:59 a.m., with Resident 23, in her room, Resident 23 had long fingernails on both hands, with dark material under the ends of the nails. Resident 23 stated, I don't feel good with dirty nails. During an interview on 3/4/20, at 2:09 p.m., with the treatment nurse (TN), TN stated the weekend treatment nurse was responsible for trimming and cleaning residents' nails. During a review of Resident 23's March Order Summary Report, the Report indicated a physician order [REDACTED].
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviews, the facility failed to establish effective pharmaceutical service procedures to meet the needs of residents when: 1. Three of four emergency medication kits (E-Kits) were missing medications from the inventory list; nursing staff had not immediately notified Pharmacy of the need for replacement medications. 2. One of four E-Kits contained expired medications. These failures had the potential to result in administration of ineffective medications, and a lack of sufficient emergency medications in the event of an emergency. Findings: 1. During an observation and interview on 3/2/2020, at 9:02 a.m., with Licensed Vocational Nurse 1 (LVN 1), in medication storage room [ROOM NUMBER], LVN 1 removed two clear plastic containers from a locked cabinet. The containers were labeled E-Kit #0123, and E-Kit #1129. LVN 1 stated the container labeled E-Kit #0123, which was secured by a red tamper-evident plastic seal, was missing one tablet of the antibiotic, [MEDICATION NAME]. LVN 1 stated the red seal indicated the E-Kit had been opened after delivery to the facility. During a concurrent review of documents stored inside the E-Kit titled, Drug Kit Usage Report, LVN 1 stated the report indicated a nurse had removed the tablet of [MEDICATION NAME] for resident use on 2/29/2020. During an observation, and interview with Licensed Vocational Nurse 3 (LVN3) on 3/2/20, at 9:45 a.m., in medication storage room [ROOM NUMBER], LVN 3 removed two E-Kits from a locked cabinet. One E-Kit was for oral medications; the second E-Kit was for injectable medications. Both E-Kits were secured by red tamper-evident seals. LVN 3 confirmed the oral medication E-Kit was missing two tablets of the antibiotic, [MEDICATION NAME]. During a concurrent review of the documents stored inside the kit titled, Drug Kit Usage Report, LVN 3 confirmed the report indicated a nurse had removed the two tablets of the [MEDICATION NAME] for resident use on 2/28/2020. During a continued observation and interview, of the injectable medication E-Kit, in medication storage room [ROOM NUMBER], with LVN 3, LVN 3 confirmed the E-Kit was missing one vial of the antibiotic Ertapenem, and one vial of the local anesthetic (numbing medication), [MEDICATION NAME]. During a concurrent review of the document stored inside the E-Kit titled, Drug Kit Usage Report, LVN 3 confirmed the report indicated both medications were removed from the E-Kit on 2/27/2020. 2. During an observation and interview on 3/2/2020, at 9:02 a.m., with LVN 1, E-Kit #1129 was secured by a green tamper-evident plastic seal. LVN 1 stated the green seal indicated the E-Kit had not been opened at the facility; pharmacy delivered E-Kits with a green seal in place. During a review of the medications in E-Kit #1129, LVN 1 confirmed the following items had passed their expiration dates: a. Three vials of [MEDICATION NAME] 25 milligram (mg) per 1 milliliter (ml), expiration dates of 9/19. b. Two vials of [MEDICATION NAME] 0.5 mg per 2 ml, expiration dates of 1/20. c. Three vials of [MEDICATION NAME] 20 mg per 2 ml, expiration dates of 11/19. d. Three vials of [MEDICATION NAME] 80 mg per 2 ml, expiration dates of 2/20. e. One [MEDICATION NAME] vial, expiration date of 2/20. f. Two vials of [MEDICATION NAME] 5 mg per 1 ml, expiration dates of 10/19. g. One vial of [MEDICATION NAME] units per 1 ml, expiration date of 11/19. h. One vial of [MEDICATION NAME] 20 mg per 1 ml, expiration date of 12/19. During an interview on 3/2/2020, at 10 a.m., with the Director of Staff Development (DSD), the DSD stated the facility procedure for replacement of missing E-Kit medications, was for the nurse who removed the E-Kit medication to send notification to the pharmacy of the need for replacement. During a review of the facility's policy and procedure (P & P) titled, Medication Ordering and Receiving from Pharmacy Provider, Emergency Pharmacy Service and Emergency Kits (E-Kits), dated 05/16, the P & P indicated, Upon removal of any medication or supply from the emergency kit, the nurse documents the medication or items used on an emergency kit log. One copy of this information should be immediately faxed to the pharmacy .The fax log sheet will inform pharmacy of items used from the emergency kit. This will notify the pharmacy to replace the kit.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviews, the facility failed to: 1. Discard expired medications and supplies from resident medication storage areas. 2. Label and refrigerate unopened insulin (medication used to lower blood sugar). 