STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055011	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River View Post Acute	1611 Scenic Drive Modesto, CA 95355

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369 Based on observation, interview, and record review, the facility failed to ensure 1 of 29 sampled residents (Resident 1) was provided with alternate methods of communication and entertainment when Resident 1's physical limitations prevented the use of a cell phone or tablet device. This failure had the potential to negatively impact Resident 1's psychosocial well-being. Findings: A review of Resident 1's ADMISSION RECORD, indicated Resident 1 was readmitted to the facility in early 2024 with diagnoses which included, spastic diplegic cerebral palsy (a chronic neuromuscular condition that causes muscle stiffness and spasms in a person's legs and sometimes arms) and adjustment disorder with mixed anxiety and depressed mood (a mood disorder with symptoms of nervousness, worry, difficulty concentrating, and feeling overwhelmed). During an interview on 8/13/24, at 2:53 PM, family member (FM) 1 stated due to the limited movement of Resident 1's arms the family had provided Resident 1 with an [NAME] device to allow her to receive phone calls and listen to music. FM 1 further stated Resident 1 loved to hear her music. FM 1 stated the facility repeatedly unplugged the device and stated Resident 1 was not allowed to use it. A review of Resident 1's Minimum Data Set (MDS, a resident assessment and screening tool which identifies care needs) dated 6/25/24, indicated, .Section F- Preferences for Customary Routine and Activities .How important is it to you to be able to use the phone in private . the document indicated, .2 - Somewhat important .How important is it to listen to music you like . the document indicated, .1- Very important . During an observation on 8/15/24, at 3:09 PM, in Resident 1's room, the [NAME] device was observed unplugged on Resident 1's bedside cabinet. During an interview on 8/15/24, at 3:10 PM, Licensed Nurse (LN) 3 stated Resident 1's family brought in the [NAME] device because Resident 1 liked to listen to white sounds (a constant background noise that [NAME] out other sounds). LN 3 further stated the staff were informed to unplug the device to prevent it from bothering Resident 1's roommate. LN 3 stated it was unfortunate because listening to the device calmed Resident 1. LN 3 stated at times Resident 1 felt lonely and enjoyed listening to the device, but staff were told to unplug it, no other device was provided. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24, at 3:34 PM, the Director of Nursing (DON) stated Resident 1 had the right to use her [NAME] device, especially if it helped her to relax or sleep well. During an interview on 8/15/24, at 3:59 PM, the Administrator (ADM) stated the [NAME] device allowed the family to instantly connect with it at any time without the facility knowing. The ADM further stated Resident 1 had not been allowed to use her electronic device due to a concern that Resident 1's family members may overhear the roommate's conversations. The ADM stated he was unaware that Resident 1 enjoyed listening to white noise and music. A review of a facility policy titled, Personal Property, revised August 2022, indicated, .Residents are permitted to retain and use personal possessions .Residents are encouraged to use personal belongings to maintain a homelike environment and foster independence . A review of a facility policy titled, Homelike Environment, revised February 2021, indicated, . Residents are provided with a .comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .Staff provides person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47369 Based on observation and interview, the facility failed to accommodate the needs of 1 of 29 sampled residents (Resident 1) when Resident 1's call light (device used to contact staff for assistance) was not within her reach. This failure placed Resident 1 at risk of falls and unmet care needs. Findings: A review of Resident 1's ADMISSION RECORD, indicated Resident 1 was readmitted to the facility in early 2024 with diagnoses which included, spastic diplegic cerebral palsy (a chronic neuromuscular condition that causes muscle stiffness and spasms in a person's legs and sometimes arms) and adjustment disorder with mixed anxiety and depressed mood (a mood disorder with symptoms of nervousness, worry, difficulty concentrating, and feeling overwhelmed). During a concurrent observation and interview on 8/13/24, at 9:03 AM, with Resident 1 in Resident 1's room, Resident 1 was observed with contractures (shortening or hardening of muscles, tendons or other tissue leading to deformity and rigidity of joints) of both arms and hands which were held against her chest. Resident 1's call light was observed lying on the lower right side of her abdomen. Resident 1 attempted to reach her call light but was unable to extend her arms enough to access it. Resident 1 stated if she could not reach the call light she would yell for help. During a concurrent observation and interview on 8/13/24, at 9:25 AM, with Licensed Nurse (LN) 2 in Resident 1's room, LN 2 confirmed Resident 1 was unable to reach her call light. LN 2 stated Resident 1's call light should be in reach. A review of Resident 1's care plan revised 7/8/24, indicated, .The resident is at risk for falls r/t [related to] Confusion .The resident will be free of falls .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance . During an interview on 8/14/24, at 8:28 AM, LN 2 stated Resident 1 should have her call light in reach to voice any concerns that she may have such as requesting to be changed, a drink, or any kind of help. LN 2 further stated if Resident 1's call light was not in reach she was at risk of not having her needs met. During an interview on 8/14/24, at 8:30 AM, the Director of Nursing (DON) stated it was her expectation that residents call lights would be in reach at all times. The DON further stated if Resident 1's call light was not in reach there was the potential for staff to be unaware of Resident 1's needs. A review of a facility policy and procedure titled, Answering the Call Light, revised September 2022, indicated, .The purpose of this procedure is to ensure timely responses to the resident's requests and needs . Ensure the call light is accessible to the resident when in bed .answer the resident call system immediately .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40911 Based on observation, interview, and record review, the facility failed to ensure a resident's right to be free from physical abuse for 1 of 29 sampled residents (Resident 33) when Resident 33 was assaulted by Resident 20 and witnessed by Certified Nurse Assistant (CNA) 7 on 8/3/24. This failure had the potential to cause physical injury, and could negatively affect Resident 33's psychosocial well-being. Findings: On 8/5/24, the Department received a report from the facility regarding an alleged resident to resident physical altercation when Resident 20 pinched Resident 33 on the right arm and hit Resident 33 on the right side of her face, on 8/3/24. The investigation was conducted during the facility's unannounced annual recertification survey. A review of Resident 33's ADMISSION RECORD, indicated Resident 33 was admitted to the facility in early 2023 with diagnoses which included Alzheimers Disease (AD, brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A review of Resident 33's Minimum Data Set (MDS, an assessment tool) dated 6/26/24, indicated Resident 33's BIMS (Brief Interview for Mental Status) score was 0 out of 15 suggesting a severe cognitive impairment. A review of Resident 20's ADMISSION RECORD, indicated Resident 20 was admitted to the facility in early 2023 with diagnoses which included adjustment disorder with mixed anxiety and depressed mood and bipolar disorder (a mental illness that causes unusual shifts in person's mood, energy, activity levels, and concentration making it difficult to carry out day-to-day tasks). A review of Resident 20's MDS dated [DATE], indicated Resident 20's BIMS score was 5 out of 15 suggesting a severe cognitive impairment. The MDS also indicated presence of verbal behavioral symptoms directed toward others. During a review of Resident 20's behavior care plan, date initiated 1/23/23, the care plan indicated Resident 20 had sudden episodes of physical aggression toward others without precursors and to anticipate and meet resident's needs. Another behavior care plan, date initiated 9/21/23, indicated Resident 20 had the potential to be physically aggressive related to history of harming others and poor impulse control. This care plan also indicated to assess and anticipate resident's needs. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/16/24, at 9:38 a.m., with the Social Service Director (SSD), Resident 20's Interdisciplinary Team [IDT- group of healthcare professionals with different disciplines] Progress Notes, dated 11/28/23 was reviewed. The IDT notes indicated to monitor Resident 20's whereabouts. Another IDT Progress Notes, dated 12/21/23 was reviewed. The IDT notes indicated to monitor Resident 20's whereabouts and to monitor for mood changes. The SSD confirmed the IDT notes indicated Resident 20 had a history of physical aggression and to monitor her whereabouts. The SSD stated Resident 33 and Resident 20 would spend most of their time in the Circle (a space in the facility for residents to gather) and staff were in the Circle or around the Circle supervising and watching the residents because Resident 20 could strike anyone at anytime. During a telephone interview on 8/16/24, at 10:27 a.m., with CNA 7, CNA 7 stated on the day of the incident she saw Resident 33 and Resident 20 at the Circle sitting next to each other by themselves. CNA 7 further stated she then saw Resident 20 grab Resident 33's right arm and slap her on the right cheek. CNA 7 stated she could not get to Resident 20 because she was attending to another resident. She then called the attention of the licensed nurse who was at the nurses' station at that time. During an interview on 8/16/24, at 12:38 p.m., with the Director of Nursing (DON), the DON stated she expected the interventions to monitor Resident 20's whereabouts to be followed. The DON further stated staff should have been more watchful and should have been closely monitoring Resident 20. During a review of the facility's policy titled, Resident Rights, revised February 2022, indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .be free from abuse . During a review of the facility's policy titled, Resident-to-Resident Altercations, revised February 2021, indicated, .Facility staff will monitor residents for aggressive .behavior towards other residents . During a review of the facility's policy titled, Abuse Prevention Program, revised February 2022, indicated, . As part of the resident abuse prevention, the administration will protect our residents from abuse by anyone including, but not necessarily limited to .other residents .