3. Label one insulin vial with the date of opening. These failures had the potential for medications and supplies to be inadequate or ineffective for resident use. Findings: During an observation and interview on 3/2/2020, at 9:02 a.m., in medication storage room [ROOM NUMBER], with Licensed Vocational Nurse 1 (LVN 1), LVN 1 confirmed the medication refrigerator contained an opened bottle of [MEDICATION NAME] (an anti-anxiety medication), labeled with an expiration date of 2/11/2020. During an observation and interview on 3/4/2020, at 10:15 a.m., of the medication cart at nurse station 1, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 confirmed the medication cart contained the following expired items: a. One opened bottle of stock use sodium [MEDICATION NAME], 650 milligrams, with an expiration date of 1/20. b. Resident 52's [MEDICATION NAME] insulin, labeled with an opened date of 1/24/2020. c. Resident 18's [MEDICATION NAME] insulin, labeled with an opened date of 1/24/2020. LVN 2 stated unrefrigerated insulin should be discarded 28 days after opening the bottle. (A calculation of 28 days after 1/24/2020, showed a date of 2/21/2020.) LVN 2 confirmed the medication cart contained an open bottle of Resident 52's [MEDICATION NAME], with no label for the date of opening. LVN 2 also confirmed the medication cart contained two unopened bottles of [MEDICATION NAME] insulin, undated. During a telephone interview on 3/4/20, at 12:24 p.m., with the Pharmacy Consultant (PC), PC stated should be labeled with an opened date, as nurses should discard insulin 28 days after opening. PC also stated unopened insulin should be stored in a refrigerator according to manufacturer's guidelines. During a review of the manufacturer's package insert for [MEDICATION NAME] insulin, dated 12/2018, the insert indicated unopened [MEDICATION NAME] should be refrigerated at temperatures between 36 and 46 degrees Fahrenheit, in order to maintain product potency until the bottle expiration dated. The insert indicated if the unopened insulin was stored at room temperature, the bottle should be discarded after 28 days, even if still unopened. Review of the facility's policy and procedure (P & P) titled, Medication Storage, dated 05/16, indicated, Medication and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain integrity and to support safe effective drug administration .Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used .Outdated, contaminated, discontinued or deteriorated medications are removed from stock, disposed of according to procedures for medication disposal.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 follow professional standards for food preparation and food safety as follows: 1. Failed to follow cooling procedures, including maintenance of a cooling log for chicken and rice. 2. Failed to prevent contaminated handwashing water from splashing onto clean dishware. 3. Failed to

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) label and date residents' personal food brought in from outside the facility, for storage in the facility refrigerator. This failure had the potential to cause food-borne illness among residents consuming this food, or using the contaminated dishware. Findings: 1. During a concurrent observation and interview on 3/2/20, with Cook 2 at 8:41 a.m., in the kitchen, the oven was set on a low temperature. Inside the oven was a metal container holding cooked chicken, and a second container holding cooked rice. Cook 2 took the temperatures of the cooked chicken, and cooked rice, and confirmed the chicken's temperature was 90 degrees Fahrenheit, and the rice's temperature was 110 degrees Fahrenheit. Cook 2 stated she had cooked the chicken and rice today, between 6 a.m., and 7 a.m., and had placed the them in the oven to keep them warm. Cook 2 stated she had planned on later placing the cooked chicken and cooked rice in the refrigerator to cool, until lunch. During a review of the kitchen's, Cool Down Log, there were no entries dated 3/2/20, for cooked chicken or cooked rice. During a review of the facility's policy and procedure (P & P) titled, Cooling and Reheating Potentially Hazardous Foods, dated 2018, the P & P indicated, Cool cooked food from 140 degrees Fahrenheit to 70 degrees Fahrenheit within two hours. Then cool from 70 degrees Fahrenheit to 41 degrees Fahrenheit or less in an additional four hours for a total cooling time of six hours. The P & P further indicated, Note menu item, date, time, temperature and cook's initials on the Cool Down Log. 2. During a concurrent observation and interview on 3/4/20, at 9:22 a.m., in the kitchen, with Dietary Supervisor (DS) and Dishwasher 1 (DW 1), a handwashing station had clean dishware stacked next to the handwashing sink. Water droplets splashed onto the clean dishware when a facility visitor used the sink for handwashing. DW 1 stated the clean dishware was regularly stacked next to the handwashing sink because of limited storage space in the kitchen. DS stated stacking clean dishware next to the handwashing sink could result in contamination of the clean dishes. During a review of the United States Health and Human Services, Food and Drug Administration, Food Code 2017, section 4-903.11, Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, the Code stated cleaned equipment and utensils shall be stored in a clean, dry location, where they are not exposed to splash, dust, or other contamination. 