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 50161 Based on observation, interview, and record review, the facility failed to ensure 1 of 29 sampled residents (Resident 19) was free of restraints (any method, physical or chemical, or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move or access any part of his/her body) when; Resident 19 was observed trying to get up from his Geri chair (geriatric wheelchair, a comfortable, fully reclining chair with wheels) which was reclined with the chair footrest placed in an elevated position, and Resident 19 could not freely get out of the chair. This failure resulted in Resident 19 not being able to move freely and had the potential to affect Resident 19's dignity, and to cause an avoidable injury to him. Findings: Review of Resident 19's ADMISSION RECORD, indicated Resident 19 was admitted to the facility in 2023 with a diagnosis of history of falling, fracture of left acetabulum (break of the hip joint), fracture of the left femur (break of thigh bone) and altered mental status. Review of Resident 19's physician progress notes dated 6/20/24, indicated, .[Resident 19] is alert however not oriented. Sitting comfortably in the Geri chair at the time of interaction. Patient makes frequent attempts to get out of the chair requiring frequent redirection. Patient has advanced dementia [impaired ability to remember, think, or make decisions] .completely dependent on nursing staff to achieve ADL's [activities of daily living related to activities of personal care] . During an observation on 8/13/24, at 9:05 a.m., in the hall outside of Resident 19's room, Resident 19 was observed sitting in a Geri chair. The Geri chair was noted to be reclined and the foot of the chair was in an elevated position. Resident 19 was awake, and he was observed mumbling words, and pointing to his left leg that appeared to have scratches on it. During an observation on 8/13/24, at 2:18 p.m., Resident 19 was observed in his room, sitting in a Geri chair, with the chair reclined and the foot of the chair was elevated. Resident 19 was further observed attempting to get out of the chair. During a subsequent observation on 8/13/24, at 2:21 p.m., the Director of Staff Development (DSD) and Certified Nurse Assistant (CNA) 1 were observed running into Resident's 19's room and attempted to help Resident 19 get out of the Geri chair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/13/24, at 2:31 p.m., outside of Resident 19's room, the DSD confirmed Resident 19 was in his room sitting in a Geri chair that was reclined with the foot of the chair elevated. The DSD further confirmed Resident 19 was awake and trying to get out of the Geri chair. The DSD stated the Geri chair should be upright with the foot of the chair in a down position if the resident was awake. The DSD further stated if the foot of the Geri chair was in an up position and the resident was awake then the chair would be considered a restraint. The DSD stated the risk to the resident if the chair was used in this manner would be a fall. The DSD further stated if the Geri chair was used as a restraint, then the resident would not have free will and their freedom would be taken away. The DSD explained residents could not be restrained. During an interview on 8/16/24, at 12:21 p.m., the Director of Nursing (DON) stated CNAs and licensed nurses (LN)s received training on the use of Geri chairs. The DON further stated Geri chairs provided a more comfortable chair for residents to sit in. The DON stated the expectation for the use of the Geri chair was that the footrest should be down in case residents wanted to get out of the chair. The DON explained it was easier for residents to get in and out of the chair if the footrest was in the down position. The DON stated the risk to the resident if the footrest was elevated would be skin injury and fall. The DON further stated if staff were using the Geri chair to keep residents in the chair this would be seen as a restraint. The DON explained this would be due to the Geri chair impeding the resident's movement or from doing what the residents want to do and the chair was not intended to restrict movements. Review of a facility policy titled, Resident Rights, revised February 2022, indicated, .Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .a dignified experience .be free from physical or chemical restraints . Review of a facility policy titled, Use of Restraints, revised April 2022, indicated, .Restraints shall only be used to treat the residents medical symptom (s) and never for discipline or staff convenience, or for the prevention of falls .Physical Restraints .are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body .Examples of devices that are/may be considered physical restraints include leg restraints .geri-chairs .that the resident cannot remove . Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including .placing a resident in a chair that prevents the resident from rising .

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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** 40911 Based on observation, interview, and record review, the facility failed to develop and implement a resident specific care plan (provides direction on the type of nursing care the resident may need based on their health, medication, behavioral, and psychosocial needs) for 3 of 29 sampled residents when: 1. Resident 32 did not have a care plan developed for the dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) services she was receiving, 2. Resident 197 did not have a care plan developed for splint care to the left arm; and, 3. Resident 46 did not have a care plan developed after an altercation involving Resident 23 (unsampled). These failures had the potential for care needs not being met for Resident 32, Resident 46, and Resident 197. Failure to address behavioral health needs placed Resident 46 and Resident 23 at risk for psychosocial harm and injury. Findings: 1. A review of Resident 32s ADMISSION RECORD, indicated Resident 32 was admitted to the facility in early 2024 with diagnoses which included end stage renal disease (ESRD- the last stage of long-term kidney disease when the kidneys can no longer support the body's needs) and dependence on renal dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working). During a review of Resident 32's Minimum Data Set, (MDS- an assessment tool) dated 5/13/24, the MDS indicated Resident 32 was receiving dialysis treatment in a dialysis center while residing in the facility. A review of Resident 32's Order Summary Report, indicated Resident 32 had dialysis treatment three times a week. During a concurrent interview and record review on 8/16/24, at 11:47 a.m., with Licensed Nurse (LN) 1, Resident 32's care plan dated 2/12/24 was reviewed. LN 1 stated she did not see a care plan for dialysis. LN 1 confirmed there was no care plan developed related to Resident 32's dialysis treatment and services. During an interview on 8/16/24, at 1:55 p.m., with LN 1, LN 1 stated there should be a dialysis care plan for Resident 32 to properly care for and to meet all her dialysis needs. LN 1 further stated there would be an increased risk for the interventions to not be implemented and therefore goals related to dialysis care would not be met. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy titled, End-Stage Renal Disease, Care of a Resident with, revised September 2010, indicated, .Agreements between the facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including .how the care plan will be developed and implemented .The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care . 2. A review of Resident 197's ADMISSION RECORD, indicated Resident 197 was admitted to the facility in early 2024 with diagnoses which included chronic pain syndrome. During a review of Resident 197's MDS, dated [DATE], the MDS indicated a BIMS (Brief Interview for Mental Status) score of 15 out of 15 indicating an intact cognitive functioning. During an interview on 8/14/24, at 8:30 a.m., with Resident 197, Resident 197 stated she was admitted to this facility with a splint (brace) to her left arm down to her wrist and wrapped with ace bandage due to complaint of pain. During an interview on 8/15/24, at 10:05 a.m., with LN 8, LN 8 confirmed Resident 197 was admitted to the facility with a splint (brace). A review of Resident 197's clinical record, Progress Notes, dated 4/8/24, indicated Resident 197 had a left wrist splint (brace) from a previous injury sustained while at a previous facility. During a concurrent interview and record review on 8/16/24, at 8:43 a.m., with the Director of Nursing (DON), the DON confirmed there was no documented evidence a care plan for the left arm and wrist splint (brace) was developed. The DON stated there should be a care plan to meet the specific care needs of Resident 197. The DON further stated without a care plan, there would be no interventions for staff to follow, the splint (brace) would not be monitored, and there would be an increased risk for skin problems under and surrounding the splint (brace). During a review of an undated facility policy titled, Splinting, indicated, .Provide guidelines for .monitoring, and management of splints .and reviewed regularly as part of the resident's care plan . During a review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 50161 3. Review of Resident 46's ADMISSION RECORD indicated Resident 46 was admitted to the facility in 2022 with diagnoses including palliative care (providing relief from pain and other symptoms of a serious illness), major depressive disorder (persistent feeling of sadness and loss of interest), and anxiety disorder (experience fear and worry that is both intense and excessive). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 46's clinical record, Progress Note, dated 7/29/24, indicated, .resident is on 72 hour monitoring for anger outburst and found in another resident room yelling at him, resident was upset and stated she threw water on him, she was escorted out of his room by staff. will cont [continue] to monitor . Review of Resident 46's clinical record, Progress Note, dated 8/13/24, indicated, .L/E [late entry] for 8/12/24. Resident came into office to discuss another Resident who she believes is being aggressive to her and statements of made [sic] of resident hitting her in the back. Resident in question denies these allegations, both parties are when [sic] monitored when out on the patio, no reports of any incidents have been reported. Hospice was called to update on Resident, will be coming out to visit . During a concurrent observation and interview on 8/13/24, at 10:01 a.m., Resident 46 stated she has lived at the facility for four years and stated Resident 23 harassed her for the last two and a half years. Resident 46 stated the latest altercation involving Resident 23 was on 8/10/24 outside on the patio where they went for smoke breaks. Resident 46 explained they were yelling at each other outside on the patio and staff was helping other residents exiting the patio. Resident 46 stated a few weeks ago, after the smoke break, Resident 23 was blocking her with his wheelchair from walking in the hallway inside the facility, and she was so upset she threw water on him. Resident 46 stated the Director of Nurses (DON) met with her regarding the incident and told her not to throw water. Resident 46 stated, I don't like the way he uses people; he will go up to little [resident name] and take the cigarette right out of her hand and will grab her cigarette, and he does it to some of the men too, where he takes their cigarette out of their hands. Staff don't say anything to him. It makes me mad because there is no one protecting the weaker people out there. During an interview on 8/14/24, at 8:48 a.m., Activity Assistant (AA) 1 stated Resident 46 has been angry with Resident 23, and felt he was after her. AA 1 stated on 8/10/24, Resident 46 and Resident 23 were arguing outside on the patio. AA 1 stated she separated them. During a concurrent interview and record review on 8/15/24, at 8:40 a.m., the AD stated Resident 46 gets mad at Resident 23. The AD reviewed Resident 46's smoking care plan and confirmed it was last updated on 4/30/24 and did not address her conflict with other residents or Resident 23. The AD explained it was important for other staff to know how to deal with residents and the conflict strategies that work to redirect them. The AD stated the elements of a care plan included the focus, goal, and intervention. The AD explained care plans were important for other staff to refer to because Resident 46 and Resident 23 behaviors occur in the building as well as outside. The AD confirmed during a clinical record review, Resident 46 did not have a behavior care plan. The AD stated it would have been important because in the last month Resident 46 had been more worked up regarding Resident 23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/15/24, at 12:20 p.m., the Social Services Director (SSD) stated she was responsible for behavioral health care for residents. The SSD stated if a nurse or staff member was aware of an incident involving residents quarreling, she expected them to let her know. The SSD stated this was important so she could check in with both residents and care plan the incident. The SSD stated it was important to share the incident with all staff to prevent similar or worse circumstances from occurring, and stated the residents could experience physical and/or mental anguish. The SSD explained the purpose of the care plan was to give a good snapshot of the resident including addressing psychosocial needs and provide ways to mitigate the issues and conflicts. The SSD confirmed through record review there was no behavioral care plan in place for Resident 46 regarding the tension and behaviors between her and Resident 23. During an interview on 8/16/24, at 11:30 a.m., the Director of Nursing (DON) stated she was aware of the altercation between Resident 46 and Resident 23. The DON stated if staff became aware of a situation, they needed to let the nurse know so they can check on the resident. The DON explained any changes with a resident should be care planned, to ensure monitoring. The DON explained the care plan would include interventions for the resident, and stated if the behaviors were not care planned, there could be escalation of the problem. Review of a facility policy titled Resident-to-Resident Altercation, revised February 2021, indicated, .If two residents are involved in an altercation, staff will .Make necessary changes in the care plan approaches to any or all of the involved individuals; Document in the resident's clinical record all interventions and their effectiveness; Consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the Attending Physician . Review of a facility policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' change of condition .the interdisciplinary team reviews and updates the care plan .where there is a significant change in the resident's condition .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50716 Based on interview, and record review, the facility failed to update or revise the comprehensive care plan for 2 of 29 sampled residents (Resident 83 and Resident 71) when: 1. Resident 83 had a documented change in condition related to a skin wound or ulcer (an open sore caused by a break in the skin); and, 2. Resident 71's smoking care plan was not updated. This failure had the potential to result in Resident 83 and Resident 71 not receiving adequate and appropriate care and services necessary to reach their highest practical physical, mental, and psychosocial well-being. Findings: 1. During a review of Resident 83's SBAR (Situation, Background, Assessment, and Recommendation- a written communication tool used in healthcare) Summary for Providers Record, dated 7/23/24, the SBAR indicated Resident 83 had a change in condition related to a skin wound or ulcer. Further review of the record indicated, .Resident noted to have new wounds to right knee measuring 0.7 x 0.5, left knee 2.5 x 1.5, left foot 2x1, left heel 2.3x3. MD [physician] notified and ordered wound care consult . During a concurrent interview and record review on 8/15/24, at 4:08 PM, with the Director of Nursing (DON), the DON acknowledged no care plan was initiated for Resident 83's change of condition related to pressure ulcer or wounds. The DON further stated the risk for not care planning would include staff not knowing if something needed to be reviewed, re-evaluated, or if the resident's condition was worsening. The DON stated her expectation for care plans were to be revised or updated with any change or doctor's orders. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, The interdisciplinary [IDT- group of professionals from different disciplines] team review and updates the care plan, when there has been a significant change in the resident's condition . 2. A review of Resident 71's Admission Record, indicated Resident 71 was admitted to the facility in the winter of 2022 with multiple diagnoses including but not limited to chronic obstructive pulmonary disease (COPD- a common lung disease causing restricted airflow and breathing problems) and centrilobular emphysema (a chronic obstructive lung disease that occurs when there is damage to the center of the lungs). During a review of Resident 71's Smoking and Safety, record dated 6/27/24, tobacco was the only product listed which she was able to use. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 71's Smoking and Safety, record dated 8/14/24, tobacco and vape (an electronic cigarette for the delivery of nicotine in a vapor) products were listed which she was able to use. During a review of Resident 71's care plan initiated on 8/14/24 indicated, Focus .[Resident 71] is able to use her vape . In the section titled, Interventions, indicated, .Observe [Resident 71] for changes in her ability to use her vape . During an interview on 8/15/24, at 12:19 PM, with the Activity Director (AD), the AD stated Resident 71 started to smoke vapes around the end of June or early July. The AD further stated Resident 71 had her smoking privileges revoked as she had violated the smoking policy four times. The AD stated Resident 71 was allowed to smoke at the facility if she switched over to vape products instead of tobacco products. The AD further stated she was not sure if she had updated the smoking care plan for Resident 71. The AD stated maybe she should have made a vaping care plan for Resident 71. During an interview on 8/16/24, at 8:58 AM, with the Director of Staff Development (DSD), the DSD stated any changes to smoking care plans should be updated immediately. The DSD stated not having a vaping care plan in place for Resident 71 could lead to confusion as to what Resident 71 could or could not do. During an interview on 8/16/24, at 9:46 AM, with Licensed Nurse (LN) 8, LN 8 stated smoking care plans were important to make sure staff knew what residents were allowed to smoke. LN 8 further stated that having smoking care plans in place allowed staff to know the smoking preferences for individual residents. LN 8 stated the risks of not having a smoking care plan in place would be that staff would not be aware of what precautions to take and what effects may come up. LN 8 further stated it would be more of a risk if staff were not aware of the most updated smoking care plans for residents. During an interview on 8/16/24, at 9:57 AM, with the Director of Nursing (DON), the DON confirmed the smoking care plan for Resident 71 was not updated until 8/14/24. The DON stated staff may not know which smoking products would be okay to give to Resident 71 without having an updated smoking care plan in place. During an interview on 8/16/24, at 11:03 AM, with the AD, the AD stated he had forgotten to make the vaping care plan for Resident 71 when she first started vaping about a month and half ago. The AD further stated the risk of not having an updated smoking care would be that other staff would not know Resident 71's smoking preferences. The AD stated Resident 71 could get angry if staff did not know what the most current interventions were for her. During a review of the facility's document titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the Policy and Procedure indicated, 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual, or Significant Change in Status) .a. includes measurable objectives and timeframes c. includes the resident's stated goals upon admission and desired outcomes .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .

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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. 40911 Based on observation, interview, and record review, the facility failed to follow a physician's order for 1 of 29 sampled residents (Resident 197) when Resident 197's orthopedic referral was not carried out in a timely manner. This failure placed Resident 197 at risk to not receive immediate and appropriate treatment. Findings: During a review of Resident 197's ADMISSION RECORD, indicated Resident 197 was admitted to the facility in early 2024 with diagnoses which included chronic pain syndrome and history of falling. Resident 197's Minimum Data Set (MDS- an assessment tool) dated 5/10/24 revealed a BIMS (Brief Interview for Mental Status) score of 15 out of 15 indicating an intact cognitive functioning. During an interview on 8/14/24, at 8:30 a.m., with Resident 197, Resident 197 stated she was admitted to the facility with a splint (brace) to her left arm down to her wrist and was wrapped with an ace bandage due to complaint of pain. Resident 197 further stated she had the splint (brace) due to an injury she suffered while at another facility. Resident 197 explained she received a referral from the facility's Medical Director (MD) to be seen by an orthopedist (doctor who specializes in the surgery of bones, joints, and muscles) due to persistent pain to her left arm. Resident 197 stated it had been six months till now and she still had not seen an orthopedist for her left arm and the sling (brace) had not been removed nor replaced since she was admitted to the facility. During a record review of Resident 197's clinical record titled, Progress Notes, dated 11/4/23, the record indicated Resident 197 was seen at the acute hospital emergency room (ER) for concerns of a left arm injury while showering. Further review of the document indicated Resident 197 was placed on a fiberglass splint wrapped with an ace bandage to the left wrist and a follow-up orthopedic appointment was requested due to complaint of pain. During a record review of Resident 197's Order Summary, dated 3/9/24, indicated Resident 197 had a referral to see an orthopedist for a consultation for the left elbow. During a record review of Resident 197's Progress Notes, dated 4/8/24, indicated Resident 197 had a left wrist brace from a previous injury. During a record review of Resident 197's Radiology Interpretation Report, dated 5/20/24, indicated a written order by the facility MD dated 5/23/24 to refer to orthopedics due to complaint of pain to the left shoulder and left elbow. During an interview on 8/15/24, at 10:05 a.m., with licensed nurse (LN) 8, LN 8 confirmed Resident 197 was admitted to the facility with a splint (brace) to the left wrist and a referral to see an orthopedist for consultation was ordered. LN 8 further stated she did not know what had happened to the referral and stated the order had not been carried out. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/15/24, at 10:15 a.m., with the Social Service Director (SSD) and the Director of Nursing (DON), the SSD stated Resident 197 had not been seen by an orthopedist because there were no transport that would take her to an orthopedic clinic due to her wheelchair exceeding the transport's capacity, and the clinic would not accommodate a resident in a gurney if taken by an ambulance. The DON confirmed the splint had brown spots and brown debris in the area against the skin and a foul odor was also noted coming from Resident 197's splint. The DON stated Resident 197 may have not needed the splint and could possibly have affected her functional mobility, and a potential risk for skin issues under the splint and the surrounding areas. The DON confirmed Resident 197's orthopedic referral order had not been done and Resident 197 had the splint on to the left wrist since admission. During an interview on 8/16/24, at 10:53 a.m., with the MD, the MD explained that he gave the orthopedic referral order because he wanted Resident 197 to be seen by a specialist. The MD stated that he did not discontinue the referral order considering that he might have missed something that could be possibly causing the pain to Resident 197's left arm. The MD explained Resident 197's splint to the left wrist should have been removed given that Resident 197 was non-compliant to splint care. The MD further explained Resident 197 should have been sent to the ER if no transport would take her or no orthopedic clinic would see her. A review of the facility's job description titled, Licensed Vocational Nurse (LVN), dated 3/1/14, indicated, . Correctly .intervenes in accordance with clinical standards of practice and per physician orders .Follow through on resident care services needed to meet the individualized needs of each resident .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 50161 Based on observation, interview, and record review, the facility failed to ensure vision care was provided to 1 of 29 sampled residents (Resident 46) when, Resident 46 complained of worsening eyesight and requested to be seen by an ophthalmologist (physician who specializes in eye and vision care), and the facility did not assist her in obtaining vision appointments. This failure had the potential for Resident 46 to develop worsening eyesight and had the potential to negatively impact her activities of daily living and quality of life. Findings: Review of Resident 46's ADMISSION RECORD indicated Resident 46 was initially admitted to the facility in 2022 with diagnoses including palliative care (providing relief from pain and other symptoms of a serious illness), history of falling, major depressive disorder (persistent feeling of sadness and loss of interest), and anxiety disorder (experience fear and worry that is both intense and excessive). Review of Resident 46's Medication Review Report, indicated, .MAY HAVE PODIATRY/DENTAL/EYE/HEARING EVAL AND TX [treat] .Order date .11/01/2022 . Review of Resident 46's Medication Review Report, indicated, .REQUEST FOR EYE-HEALTH AND VISION CONSULT WITH FOLLOW-UP TREATMENT AS INDICATED .Order date .03/05/2023 . Review of Resident 46's care plan, initiated on 1/17/24, indicated, Focus .[Resident 46] expressed vision as worsening and reports ophthalmology referral is needed .Interventions/Tasks .SS [social services] will make referral for ophthalmology/optometry [healthcare provider who specializes in caring for your eyes] .Created by .Social Services Director . During a concurrent observation and interview on 8/13/24, at 10:01 a.m., Resident 46 stated an optometrist came to the facility a year ago and he told her she needed to be immediately seen by an ophthalmologist. Resident 46 explained she was still waiting for an appointment and had not been seen by an ophthalmologist. Resident 46 stated two SS staff were aware she needed to be seen by the ophthalmologist. During an interview on 8/15/24, at 11:06 a.m., Resident 46 stated she had spoken to the social services department many times trying to get a vision appointment. Resident 46 explained her right eye faded to black and then faded to nothing for 5-20 minutes, then came back with lightening flicks appearing, (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/15/24 at 12:20 p.m., the Social Services Director (SSD) stated she was responsible for ancillary care (providing necessary support to primary activities including vision care) for residents at the facility. The SSD stated Resident 46 mentioned needing an ophthalmology appointment to her earlier in the year. The SSD confirmed through review of Resident 46's vision care plan dated 1/17/24, an intervention listed for her to be seen by an optometrist or ophthalmologist for follow-up. The SSD stated an appointment should have been made for Resident 46 within a couple of weeks of the creation of the care plan. The SSD explained the risk to Resident 46 not seeing the ophthalmologist included increased risk for falls and diminished quality of life. The SSD confirmed there was no progress note in the Resident 46's clinical record regarding her vision concerns nor optometrist/ophthalmologist visits. During a concurrent interview and record review on 8/16/24, at 11:30 a.m., the Director of Nursing (DON) stated the SSD was responsible for follow-up and making necessary vision appointments for residents. The DON explained the expectation was the SSD should place a note in the residents' medical record so the issue can be documented and followed-up on. The DON confirmed through record review of Resident 46's medical record there was no social service note regarding vision complaints from Resident 46 and confirmed Resident 46's vision care plan indicated she needed follow up vision appointments. The DON stated the risk to Resident 46 was continued decline in vision, which could affect her mobility and placed her at risk for falling. Review of a facility policy titled Visually Impaired Resident, Care of, revised March 2021, indicated, . Residents with visual impairment will be assisted with activities of daily living as appropriate .it is our responsibility to assist the resident and representatives in locating available resources .scheduling appointment and arranging transportation to obtain needed services .