3. During a concurrent observation and interview on 3/4/20, at 10:40 a.m., with Director of Nursing (DON), the DON confirmed the resident food refrigerator contained the following items: a. one package of cheese, undated, with no resident name label, b. one undated plastic bag, holding multiple take-out food containers, c. two mangos in a plastic bag, with a received date of 2/25/20, d. one plastic container holding cherry tomatoes, with a received date of 2/25/20. A sign posted on the refrigerator indicated, Refrigerator for residents only please date and remove after 72 hours. DON stated resident food brought into the facility from outside, should only be stored for 72 hours in the resident food refrigerator, and then should be discarded. During a review of the facility's policy and procedure (P & P) titled, Foods Brought by Family/Visitors, dated 12/2008, the P & P indicated, Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item, and the 'use by' date.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to ensure policy and procedures for infection control were followed when two Licensed Nurses did not perform hand hygiene (HH, the process of handwashing or sanitizing the hands with an alcohol-based rub) between medication administration for different residents. These failures had the potential to spread infection, causing resident illness. Findings: During an observation on 3/3/2020, at 8:02 a.m., in Resident 71's room, Licensed Vocational Nurse 1 (LVN 1) administered a medication to Resident 71, removed her gloves, and exited the room. Without performing HH, LVN 1 pushed the medication cart to Resident 34's room, entered the room, checked Resident 34's blood pressure, returned to the medication cart, and began preparing Resident 34's medications. During an observation on 3/3/ , at 9:35 a.m., Licensed Vocational Nurse 4 (LVN 4) administered medications to Resident 23. Without performing HH, LVN 4 exited Resident 23's room. During an interview on 3/4/20, at 12:36 p.m., with the Director of Nursing (DON), the DON stated staff were expected to perform HH before entering a resident room, when exiting a resident room, and after direct contact with residents. A review of the facility's policy titled, Handwashing/Hand Hygiene, dated August 2015 indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the infections to other personnel, residents, and visitors .Use an alcohol-based hand rub .or, alternatively, soap and water for the following situations: .Before and after direct contact with residents, before preparing or handling medication .After removing gloves .The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.
F 0914 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide bedrooms that don't allow residents to see each other when privacy is needed.** Based on observation, interview, and record review, the facility failed to ensure resident rooms had privacy curtains for one of 20 residents (Resident 10). This failure resulted in a loss of privacy and dignity for this resident. Findings: During an observation on 3/2/20, at 9:11 a.m., Resident 10's room was a fully occupied, three-bed room. Resident 10's bed did not have privacy curtains fully surrounding the bed. During an interview on 3/2/20, at 9:12 a.m., with Certified Nursing Assistant 7 (CNA 7), CNA 7 stated Resident 10 received bed baths and personal care in bed from nursing staff. CNA 7 stated curtains were needed for Resident 10's privacy. During an interview on 3/2/20, at 9:58 a.m., with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated Resident 10 did not have a privacy curtain surrounding her bed. During an interview on 3/2/20, at 11:34 a.m., with Resident 10, Resident 10 stated it bothered her to not have a privacy curtain, My roommate can see me. During a concurrent observation and interview on 3/3/20, at 11:22 a.m., with the Nursing Home Administrator (NHA), in Resident 10's room, the NHA confirmed Resident 10's privacy curtain did not provide visual privacy between Bed B and Bed C, which could result in lack of visual privacy from her roommate during personal care. During an interview on 3/3/20, at 12:32 p.m. with the Director of Nursing (DON), the DON stated nursing staff should close the privacy curtain before providing resident care.
F 0920 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.** Based on observation and interview, the facility failed to provide adequate space for resident dining and activities. This failure had the potential to result in exclusion of residents from eating in the dining room or participating in group activities. Findings: During an interview with the resident council on 3/3/20, at 10:04 a.m., Resident 36 stated the dining room used to be in an area up front, which was now being used for physical therapy. Resident 36 stated the current dining room was too small, and we can't all fit in. During an observation on 3/04/20, at 8:24 a.m., the Dining/Activity room had a total of three tables and two chairs. During an observation in the dining/activity room on 3/04/20, at 2:20 p.m. Resident 10's sister stood next to Resident 10, and ate food she had brought to the facility for herself and Resident 10. Resident 10 was seated in a wheelchair at one of the tables. There were no chairs available for family/visitor use in the dining room.