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50716 Based on observation, interview, and record review, the facility failed to ensure 1 of 29 sampled residents, (Resident 83) received consistent treatment to promote the healing and prevention of pressure ulcers (localized damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with friction) when Resident 83's physician order for heel protectors (devices that help reduce the risk of pressure damage to the heels of patients by completely offloading the heel) was not followed. This deficient practice placed Resident 83 at risk for worsening his current pressure ulcer and increased the chance for the development of new pressure ulcers. Findings: Review of Resident 83's Admission Record indicated Resident 83 was admitted to the facility in 2024 with diagnoses including pressure ulcer to the sacral region (portion of the spine between lower back and tailbone) and pressure ulcer to the left heel. During a review of Resident 83's Treatment Administration Record, (TAR, a written record of treatments ordered by the physician) dated August 2024, indicated, Heel protectors to bilateral (both) feet, every shift for Pressure Ulcer Prevention. During a concurrent observation and interview on 8/13/24, at 4:27 PM, with Certified Nurse Assistant (CNA) 4, Resident 83's feet were observed, CNA 4 confirmed Resident 83's feet and heels were bare, and without protection. During a concurrent observation, interview, and record review on 8/14/24, at 4:44 PM, with the Director of Staff Development (DSD) in Resident 83's room, the DSD observed Resident 83's heels. The DSD confirmed there was nothing on Resident 83's heels. Further review of Resident 83's August TAR, indicated a treatment order for heel protectors to be worn by the resident. The DSD stated the treatment order for Resident 83's heel protectors should have been followed. During an interview on 8/14/24, at 4:52 PM, with the Director of Nursing (DON), the DON acknowledged Resident 83's treatment order for heel protectors was not followed. The DON stated heel protectors were usually blue foam and attached to the heels with velcro (nylon fabric that can be fastened to itself). The DON further stated the risk of not doing the treatment could cause further skin to break down. During a review of the facility's policy and procedure titled, Wound Care, revised October 2010, indicated, . The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .Apply treatments as indicated .Use supportive devices as instructed .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47369 Based on observation, interview, and record review, the facility failed to ensure the provision of care and services to assure 1 of 29 sampled residents (Resident 74) maintained his highest level of range of motion (ROM, the full movement potential of a joint) when: 1. Resident 74's order for Restorative Nurse Assistant (RNA) services (care to improve or maintain the functional mobility of residents) was not implemented; and, 2. Resident 74 did not have a care plan developed for his arm and hand contractures (shortening or hardening of muscles, tendons or other tissue leading to deformity and rigidity of joints). These failures placed Resident 74 at risk of a decline in ROM and worsening contractures. Findings: 1. A review of Resident 74's ADMISSION RECORD, indicated he was admitted to the facility in mid-2024 with diagnoses which included quadriplegia (loss of movement that affects all limbs and the body from the neck down). During an observation on 8/13/24, at 11:22 AM, in Resident 74's room, Resident 74 stated he had not had therapy in two weeks. Resident 74 further stated he had just received a hand roll for his right hand that morning. A review of Resident 74's Medication Review Report, indicated, .RNA 3 x [times] week x 12 weeks for donning [putting on]/ doffing [taking off] bilateral [both sides] orthotics [a device made to support, or align a weakened or damaged part of the body] .PROM [passive range of motion, movement of a joint through the range of motion with no effort from the patient] to BUE [bilateral upper extremities, arms] and BLE [bilateral lower extremities, legs] .Order Date 07/31/2024 . A review of Resident 74's Restorative Nursing Assistant Referral, dated 7/31/24, indicated, .Referral date . 7/31/2024 .RNA Goal .donning/doffing bilateral orthotics with patient to wear no more than 2 hours with nursing to monitor .PROM to BUE and BLE as tolerated . A review of Resident 74's Occupational Therapy OT Discharge Summary, dated 7/31/24, indicated, . Prognosis [doctor's judgement] to maintain CLOF [current level of function] = Good with consistent staff follow through .Restorative Program Established/Trained .Prosthetic Mgmt. Program Established /Trained: bilateral orthotics .Range of Motion Program Established / Trained: PROM BUE . During a concurrent interview and record review on 8/15/24, at 9:20 AM, RNA 1 stated when a resident was referred to the RNA program the orders were handed to the RNAs to review and sign and then returned to the therapy department. RNA 1 further stated there was no order in her RNA binder for Resident 74 to participate in the RNA program. RNA 1 confirmed Resident 74 had not received RNA services. RNA 1 stated she was not aware Resident 74 required hand orthotics. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24, at 9:24 AM, the Occupational Therapy Director (OTD) stated she did not know what happened to the referral for Resident 74. The OTD further stated the purpose of communicating referrals was to ensure the RNAs were aware of the services to provide. The OTD stated Certified Nurse Assistants (CNA) and RNAs were trained to apply splints or hand rolls when residents required the use of them to ensure both were aware of their use. During an interview on 8/15/24, at 9:29 AM, CNA 5, who was caring for Resident 74, stated she did not know anything about Resident 74's hand splints and she was not sure if she was supposed to perform range of motion exercises with him. During an interview on 8/15/24, at 9:31 AM, Licensed Nurse (LN) 3, who was caring for Resident 74, stated she did not know anything about Resident 74's hand splints. LN 3 further stated she just gave Resident 74 his medications. During an interview on 8/15/24, at 9:44 AM, Resident 74 stated he did not take off the left-hand splint because his hand would fold up. Resident 74 further stated his mother came in at night and removed the splint and cleaned his hand. During an interview on 8/15/24, at 3:38 PM, the Director of Nursing (DON) stated it was her expectation that RNA program referrals would be communicated to the RNAs and nursing staff to inform them of the resident's needs. The DON further stated Resident 74 was at risk of increased contractures and further decline if the RNA orders were not implemented. 2. During a concurrent interview and record review on 8/15/24, at 12:30 PM, the Medical Records (MR) staff confirmed Resident 74 did not have a care plan developed for his contractures. During an interview on 8/15/24, at 3:38 PM, the DON stated it was her expectation that Resident 74 would have a care plan in place for his contractures. The DON further stated a care plan was necessary to communicate Resident 74's care needs and ensure staff were aware of those needs. A review of a facility policy titled, Specialized Rehabilitative Services, revised December 2009, indicated, . Once a resident has met his/her care plan goals, a licensed professional can .initiate a maintenance program which either Nursing or Restorative Aides will implement to assure that the resident maintains his/her functional and physical status . A review of an undated facility provided document titled, RESTORATIVE NURSING PROGRAM FLOW CHART, indicated, .Restorative Nursing Program candidate .Therapy trains RNA .Resident discharged from skilled therapy .Therapy completes .referral form, which includes setting goals and establishing resident care plan .RNA notified of start date .Resident status discussed regularly (e.g. [for example] weekly) . A review of a facility policy titled, Restorative Nursing Services, revised July 2017, indicated, .Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50161 Based on interview, observation, and record review, the facility failed to ensure 1 of 29 residents (Resident 12) had appropriate fall precaution measures in place when, Residents 12's bedside table was not in reach and two fall mats (used to cushion a fall) were not in place next to Resident 12's bed and were not included in Resident 12's care plan. This failure had the potential for Resident 12 to be injured during a fall. Findings: A review of Resident 12's ADMISSION RECORD indicated Resident 12 was admitted into the facility in 2015 with diagnoses including muscle weakness, low back pain, and Alzheimer disease (a brain disorder which gets worse over time and affects memory, thinking, and behavior). During a concurrent observation and interview on 8/13/24 at 9:27 a.m., in Resident 12's room, Certified Nurse Assistant (CNA) 1 confirmed there was one fall mat folded up and resting against the wall of Resident 12's room, there was a second fall mat located directly under Resident 12's bed, and Resident 12's bedside table was out of reach. CNA 1 stated Resident 12 needed fall mats and stated sometimes staff moved them while assisting with feeding. CNA 1 stated the fall mats should have been placed back where they belonged on either side of Resident 12's bed. CNA 1 stated the fall mats were used to prevent Resident 12 from being hurt in a fall. CNA 1 stated Residents' 12 bedside table was away from her bed, and she could not reach her drinks. CNA 1 stated Resident 12 might try to reach the table and fall. During an interview on 8/13/24, at 9:47 a.m., Licensed Nurse (LN) 2 stated Resident 12 was at risk for falling and should have falls mats on either side of her bed, as well as padded side rails because she was at risk for seizures. LN 2 stated if the fall mats were not used appropriately, the risk would be fall with possible injury, including fracture. During a concurrent interview and record review on 8/16/24 at 8:25 a.m., LN 1 stated the need for fall mats should be documented in the medical record for staff on other shifts to be aware. LN 1 confirmed Resident 12 had a fall on 7/11/24 and stated as far as the post fall evaluation and post fall note dated 7/11/24, there was no mention of fall mats for Resident 12. LN 1 confirmed Resident 12's fall care plan did not include fall mats as an intervention. LN 1 stated items should be within reach to help prevent a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/16/24, at 12:11 p.m., the Director of Nurses (DON) stated residents with continued falls should have fall mats in place. The DON stated fall mats lessened the risk of injury to the resident. The DON stated an important part of care planning was education of staff, so they are aware of the resident's plan of care and so the interventions which are needed can be put in place. The DON confirmed Resident 12's Fall Risk Evaluation document dated 5/22/24, indicated a score of 15. The DON stated this score indicated a high fall risk for Resident 12. The DON confirmed Resident 12 had a care plan, dated 6/28/24, which was created for her after her last fall with a focus of . [Resident 19] has had an actual fall with no injury, Poor Balance, Poor communication/comprehension, Unsteady gait . The DON confirmed the document did not include falls mats as an intervention for Resident 12. The DON stated due to Resident 12's likelihood of possible injury from a fall, Resident's 12's use of fall mats should have been documented on her care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47369 Based on observation, interview, and record review, the facility failed to obtain a physician's order for an indwelling foley catheter (a flexible, sterile tube inserted externally into the bladder to drain urine in a collection bag outside of the body) for one of three sampled residents (Resident 1) with an indwelling foley catheter. This failure placed Resident 1 at risk of a catheter- associated urinary tract infection (CAUTI- infection caused when germs enter the body through a urinary catheter), skin breakdown, and discomfort. Findings: A review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility in early 2024 with diagnoses which included urinary tract infection (UTI), acute kidney failure (condition in which kidneys suddenly stop filtering waste from the blood), and retention of urine. A review of Resident 1's Minimum Data Set (MDS, a resident assessment and screening tool which identifies care needs) dated 7/12/24, indicated, .Section H- Bladder and Bowel .Appliances .Indwelling catheter . A review of Resident 1's care plan revised 11/16/23, indicated, .Presence of indwelling catheter .Resident is at risk for urinary tract infection, urethral irritation, discomfort/pain due to presence of urinary appliance .F/C [foley catheter] as ordered .F/C care QS [every shift] & PRN [as needed] .observe for any s/s [signs and symptoms] of infection . A review of Resident 1's NURSES WEEKLY SUMMARY, (a comprehensive review of the resident care needs over the past week) dated 8/7/24, indicated, .BLADDER FUNCTION .CATHETER .N/A [not applicable] . A review of Resident 1's NURSES WEEKLY SUMMARY, dated 8/14/24, indicated, .BLADDER FUNCTION . CATHETER .N/A [not applicable] . During an interview on 8/13/24, at 2:48 PM, family member (FM) 1 stated she was concerned because Resident 1 had suffered from worsening kidney damage and frequent UTI's to the point of sepsis (a serious condition in which the body responds improperly to an infection). During an observation on 8/16/24, at 7:45 AM, Resident 1 was observed lying in bed in her room. Resident 1's foley catheter tubing was observed at the bedside, the tubing appeared cloudy, and no urine was visible. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/16/24, at 7:56 AM, the Assistant Director of Nurses (ADON) confirmed there was no physician order in Resident 1's clinical record for foley catheter use and there should have been. The ADON stated the importance of a physician's order was to ensure the nurses who cared for Resident 1 and the Infection Preventionist were aware a catheter was in use. The ADON stated the nursing staff should have been monitoring Resident 1's catheter for urine color, clarity, odor, amount of urine output and for signs and symptoms of infection. During an interview on 8/16/24, at 11:04 AM, the Director of Nursing (DON) stated Resident 1's clinical record should have indicated a foley catheter order to ensure staff were aware of Resident 1's care needs. The DON further stated not having an order for the foley catheter, which would include an order to routinely change the catheter and to irrigate as needed for clogging, put Resident 1 at risk of infection. The DON further stated it was her expectation that the nursing staff's assessments would accurately match their residents. A review of a facility job description titled, Licensed Vocational Nurse (LVN), dated 3/1/14, indicated, . Perform assigned duties in a manner that provides for the physical, psychosocial .needs of the chronically ill . Provide treatment administration in a proficient manner .which includes .indwelling catheter care .Maintain knowledge of, and implement resident care activities to promote, maintain, and/or restore health for assigned residents . A review of a facility policy and procedure titled, Policies and Practices- Infection Control, revised October 2018, indicated, .The objectives or our infection control policies and practices are to .Prevent, detect, investigate, and control infections in the facility .Maintain a safe, sanitary, and comfortable environment .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 297) who received intravenous (IV) therapy (infusion of liquid medication directly into the vein) was provided services consistent with professional standards of practice when Resident 297's IV tubing (thin flexible plastic tubing that connects the IV infusion bag to the residents IV access site) was lying on the floor during administration of the medication and Resident 297's IV infusion bag was not labeled with the date, time, and initials of the staff who administered the medication. These failures had the potential to adversely affect Resident 297's health and safety, including an increased risk of developing a new or worsening infection. Findings: A review of Resident 297's ADMISSION RECORD, indicated she was admitted to the facility in mid- 2024 with diagnoses which included methicillin resistant staphylococcus aureus infection (MRSA, a type of germ that is resistant to many commonly used antibiotics). A review of Resident 297's Order Summary, dated [DATE], indicated, .Vancomycin HCL [antibiotic] Intravenous Solution .intravenously two times a day for MRSA . A review of Resident 297's care plan revised [DATE], indicated, .The resident has potential/actual impairment to skin integrity of the (right hand) r/t [related to] infection (MRSA) .The resident will have no complications r/t (Right hand infection) . During a concurrent observation and interview on [DATE], at 8:25 AM, Resident 297 was observed lying in bed with IV medication infusing through her IV access site. The Assistant Director of Nurses (ADON) confirmed the IV tubing connected to Resident 297's access site was lying on floor. The ADON further confirmed the IV infusion bag was not labeled with the date or time the infusion was started or the initials of the nurse who started the infusion. The ADON stated it was important for the bag to be labeled to inform staff when it was administered, who administered it and to make sure it was not expired. The ADON further stated the tubing lying on the floor created a risk of infection, a potential risk for Resident 297 to trip over the tubing and fall, or for the tubing to become tangled in the furniture in the room and cause Resident 297's IV access to become dislodged. During an interview on [DATE], at 3:47 PM, the Director of Nursing (DON) stated it was her expectation that IV infusion bags would be labeled with the date, time, and initials of the staff who administered them. The DON further stated IV tubing lying on the floor created a potential for infection and it was her expectation that tubing would not be on the floor. A review of a facility policy and procedure (P&P) titled, Guidelines for Preventing Intravenous Catheter -Related Infections, revised [DATE], indicated .The purpose of this procedure is to maximally reduce the risk of infection associated with indwelling intravenous (IV) catheters . Administration set replacement .Change intermittent sets .immediately upon suspected contamination . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility P&P titled, Safety and Supervision of Residents, revised [DATE], indicated, .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents . A review of a facility P&P titled, Legal Aspects of Infusion Therapy for Nurses, dated 2009, indicated, . Nursing Responsibilities in Infusion Therapy .Performing functions and procedures that are consistent with current standards of care .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369 Based on observation, interview, and record review the facility failed to ensure respiratory care was provided in accordance with professional standards of practice for three of eleven sampled residents (Resident 53, Resident 90, and Resident 30) receiving oxygen therapy when: 1. Resident 53 received oxygen therapy without a physician's order, 2. Resident 53 and Resident 90 did not have a care plan developed for oxygen use; and, 3. Resident 30's nasal cannula (NC- flexible tubing that sits inside the nostrils and delivers oxygen) was labeled with a date which was expired and Resident 30's oxygen humidifier bottle (a plastic bottle filled with water which moistens the oxygen) was not labeled with a date of when it was changed. These failures had the potential to result in negative health impacts for the residents. Resident 53 and Resident 90 were at risk of ineffective oxygen therapy and respiratory distress. Resident 30 was placed at risk for infection. Findings: 1. A review of Resident 53's ADMISSION RECORD, indicated Resident 53 was admitted to the facility in mid-2024 with diagnoses which included chronic kidney disease stage 4 (severe loss of kidney function which can cause symptoms of nausea, increased urination, fatigue, muscle cramps, and shortness of breath) and obstructive sleep apnea (a sleep disorder that involves a blockage in the airway that keeps air from moving through the windpipe while asleep). During an observation on [DATE], at 11:13 AM, Resident 53 was observed lying in bed with oxygen in use via nasal cannula at 3 liters per minute (LPM, flow rate of oxygen). A review of Resident 53's Minimum Data Set, (MDS, a resident assessment and screening tool which identifies care needs) dated [DATE], indicated, .Section O - Special Treatments, Procedures, and Programs . Oxygen therapy .On Admission .Continuous .On Admission . During a concurrent interview and record review on [DATE], at 1:48 PM, Licensed Nurse (LN) 6 confirmed Resident 53 did not have a physician order for oxygen administration in her electronic health record (EHR) and she should have. LN 6 stated without an order there was no way of knowing the correct oxygen administration flow rate. LN 6 further stated Resident 53's oxygen flow rate was set at 3 LPM when LN 6 came on duty, and she did not check for an order. LN 6 stated she was not sure why Resident 53 received oxygen therapy. During an interview on [DATE], at 8:31 AM, the Director of Nursing (DON) stated it was her expectation that a physician's order would be in place for oxygen administration. The DON further stated an order was necessary to supply oxygen at the correct flow rate and to monitor the oxygen saturation levels (a measurement of how much oxygen is circulating in the blood). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility policy titled, Oxygen Administration, dated, [DATE], indicated, .The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . 2a. During a concurrent interview and record review on [DATE], at 1:48 PM, LN 6 confirmed there was no care plan in Resident 53's EHR for oxygen administration and there should have been. LN 6 stated there should be a care plan to inform staff why Resident 53 needed oxygen. During an interview on [DATE], at 8:31 AM, the DON stated it was her expectation that a care plan would be in place for Resident 53's oxygen therapy to alert staff to her care needs. 2b. During a review of Resident 90's Admission Record, indicated Resident 90 was admitted to the facility in the spring of 2024 with multiple diagnoses including but not limited to chronic obstructive pulmonary disease (COPD- a common lung disease causing restricted airflow and breathing problems). During an observation on [DATE], at 9:05 AM, Resident 90 was resting in bed with his nasal cannula in his nose. Resident 90's oxygen concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen) was running at a rate of 2 LPM. During a review of Resident 90's EHR in the care plans section, there were no care plans noted that addressed the need for Resident 90's oxygen usage. During an interview on [DATE], at 8:50 AM, with the Director of Staff Development (DSD), the DSD stated it was important to have care plans in place for residents who are on oxygen. The DSD stated that having a care plan in place would allow the nurses to know what the plan was for that specific resident. During an interview on [DATE], at 9:52 AM, with the DON, the DON stated care plans were important to make sure the staff were meeting the needs of the residents. The DON further stated residents who were on oxygen should have orders and care plans in place for them. The DON confirmed Resident 90 did not have a care plan in place for his oxygen needs. The DON stated the nurses may not monitor correctly or know what the needs of the residents were with no care plan in place. During a review of the facility's policy titled, Oxygen Administration, dated ,d+[DATE], indicated, 2. Review the resident's care plan to assess for any special needs of the resident . During a review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated ,d+[DATE], indicated, .a. includes measurable objectives and timeframes .c. includes the resident's stated goals upon admission and desired outcomes . 50161 3. A review of Resident 30's ADMISSION RECORD indicated Resident 30 was admitted into the facility on [DATE]. Resident 30 had an admitting diagnosis which included but not limited to chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 30's Medication Review Report, indicated, .O2 (oxygen) VIA NASAL CANNULA 3.5 liter in both nostrils every shift for SOB (shortness of breath) ,d+[DATE] liters, based on Resident preference to be administered at all times 24H (hours) day .Change O2 tubing, nasal cannula Q 7 days and PRN (as needed) every Sun for preventative Change O2 tubing, nasal cannula Q 7 days and PRN . During a concurrent observation and interview on [DATE], at 10:44 a.m. in Resident 30's room, Licensed Nurse (LN) 1 confirmed Resident 30 was receiving oxygen via nasal canula tubing and the tubing was attached to water for humidification. LN 1 stated the NC tubing was dated [DATE] and there was no label on the humidification water canister. LN 1 stated the tubing was nine days old, and it was expired. LN 1 stated oxygen tubing and the water used for humidification should be changed out every seven days. LN 1 confirmed Resident 30's tubing was 9 days old and expired. LN 1 stated the tubing and water was changed every seven days for cleanliness, and to ensure tubing does not get clogged and impede the flow of oxygen, and to reduce infection. During a concurrent observation and interview on [DATE], at 12:02 a.m. in Resident 30's room, Resident 30 stated she had pneumonia a month ago and she gets pneumonia often. During an interview on [DATE], at 12:26 p.m., the Director of Nurses (DON) stated oxygen tubing should be labeled with the date and changed out weekly or every seven days. The DON stated the risk to the resident if this was not done would be infection. During an interview on [DATE], at 2:20 p.m., the Infection Preventionist (IP) stated for residents receiving oxygen, the tubing should be dated and changed weekly or every seven days. The IP stated the risk to the resident if the tubing was to be used for more than seven days was risk for infection and damage to the tubing and the tubing not working properly. The IP stated the water used for humidification should be changed out every seven days and labeled.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369 Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in two out of four medication carts and two out of two medication storage rooms when: 1. Expired, unlabeled, and undated prescription medications were stored in the active storage areas of medication cart 2, 2. Undated prescription medications were stored in the active storage areas of medication cart 4, 3. Undated and discontinued prescription medications were stored in the active storage areas of the two medication storage rooms; and, 4. Containers of over the counter (OTC) liquid medications with dry, crusty debris around their rims and sides were stored in the active storage areas of medication carts 2 and 4. These failures had the potential for the use of discontinued medications, possible medication ineffectiveness, and the possibility for a medication to be administered to the wrong resident. Findings: 1. During a concurrent observation and inspection of medication cart 2, on [DATE], at 1:59 PM, accompanied by Licensed Nurse (LN) 6, the following medications were found expired, undated, or unlabeled: a. A vial of opened Atropine Sulfate Ophthalmic Solution (prescription eye drops) was dated as opened on , d+[DATE], no year was indicated. b. A container of Latanoprost Ophthalmic Solution (prescription eye drops) was dated as opened on , d+[DATE] no year was indicated. The label on the box indicated, .Once bottle is opened for use, it may be stored at room temperature .for 6 weeks . c. A vial of Latanoprost Ophthalmic Solution was found opened with no open date. d. An opened vial of Latanoprost Ophthalmic Solution was found with no prescription label indicating the resident name or date it was filled and no open date. LN 6 stated the vials should be labeled, dated when opened, and disposed of after 30 days of opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and inspection of medication cart 4, on [DATE], at 9:48 AM, accompanied by LN 5, a foil package containing Ipratropium Bromide and Albuterol Sulfate inhalation Solution (a prescription medication used to treat shortness of breath) was found opened and undated. The label on the box indicated, .Once removed from the foil pouch, the individual vials should be used within one week . LN 5 confirmed the foil pack should have been dated when opened and the medication disposed of after seven days. 3a. During a concurrent observation and inspection in the Station 1 medication room with LN 2, on [DATE], at 10:16 AM, an open foil package of Albuterol Sulfate Inhalation Solution (a prescription medication used to treat shortness of breath) was found undated. LN 2 stated the medication should have been dated when opened and disposed of after one week. 3b. During a concurrent observation and inspection in the Station 2 medication room with LN 7, on [DATE], at 10:28 AM, a vial of liquid Lorazepam (a prescription anti-anxiety medication), belonging to a resident who had been discharged , was found in the locked refrigerator. LN 7 confirmed medications should be removed from the storage area once a resident had been discharged . 4a. During a concurrent observation and inspection of medication cart 2, on [DATE], at 1:59 PM, accompanied by LN 6, LN 6 confirmed an opened bottle of OTC cough syrup had dry caked on liquid dripping down the sides of the bottle and it should not. 4b. During a concurrent observation and inspection of medication cart 4, on [DATE], at 9:48 AM, with LN 5, LN 5 confirmed an opened bottle of OTC cough syrup had dry caked on liquid dripping down the sides of the bottle and needed to be cleaned. During an interview on [DATE], at 3:42 PM, the Director of Nursing (DON) stated it was her expectation that medications would be pulled for destruction when expired, undated when opened, unlabeled, or belonged to discharged residents. The DON further stated if they were not removed from use there was the potential risk of expired or ineffective medications to be administered to the residents. A review of a facility policy and procedure titled, Medication labeling and Storage, revised February 2023, indicated, .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .If medication containers have missing, incomplete, improper, or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on observation, interview, and record review, the facility failed to ensure safe food production in accordance with professional standards for food safety for the 91 residents who received facility prepared meals when: 1. Opened food packages and/or containers were not labeled with an open date, 2. Spoiled and expired food products were not removed, 3. Kitchen equipment and food contact surfaces were not cleaned; and, 4. A partially consumed bottle of drinking water was found on a shelf with food items in the dry food storage area. These failures had the potential to put residents eating facility prepared meals at risk for foodborne illnesses. Findings: On [DATE], at 8:30 a.m., during an initial tour of the kitchen accompanied by the Dietary Director (DD), the following findings were observed: 1a. During a concurrent observation and interview on [DATE], at 8:32 a.m., with the DD in the kitchen food prep area. The DD confirmed an open container of ground mustard had an illegible label with no open date. 1b. During a concurrent observation and interview on [DATE], at 8:33 a.m., with the DD in the kitchen food prep area. The DD confirmed an opened container of rubbed sage spice was unlabeled. 1c. During a concurrent observation and interview on [DATE], at 8:36 a.m., with the DD in the kitchen food prep area. The DD confirmed an opened container of baking powder was unlabeled. 1d. During a concurrent observation and interview on [DATE], at 8:49 a.m., with the DD in the dry food storage area. The DD confirmed opened containers of parsley flakes and oregano leaves noted on a shelf were unlabeled. 1e. During a concurrent observation and interview on [DATE], at 8:49 a.m., with the DD in the dry food storage area. The DD confirmed an opened box of cream of wheat dry cereal noted on a shelf was unlabeled. 1f. During a concurrent observation and interview on [DATE], at 8:50 a.m., with the DD in the dry food storage area. The DD confirmed an opened bin containing a white substance was found unlabeled on a shelf. (continued on next page)

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	055011	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River View Post Acute	1611 Scenic Drive Modesto, CA 95355

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1g. During a concurrent observation and interview on [DATE], at 8:50 a.m., with the DD in the dry food storage area. The DD confirmed an opened bag of dry cereal was noted on a shelf and was unlabeled. A review of an undated facility policy and procedure (P&P) titled, Labeling and Dating of Foods, indicated, . All food items in the storeroom, refrigerator, and freezer need to be labeled and dated .Procedure .Food delivered to facility needs to be marked with a received date .Newly opened food items will need to be closed and labeled with an open date and use by the date . A review of a facility P&P titled, Storage of Foods and Supplies, dated 2023, indicated, .Procedures for Dry Storage .6. Dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc.) should be stored in seamless metal or plastic containers with tight covers, or in bins which are easily sanitized .Bins/containers are to be labeled, covered and dated .All food will be dated - month, day, year . A review of the FDA Food Code 2022, section ,d+[DATE].17 (A) (B) (C) (D) indicated, .required food labeling and dating .the day the original container is opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date .mark the date or day of preparation, with a procedure to discard the food on or before the last date . 2a. During a concurrent observation and interview on [DATE], at 8:33 a.m., with the DD in the kitchen food prep area. An opened container of Italian seasoning was noted. The DD confirmed the label date indicated the seasoning was expired. 2b. During a concurrent observation and interview on [DATE], at 8:37 a.m., with the DD in the kitchen food prep area. The DD confirmed a red onion with mold growth was noted on a tray with loaves of bread. 2c. During a concurrent observation and interview on [DATE], at 8:37 a.m., with the DD in the kitchen food prep area. The DD confirmed loaves of bread on a tray in the kitchen food prep area were expired. 2d. During a concurrent observation and interview on [DATE], at 8:45 a.m., with the DD in the walk-in refrigerator. The DD confirmed a flat of eggs was noted with a cracked egg in it. A review of an undated facility P&P titled, General Receiving of Delivery of Foods and Supplies, indicated, . Produce is to be fresh and free of any wilting or spoilage . A review of a facility P&P titled, Storage of Food and Supplies, dated 2023, indicated, .13. Bread will be delivered frequently and used in the order that it is delivered to assure freshness . A review of the FDA 2022 Food Code Section ,d+[DATE].13, indicated, .Eggs shall be received clean and sound . A review of an article titled, Salmonella and Eggs What You Need to Know, accessed [DATE] from www. foodsafety.gov indicated, .Salmonella can get on the shells of eggs .to reduce the chance of getting sick from eggs .buy eggs from stores or suppliers that keep eggs refrigerated .discard cracked eggs . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3a. During a concurrent observation and interview on [DATE], at 8:39 a.m., with the DD, in the food prep area. The DD confirmed a can opener was noted with a dried grayish substance build-up on the blade. A review of a facility P&P titled, Can Opener and Base, dated 2023, indicated, .Proper sanitation and maintenance of the can opener and base is important to sanitary food preparation .Cleaning Procedure .1. The can opener must be thoroughly cleaned each work shift and, when necessary, more frequently . 3b. During a concurrent observation and interview on [DATE], at 8:40 a.m., with the DD in the walk-in refrigerator. The DD confirmed areas of rust, black, and whitish substances were noted on walls near where the internal digital thermometer was mounted in the walk-in refrigerator. The DD stated that staff did not use the digital thermometer mounted on the wall and instead; staff used the mercury thermometer mounted on the shelf in the walk-in refrigerator. A review of a facility P&P titled, Procedure for Refrigerated Storage, dated 2023, indicated, .2. Two thermometers, placed to be easily visible for checking, should be inside all walk-in, reach in refrigerators. The second thermometer is a check against the first thermometer for accuracy. A temperature will be logged twice daily by a designated employee upon opening of the kitchen and upon closing of the kitchen .3. Refrigeration equipment should be routinely cleaned . A review of the FDA 2022 Food Code, section ,d+[DATE].11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, dated [DATE], indicated, .(C) Non-Food Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris . 3c. During a concurrent observation and interview on [DATE], at 9:51 a.m., with the DD in the kitchen. The DD confirmed there was black, grimy build-up noted to the inside of the oven doors, inside bottoms of the oven cavities, and back walls of the oven cavities. A review of a facility P&P titled, Ranges and Ovens, dated 2023, indicated, .Ovens .Cleaning Procedure .2. Weekly, and as often as necessary, racks and shelves should be removed and cleaned in a warm detergent solution following manufactures instructions .3. Use a blunt scraper or wire brush to remove encrusted material from oven surface . 3d. During a concurrent observation and interview on [DATE], at 8:52 a.m., with the DD in the kitchen. The DD confirmed a metal strainer was noted with a discoloration and dried brownish substance while stored on a rack with clean pots and pans. 3e. During a concurrent observation and interview on [DATE], at 9:02 a.m., with the DD in the kitchen. The DD confirmed the toaster oven was noted with a crusted brownish and black build-up on the inside walls and the bottom inside rack of the toaster. The DD further confirmed there was a crusted brown stain on the outer front top edge of the toaster. 3f. During a concurrent observation and interview on [DATE], at 9:49 a.m. with the DD in the food prep area. The DD confirmed a commercial mixer was noted with a dried whitish material in the mixer pitcher. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3g. During a concurrent observation and interview on [DATE], at 9:53 a.m., with the DD in the kitchen. The DD confirmed a muffin tin was noted with a dried brown flaky substance while being stored on a rack with clean pots and pans. 3h. During a concurrent observation and interview on [DATE], at 12:20 p.m., with the DD in the kitchen. The DD confirmed a metal rack was noted with a brown flaky substance on it. The DD further confirmed the rack was being used to store clean pots and pans. A review of the FDA 2022 Food Code, section ,d+[DATE].11, titled, Clean - Food Contact Surfaces, indicated, It is the standard of practice to ensure food contact surfaces of equipment shall be cleaned at any time during the operation . A review of the FDA Food Code 2022, section ,d+[DATE].11, titled, Equipment, Food Contact Surfaces, Nonfood-Contact Surfaces and Utensils, indicated, (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. 4. During a concurrent observation and interview on [DATE], at 8:51 a.m., with the DD in the dry food storage area. The DD confirmed a partially consumed water bottle was noted on the shelf with other food items and removed the water bottle. A review of the FDA Food Code 2022, section ,d+[DATE].11(A), titled, Designated Areas, indicated, .Areas designated for EMPLOYEES to eat, drink, and use TOBACCO PRODUCTS shall be located so that FOOD, EQUIPMENT, LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES are protected from contamination .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50018 Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 93, when 1 of 29 sampled resident's (Resident 90) urinal was unlabeled. This failure had the potential for spread of infection if Resident 90's urinal was used by another resident. A review of Resident 90's Admission Record, indicated Resident 90 was admitted to the facility in the spring of 2024 with multiple diagnoses including end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), dependance on renal dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to), and anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues) in chronic kidney disease. During an observation on 8/13/24, at 11:34 AM, Resident 90 was observed resting in bed. Resident 90's unlabeled urinal was placed on his bedside table. During a concurrent observation and interview on 8/13/24, at 11:37 AM, with Certified Nurse Assistant (CNA) 4, CNA 4 confirmed that an unlabeled urinal was placed on Resident 90's bedside table. CNA 4 stated urinals should be labeled so people were not confused as to who it belonged to. CNA 4 further stated it was the CNA's job to make sure urinals were labeled correctly. During a concurrent observation and interview on 8/13/24, at 11:40 AM, with Licensed Nurse (LN) 4, LN 4 confirmed that an unlabeled urinal was placed on Resident 90's bedside table. LN 4 stated that he would have liked for the urinal to be labeled. During an interview on 8/14/24, at 3:30 PM, with the Infection Preventionist (IP), the IP stated urinals should be labeled with the resident's room number, last name, or initials at the very least. The IP further stated if urinals were not labeled, they could get mixed up and used by the wrong person. The IP explained the mix-up of resident urinals could lead to an infection. The IP stated each urinal should be labeled individually. During an interview on 8/15/24, at 9:45 AM, with the Director of Nursing (DON), the DON stated urinals should be labeled at least with the initials of the resident. During a review of the facility's document titled, Policies and Practices - Infection Control, dated 10/2018, indicated, .Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .