STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055039	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Rehab and Care Center	1630 N. Edison Street Stockton, CA 95204

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50778 Based on observation, interview, and record review, the facility failed to ensure privacy and dignity were maintained for 1 of 21 sampled residents (Resident 287) when, Resident 287's urinary catheter bag (a bag that collects urine draining from the bladder) did not have a privacy cover over it. This failure had the potential to negatively impact Resident 287's feelings of dignity and self-worth. Findings: During an observation on 2/18/25, at 12:25 PM, in Resident 287's room, Resident 287's urinary catheter bag was not covered with a privacy cover. During a concurrent observation and interview on 2/18/25, at 12:25 PM, with Certified Nursing Assistant (CNA) 1 in Resident 287's room, CNA 1 stated the urinary catheter bag hanging on the bed did not have a privacy cover. CNA 1 stated it should have been covered for privacy and dignity of Resident 287. During a concurrent observation and interview on 2/18/25, at 12:36 PM, with Licensed Nurse (LN) 1 in Resident 287's room, LN 1 confirmed the urinary catheter bag was hanging on the bed and not covered (with a privacy cover). LN 1 stated the purpose of the privacy cover, besides maintaining Resident 287's dignity, was not all residents were comfortable with the bag visible both inside and outside of the resident's room. A review of Resident 287's PHYSICIAN ORDERS, dated 2/11/25, indicated, .catheter .to drainage bag . [diagnosis] urinary retention [unable to empty the bladder completely] . During an interview on 2/21/25, at 9:25 AM, with the Director of Nursing (DON), the DON stated the urine catheter bag needs to be covered to maintain Resident 287's dignity. The DON stated it was the (facility's) policy to always use a privacy cover for urinary catheter bags. The DON explained her expectation was for the bag to be covered to preserve Resident 287's dignity. A review of an undated facility policy titled, RESIDENT RIGHTS, indicated, .It is the policy of this facility to promote and protect the rights of the residents residing in the facility .to assure that the resident is always treated with respect, kindness, and dignity . (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an undated facility policy titled, RESIDENT RIGHTS, indicated, .The Social Services Coordinator will be involved in educating the staff at least annually .to observe and monitor compliance with the implementation of resident's rights at all times .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 50778 Based on interview, and record review, the facility failed to ensure 1 of 21 sampled residents (Resident 29) was informed in advance by a physician or other professional in charge of Resident 29's care of the risks and benefits of psychotropic medication use (any drug capable of affecting the mind, emotions, and behavior) when Risperidone (medicine which may help symptoms such as aggressive or agitated behavior for some mental health conditions) and Valproic Acid (a medication which may help reduce behaviors that can include agitation, restlessness, combativeness, and verbal aggression) were prescribed and given without consent from Resident 29's Responsible Party (Resident 29's responsible party was a conservator-a person appointed by a court to make medical decisions for another adult who cannot care for themselves). The failure had the potential for not honoring the resident's right to be informed about his medical treatment including medication side effects or other alternative options. Findings: A review of Resident 29's ADMISSION RECORD, indicated Resident 29 was admitted to the facility with the diagnosis of DEMENTIA (a decline in mental ability that affects a person's memory, thinking, and behavior). Resident 29's admission record listed a Deputy Public Guardian as Resident 29's responsible party/conservator. During a concurrent interview and record review on 2/21/25, at 9:12 AM, with Licensed Nurse (LN) 1, Resident 29's undated FACILITY VERIFICATION OF RESIDENT INFORMED CONSENT FOR PHYSICAL RESTRAINTS, PSYCHOTHERAPEUTIC DRUGS OR 'PROLONGED USE OF A DEVICE' (informed consent form) for Risperidone and Valproic Acid were reviewed. LN 1 stated he was not sure when the doctor signed the forms because they did not include a date and there was not a check mark indicating with whom the informed consent was discussed. LN 1 stated the purpose (of obtaining informed consent) was to explain the medication risks and benefits to the resident (or their Responsible Party/Conservator) and allow them to make an informed decision (regarding treatment with medications). During a concurrent interview and record review on 2/21/25, at 9:21 AM, with the Director of Nursing (DON), Resident 29's undated FACILITY VERIFICATION OF RESIDENT INFORMED CONSENT FOR PHYSICAL RESTRAINTS, PSYCHOTHERAPEUTIC DRUGS OR 'PROLONGED USE OF A DEVICE' for Risperidone and Valproic Acid were reviewed. The DON confirmed the forms were not dated or completely filled out and only signed (by the doctor) and a signature would indicate the physician had explained side effects, risks, and benefits (of the medications). A review of Resident 29's Order Summary Report, indicated Resident 29 was prescribed Valproic Acid on 04/26/24 and Risperidone on 7/30/24 to be used as follows: Valproic Acid Oral Capsule 250 MG [milligram - a unit of measurement of mass or weight in the metric system] .Give 1 capsule by mouth three times a day for Mood stabilizer m/b [manifested by - evidence of] physical aggression . (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Risperidone Tablet 0.5 MG Give 0.5 mg by mouth at bedtime every Mon., Wed., Fri. for Mood Stabilizer m/b verbal aggressiveness. Risperidone Tablet 1 MG Give 1 tablet my mouth at bedtime every Tues., Thu., Sat, Sun for Mood Stabilizer m/b verbal aggressiveness. A review of Resident 29's Medication Administration Record (MAR), dated 2/2025, indicated that Valproic Acid Oral Capsule 250 MG, Risperidone Tablet 0.5 MG, and Risperidone Tablet 1 MG were administered as ordered indicated by Licensed Nurses' documentation on the MAR. A review of the facility's undated policy titled, RESIDENT RIGHTS, indicated, .Free choice .the resident has the right to .Be fully informed in advance about the care and treatment and of any changes in in that care or treatment that may affect the resident's well-being . During a review of the facility's undated policy titled, POLICY AND PROCEDURE ON CHEMICAL RESTRAINTS, indicated, .The facility shall ensure that each resident receives .the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being .The facility shall use a psychotherapeutic drug .only if the resident, or his/her surrogate decision maker [conservator] has given consent to the use of the medication .Physician shall obtain an informed consent .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 50598 Based on observation, interview, and record review, the facility failed to ensure the protection to residents' personal information for a census of 81 when meal tray tickets (contained resident names and other identifying information) were thrown into the trash and outside dumpsters. This failure had the potential for identity theft and misuse of personal information. Findings: During an observation of dishwashing on 2/18/25, at 9:24 AM, with Dietary Aid 1 (DA 1) in the kitchen, DA 1 was observed removing items from residents breakfast trays. DA 1 was threw the meal tray tickets from the breakfast trays into the regular trash along with food scraps. During a concurrent observation and interview on 2/18/25, at 12:56 PM, with DA 2 in the kitchen, DA 2 was observed removing items from the residents breakfast trays. DA 1 was throwing the meal tickets from the breakfast trays into the regular trash along with food scraps. DA 2 confirmed this was the facility's practice of disposal of meal tray tickets. During an interview with the Registered Dietician (RD) on 2/21/25, at 1:26 PM, the RD acknowledged the meal tray tickets being throwing in the trash was a confidentiality issue and stated, she was unaware of any other way to dispose of them. A review of a facility's meal tray ticket indicated the meal tray ticket contained residents' information such as the residents' complete name, where the resident usually eats his/her meal, residents' unit, room, and bed number, residents' diet order, resident's allergies, resident's food notes and alerts, residents' standing food order, resident's likes and dislikes, the date, and type of meal. During an interview on 2/21/25, at 1:36 PM, with the Director of Nursing (DON), the DON stated there were privacy and confidentially concerns, all meal tray tickets should be shredded after recording the intake information. The DON stated this was a violation of the residents privacy and this practice did not meet her expectations. During a review of an undated facility's policy and procedure (P&P) titled, How To Dispose/Destruct Of Patient Health information, the P&P indicated, .The facility shall destruct or destroy medical records by shredding or otherwise destroying Patient Health Information so the PHI is rendered essentially unreadable, indecipherable, and other cannot be reconstructed prior to being placed in a dumpster or other trash receptacle .

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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. 49823 Based on observation, interview, and record review, the facility failed to ensure an environment free of accidents or hazards for two of five residents (Resident 288 and Resident 61) whom smoked when: 1. Resident 288 smoked a cigarette in the facility courtyard without supervision; and 2. Resident 61 kept a cigarette lighter in his room that was accessible to other residents. These failures had the potential to place Resident 288 and other residents in the facilit,y with a census of 81, at risk for accidental burns and injuries. Findings: 1. A review of Resident 288's ADMISSION RECORD, indicated that Resident 288 was admitted to the facility with diagnoses which included metabolic encephalopathy (a change in how the brain works which causes confusion, memory loss and loss of consciousness). During an observation in the facility courtyard on 2/19/25, at 7:58 a.m., Resident 288 and the Nursing Assistant (NA) were outside in the courtyard. The NA lit Resident 288's cigarette with a cigarette lighter and left Resident 288 in the courtyard to smoke. During am interview on 2/19/25, at 8 a.m Licensed Nurse (LN) 6 stated that there was a smoking schedule which included which facility staff were assigned to supervise the residents who were smoking in the courtyard. LN 6 stated that LNs monitored residents who smoked to make sure that the residents did not harm themselves while smoking and to make sure that the residents properly extinguished the cigarettes after smoking. LN 6 stated that the Social Services Director (SSD) reviewed the smoking policy with the residents and/or their responsible parties (RP, family) when they were admitted to the facility. LN 6 stated that the facility had smoking aprons in the medication storage rooms for residents. LN 6 stated that residents can only smoke in the courtyard. LN 6 stated that the SSD and/or LNs kept the cigarettes for residents who were not independent smokers (able to use their lighter and hold their cigarette to smoke without staff assistance). LN 6 stated that if allowed, some residents could keep their smoking paraphernalia (cigarettes and lighters) in their rooms. LN 6 stated that smoking assessments for residents were kept in their charts and in a smoking binder in the SSD's office. During an interview with the NA on 2/19/25 at 9:45 a.m., the NA confirmed that she lit Resident 288's cigarette and left him in the courtyard to smoke unsupervised. The NA stated that she was told that since she was not a certified nursing assistant, she could not supervise the resident in the courtyard, so she left the resident in the courtyard and went inside the facility. The NA confirmed that Resident 288 needed to be supervised while smoking per his smoking care plan. The NA stated that the risk of leaving Resident 288 alone on the patio to smoke without supervision was that he could get hurt. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Social Services Director (SSD) on 2/19/25, at 10:25 a.m., the SSD stated that when residents were admitted , the resident or RP was asked if the resident smoked. The SSD stated that if the resident was alert and oriented, the resident could smoke anytime, but still needed supervision per the smoking schedule. The SSD stated that the residents could go out to the courtyard to smoke, but a staff member had to go out to the courtyard with the residents to supervise. The SSD stated that the residents obtained their cigarettes and lighters from the smoking kit at the nurses' station or from the SSD before going out to smoke. The SSD stated that residents were not allowed to keep their lighters in their rooms for safety, but residents could keep their cigarettes. During a review of Resident 288's Smoking Data Collection and Assessment, dated 2/17/25, indicated .The resident may only smoke with supervision. (Notify the resident and/or authorized responsible party) . During a review of Resident 288's undated Assessment of Safe Possession of Smoking Paraphernalia, indicated, .Cognitive [thinking, reasoning, or remembering] ability of resident is assessed to be alert with periods of confusion [lack of understanding, uncertainty] .IDT's [Interdisciplinary Team, a group of healthcare professionals with various levels of expertise who work together towards the goals of their residents] recommendation .2. Resident may possess smoking paraphernalia: no . During a review of Resident 288's Smoking Risk Care Plan, dated 2/3/25, indicated, .Problem .High Risk for Accidental Injury from Cigarette burns .Keep cigarette in mouth unlighted and wheels around in facility .Goal: Resident will exhibit safe smoking practices daily .Interventions: Observe/report unsafe smoking practices . Heightened Safety Risk R/T [related to]: Cognitive issue .confusion, forgetfulness .Physical Issues: Poor trunk control [ability to control the upper body, how well a resident can hold the body upright while sitting or moving] .Medical Issues: weakness .Recommended Smoking Plan: Independent Smoking .Safety Modifications: staff to retain cigarettes .staff to retain lighter .supervised smoking . During an interview with the DON on 2/21/25 at 9:15 a.m., the DON stated that the expectation was that all residents were supervised while smoking in the courtyard. The DON confirmed that the facility policy was not followed. 2. A review of Resident 61's Admission Record, indicated that Resident 61 was admitted to the facility with diagnoses which included acute respiratory failure with hypoxia (a life-threatening condition that occurs when the lungs cannot deliver enough oxygen to the body) and chronic obstructive pulmonary disease (COPD, a lung disease causing restricted airflow and breathing problems). During an interview with Resident 61 in the courtyard on 2/19/25, at 7:55 a.m., Resident 61 stated that he smoked. Resident 61 stated that he kept his cigarettes and his lighter in his pocket. Resident 61 stated that he heard conflicting reports on whether he had to lock his cigarettes and his lighter up in his room. Resident 61 stated that he could smoke outside whenever he wanted. Resident 61 stated that smoking was only allowed in the courtyard. Resident 61 stated that the courtyard door was not locked at night. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/25, at 8 a.m., LN 6 stated that there was a smoking schedule which included which facility staff were assigned to supervise the residents who were smoking on the courtyard. LN 6 stated that residents can only smoke at the courtyard. LN 6 stated that the SSD and/or LNs kept the cigarettes for residents who were not independent smokers (able to use their lighter and hold their cigarette to smoke without staff assistance). LN 6 stated that if allowed, some residents could keep their smoking paraphernalia (cigarettes and lighters) in their rooms. During an interview with the Social Services Director (SSD) on 2/19/25 at 10:25 a.m., the SSD stated that the residents obtained their cigarettes and lighters from the smoking kit at the nurses' station or from the SSD before going out to smoke. The SSD stated that residents were not allowed to keep their lighters in their rooms for safety, but residents could keep their cigarettes. During an interview with the facility Director of Nursing (DON) on 2/19/25 at 10:30 a.m., the DON stated that residents assessed to be independent smokers could keep their cigarettes and lighters in their rooms. The DON stated that residents that kept their cigarettes and lighters in their rooms must always have their cigarettes and their lighters in their possession. The DON stated that one resident in the facility was on continuous oxygen and four or five residents had orders for as needed oxygen. The DON stated that residents who had their cigarettes and their cigarette lighters in their possession were always monitored by the staff. The DON stated that the staff were aware of which residents smoked in the facility and monitored the residents to make sure that they always kept their cigarettes and their lighters with them. The DON stated that at night, the charge nurses and the Certified Nursing Assistants (CNAs) monitored the residents at night to make sure that no one had access to their cigarettes and their lighters. The DON stated that the risk was explosion if a resident obtained a lighter and cigarette and lit it in the presence of oxygen. During an interview with the DON on 2/21/25 at 9:15 a.m., the DON stated that the expectation was that all residents were supervised while smoking in the courtyard. The DON confirmed that the facility policy was not followed. A review of an undated facility policy and procedure (P&P) titled Policy and Procedure on Smoking, the P&P indicated .Policy: It shall be this facility's policy to allow residents to smoke provided smoking is done in an area and in a manner that does not pose any harm or danger to facility, personal property or personal endangerment. In the case of any resident who is physically or mentally incapacitated, resident shall be permitted to smoke provided that smoking is done under close supervision of staff .Procedures .4. Smoking shall only be allowed in designated areas .11. Residents who are either physically or cognitively incapacitated shall be permitted to smoke only under the close supervision of staff .12. Residents who are not capable of smoking safely including handling smoking paraphernalia safely may be placed on scheduled and/or supervised smoking . A review of an undated facility P&P titled Policy and Procedure on Smoking: Smoking Paraphernalia, the P&P indicated, .Policy: It is this facility's policy to uphold resident's rights to smoke, provided smoking is done in an area and manner that does not pose potential harm or danger to self, facility/personal property or others. In this regard, smoking paraphernalia such as cigarettes, lighters and matches may be in a resident's possession only under conditions deemed safe by the facility's inter-disciplinary team. Procedures .7. Smoking materials or paraphernalia shall be made available to the resident during smoking time, only under close supervision of staff .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49823 Based on observation, interview, and record review, the facility failed to provide accurate administration of medication for 1 out of 16 residents (Resident 62) observed during medication administration when, Resident 62's medication was given when her vital signs were outside of prescribed parameters. This failure had the potential for Resident 62 to experience an adverse reaction to her prescribed medication. Findings: A review of Resident 62's ADMISSION RECORD indicated that Resident 62 was admitted to the facility with diagnoses which included cerebral infarction (a result of disrupted blood flow of the brain due to problems with the blood vessels that supply it, also known as stroke) and hypertension (a condition in which the force of blood pushing against the blood vessel walls is consistently too high which causes the heart to work harder to pump blood). During an interview and concurrent medication administration observation with Licensed Nurse (LN) 7 on 2/19/25, at 4:15 p.m., LN 7 checked Resident 62's blood pressure and obtained a reading of 102/57. LN 7 then administered an oral tablet of Amlodipine (a medication prescribed by Resident 62's physician for hypertension) to Resident 62 with water. LN 7 watched Resident 62 take the tablet and the water afterward. During a review of Resident 62's [Facility name] Order Summary Report, dated 2/20/25, indicated, . amLODIPine Besylate [medication for hypertension] Oral Tablet 5 MG [milligrams; a unit of measure] Give 1 tablet by mouth in the evening for HTN [hypertension] Hold if sBP [systolic blood pressure, (top number) which is the amount of pressure the blood exerts on blood vessel walls when the heart beats] < [symbol for is less than] 110 .Order Date .04/17/2024 . During an interview on 2/19/25, at 5:20 p.m., LN 7 stated that Resident 62's blood pressure reading was 102/57. LN 7 confirmed that the blood pressure medication given to Resident 62 had a hold parameter. LN 7 confirmed that the Medication Administration Record (MAR, a document listing medications and monitoring parameters) listed a hold parameter for the blood pressure medication that was administered to Resident 62. LN 7 confirmed that the blood pressure medication should not have been given to Resident 62. LN 7 stated that the risk was that Resident 62's blood pressure could go too low. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with the facility's Director of Nursing (DON) on 2/21/25 at 9:15 a.m., the DON stated that the expectation was that when LN's gave blood pressure medications to residents, the LN's took the residents' blood pressure then checked the medication orders and MARs for hold parameters. The DON stated that it was not acceptable to give a blood pressure medication if the resident's blood pressure was outside of the hold parameters. The DON stated that if the blood pressure medication was given to a resident whose blood pressure was outside of the hold parameters, the expectation was that the LN would call the physician to report the error and monitor the resident's blood pressure. The DON stated that the risk was that the resident's blood pressure could go too low. The DON confirmed that the facility policy was not followed. During a review of a facility policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 8/19, the P&P indicated, .Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . Procedures .A. Preparation .5) the medication administration record (MAR) is always employed during medication administration .B. Administration .2) medications are administered in accordance with written orders of the prescriber .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49823 Based on observation, interview, and record review, the facility failed to ensure safe medication and medical supplies storage in the medication cart, treatment cart, medication refrigerator, and the medication storge room for a census of 81 when: 1. Staff beverages, and staff belongings were stored in the medication storage rooms; 2. The medication refrigerator in the medication storge room which contained narcotics was not locked; 3. Expired medications and opened unlabeled medications were stored in the medication cart; 4. Multi-use wound care irrigation solutions in the treatment cart were opened but not dated; 5. Expired single use wound care ointment and cream, expired multi-use wound care ointments, and expired wound dressing material were stored in the treatment cart; and, 6. A single use sterile dressing in the treatment cart was opened but not discarded. These failures could contribute to unsafe medication use, storage, and medication errors that could affect the well-being of the facility's vulnerable elderly residents. Findings: During a concurrent observation and interview, in the medication storage room at Nursing Station #3 with Licensed Nurse (LN) 8 on 2/18/25 at 10:12 a.m., staff coffee cups, staff bags and staff drink cups with straws in them were located in the medication room. LN 8 stated that they should not be there due to a risk of infection (exposure to germs). LN 8 confirmed the medication refrigerator in the medication storage room was not locked, and a narcotic locked box in the medication refrigerator contained lorazepam (a controlled substance medication (drug tightly controlled by the government due to its abuse) used to treat panic attacks and seizures). During a concurrent observation and interview, in the medication storage room at Nursing Station #1 and #2, on 2/18/25 at 10:27 a.m. with LN 3, a staff's coffee cup and a staff's water cup were in the medication storage room. LN 3 stated that the staff cups should not be in the medication room. LN 3 stated that the risk was infection. LN 3 removed the staff cups from the medication room. During an interview on 2/18/25 at 10:37 a.m. with (LN) 9, LN 9 stated that the medication refrigerator should be locked when there were narcotics in the refrigerator. LN 9 stated that the risk was that someone could have access to the narcotics who was not authorized. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and observation of Medication Cart #3 on 2/20/25 at 11:24 a.m. with LN 5 at Nurses Station #3, LN 5 confirmed the drawer on the right side of the cart contained expired eye drops. LN 5 confirmed an expired container of oral calcium (vitamin supplement), an expired container of docusate sodium capsules (medication to prevent constipation), an opened unlabeled multi-use bottle of Milk of Magnesia (liquid medication to prevent constipation), and an expired Albuterol Sulfate inhaler (medication to improve breathing) were located in drawer two. All expired medications were removed by LN 5. LN 5 stated that the risk of using expired medications was that the residents might get sick. During a concurrent observation and review of Treatment Cart #3 with LN 5 confirmed there were two expired bottles of sterile saline solution single use for irrigation were opened, but not dated. LN 5 stated that the saline solution should have been discarded as it was for single use. LN 5 discarded the saline solution. LN 5 confirmed there was one expired tube of Fluconozole (medicated ointment for wound care) ointment, one tube of expired Fluconozole cream (medicated cream for wound care), and a box of expired triple antibiotic ointment packets located in drawer two. LN 5 confirmed there was an opened sterile Maxorb calcium alginate dressing (used to cover surgical wounds and ulcers) located in drawer three of the treatment cart. LN 5 stated that the expired items should have been discarded. LN 5 confirmed an opened multi-use bottle of povodine iodine ointment (antibiotic ointment used to kill germs in wounds) was not dated and an opened multi-use bottle of Dakin's solution (used to clean wounds) was not dated. LN 5 confirmed an opened, expired package of Medfil collagen particles (used to treat deep wounds) had spilled in the third drawer of the treatment cart. LN 5 stated that the expired items should have been discarded. LN 5 stated that when solutions for wound care were opened, they should be dated. LN 5 threw away all expired items. During an interview with the facility Director of Nursing (DON) on 2/20/25 at 12:47 p.m., the DON stated that the expectation was that no staff personal belongings were kept in the medication storage room. The DON stated that staff had lockers in the breakroom to keep their personal belongings, and the staff should have their drinks in the breakroom as well. The DON stated that the medication refrigerator must be locked when narcotics were stored in the medication refrigerator. The DON stated that there should not be any expired medications in the medication cart. The DON stated that sterile saline for irrigation in single use containers must be discarded after use. The DON stated that sterile wound dressings must remain sealed until used and should be thrown away if the packaging was opened, expired, or damaged as the dressing would no longer be sterile and could put a resident at risk for infection in the wound. The DON stated that multi-dose bottles of Dakin's solution and povodine iodine ointment must be dated when opened. The DON stated that the facility policy was not followed. A review of a facility policy and procedure (P&P) titled, Storage of Medications, dated 8/19, the P&P indicated, .Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .Procedures .H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal .I. Medication storage areas are kept clean, well-lit, and free of clutter .D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated .G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining .H. Disposal of any medication prior to the expiration date will be required if contamination or decomposition is apparent . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility P&P titled, Controlled Substances, dated 8/19, the P&P indicated, .Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations .C. All controlled substances are stored and maintained in a locked cabinet or compartment. If refrigeration is required, the refrigerator .is locked .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50598 Based on observation, interview, and record review, the facility failed to provide safe food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 81 residents who ate facility prepared meals when: 1. Raw chicken was left thawing in the sink without running water; 2. Over-ripe and spoiled produce was available for use in the walk-in refrigerator; 3. Leftover food was kept beyond a safe time frame, incorrectly dated, and the cool down process was omitted; 4. Staff food was stored in the walk-in refrigerator which contained resident food and placed on top of cooked food; 5. Boxes of food, drinks, supplies, and food products were found on the floor in the dry storage room; 6. Non-food items and staff personal items were stored in the dry storage room; 7. Dented cans were found in the dry storage room ready to serve; 8. Clean food service items were found put away wet such as trays and steam table pans; and 9. The oven was found dirty with layers of grease and food debris. These failures placed residents at risk for foodborne illnesses. Findings: 1. During a concurrent observation and interview, during the initial kitchen tour on 2/18/25, at 8:14 AM, the [NAME] (CK) confirmed there were three clear bags of raw chicken placed in an empty bucket over the sink without running water. During an interview with the Registered Dietician (RD) on 2/21/25 at 12:04 PM, when asked about the raw chicken, the RD stated the kitchen staff have been in serviced on the thawing process for raw meat. The RD stated the raw meat if thawing under water should be running at 70 degrees. The RD stated thawing meat without running water is not safe for the residents and the meat will be in the danger zone for bacteria growth. The RD stated chicken needed to be handled safely due to the risk of Salmonella (define) and can effect the quality of the meat. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of a facility provided documents titled, Thawing of Meats, dated 2023, indicated, .Submerge under running, potable water at a temperature of 70 degrees or lower, with a pressure sufficient to flush away loose particles .The food product cannot remain in the temperature danger zone (41 F- 140F [Fahrenheit, a unit of temperature measurement]) for more than four hours . Review of the Food and Drug Administration (FDA) Food Code 2022, under section 3-501.1, titled, Thawing, indicated, .(B) Completely submerged under running water: (1) At a water temperature of 21oC [celcius; a unit of temperature measurement] (70F) . With sufficient water velocity to agitate and float off loose particles in an overflow . (https://www.fda.gov/media/164194/download) 2. During a concurrent observation and interview, during the initial kitchen tour on 2/18/25, at 8:14 AM, the CK confirmed the following items were found in the walk in refrigerator in the kitchen where food was stored for residents: a. Three eggplants with black, white, yellow spots, and large indentations on them was available for use. b. One large grey tub of cucumbers was found on the floor of the refrigerator directly below One log of raw ground beef and a package of raw roast beef. c. One large clear container of minced garlic dated 1/20/24 with no use by date written on it. d. One large clear container or prepared ham sandwiches ready to serve dated 2/10/25 with a UBD of 2/14/25 e. Eight out of fifteen red bell peppers were found in pieces with exposed seeds, mushy in texture, and with green and white fuzzy substances on them ready to serve. f. One out of four tomatoes were found with a black fuzzy substance on it and mushy in texture. During an interview with the RD on 2/21/25 at 12:44 PM, the RD stated the facility policy was as soon as any brown is seen on a produce they were to be removed. The RD stated her expectation was for staff to remove produce from use as soon as there was any discoloration. The RD stated use of food in a decomposed state posed a risk to the residents due to potential exposure to bacteria. The RD stated the quality of the produce could affect the quality of the food. A review of a facility provided document titled, STORING PRODUCE, dated 2023, indicated, .Check boxes of fruit and vegetables for rotten, spoiled items. One rotten tomato, apple, or potato in a box can cause the rest of the produce to spoil faster. Throw away the spoiled items .When storing vegetables that should remain crisp such as lettuce and other leafy greens .green bell peppers .they will stay fresh longer if you place them in a sealed bag or container A record review of a facility provided document titled, Produce Storage Guidelines, dated 2023, indicated, . Garlic, Jarred, Chopped or Minced unopened on the shelf 8 months . opened in the refrigerator use by date . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of The Food and Drug Administration (FDA) Food Code 2022, under section 3-501.17 (A) (B) (C) (D), indicated, .the day the original container was 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 or day by which the food must be consumed on the premises . (https://www.fda.gov/media/164194/download) 3. During a concurrent observation and interview, during the initial kitchen tour on 2/18/25, at 8:14 AM, the CK confirmed there was the following left overs in the walk in refrigerator located in the facility kitchen where food was stored for residents: a. One medium size tray line container with left over ground beef and approximently eight hamburger patties inside of it with aluminum foil placed over and dated 2/17/25. b. One small tray line container halfway full with left over brown gravy inside of it with aluminum foil placed over and dated 2/17/25. c. One large tray line container with left over tuna salad and aluminum foil placed over it and dated 2/17/25. d. One small tray line container with left over sausage patties and bacon covered with aluminum foil and dated 2/17/25. e. One medium size tray line container with left over porkchops with aluminum foil placed over it and dated 2/14/25. f. One small tray line container with left over white rice with aluminum foil over it and dated 2/14/25. g. One medium size container of left over ground sausage with aluminum foil placed over it and dated 2/17/25. During an interview with the Certified Dietary Manager (CDM) on 2/21/25 at 11:51 AM, the CDM stated the leftovers were kept for 24 hours in the refrigerator and then discarded. The CDM stated the facility's practice is the day the leftovers were cooked they were placed into a container, dated, and then placed in the refrigerator. The CDM stated the leftovers may be used the following day for an alternative if a resident requested. The CDM stated if the leftovers will be reused, then the cook would reheat the food to 155 degrees for twenty seconds and then serve it. The CDM stated prior to storing the leftovers they do not use the cool down process (steps to monitor the temperature of cooked food to prevent bacteria growth) or any other monitoring tool. The CDM stated, when cooking food, they followed the menu strictly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 2/21/25 at 12:16 PM, the facility weekly menus for the month of Feburary 2025 were reviewed with the RD. The RD stated the expectation was for the cooks to use the cool down process and log when saving leftovers. The RD reviewed the photos taken during the initial walk through of the various leftovers. The RD stated the leftovers were unacceptable and should have been thrown out. A review of the weekly menus for 2/17/25- 2/23/25 revealed, the items that were left over were not cooked on 2/17/25 when comparing the times to the menu for 2/17/25. A review of the menu for 2/10/25-2/16/25 showed no items that were leftover in the fridge were cooked on 2/16/25 and 2/15/25. Further review of the menu indicated the left-over items were first listed on the menu on 2/14/25 and earlier in February. A concurrent review of a document titled Meal Service Alternatives for winter 2024-2025 was reviewed as well with no correlation to the leftovers. The RD stated her expectations were that the leftovers should be disposed of 24 hours after being cooked. The RD stated leftovers that were kept longer than the 24 hours have a decrease in the quality of the food and placed the residents at risk for food born illness. A review of an undated facility provided document titled, Cool Down Log, indicated the last documented entry was on 12/19/25 for roast beef. A review of a facility provided document titled, Leftover foods, dated 2023, indicated, .Policy: Left over foods will be stored and served in a safe manner .Should food be cooled off before placing in the refrigerator? .The answer is that food is not safe when it is between 41 F to 140F. Therefore, as soon as hot food has dropped to 140 F the proper methods of cooling food must be used . Review of The Food and Drug Administration (FDA) Food Code 2022, under section 3-501.17 (A) (B) (C) (D), indicated, .the day the original container was 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 or day by which the food must be consumed on the premises . (https://www.fda.gov/media/164194/download) 4. During a concurrent observation and interview, during the initial kitchen tour on 2/18/25, at 8:14 AM, the CK confirmed there was raw tilapia with only the heads cut off found in a small tray line container with aluminum foil placed over the container and written with marker Tilapia Head without a date . The CK confirmed the tilapia was stacked on top of cooked food and vegetables in the refrigerator. During an interview on 2/18/25 at 8:43 AM, with the Dietary Aide (DA) 3, when asked about the tilapia, DA 3 stated the tilipia was going to be cooked by the CDM for their personal consumption. During an interview with the CDM on 2/18/25 at 3:45 PM, the CDM stated the tilapia was something she was going to cook for the staff. The CDM confirmed the facility was not supposed to store and cook food where the resident's food was cooked and stored. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the RD on 2/21/25 at 12:57 PM, the RD stated the food should be stored in the refrigerator and handled properly for food safety practices which was not the case with the tilapia. The RD stated the tilapia that was in the resident's refrigerator and the improper placement in the refrigerator placed the residents at risk for cross contamination and food borne illnesses. The RD stated the facility was not aware of the origin of the tilapia and if safe handling practices were implemented. The RD stated the tilapia belonging to the staff being stored in the resident's refrigerator did not meet her expectations. The RD stated her expectations were for the staff to store their items in the designated areas for staff. A review of the facility's provided document titled, Good For Your Health Menus, for the following dates 2/17/25-2/23/25 indicated, no future item listed as Head of Tilapia. A review of a facility provided documents titled, Thawing of Meats, dated 2023, indicated, .Store raw meat, poultry, and fish separately from cooked and ready to eat food to prevent cross contamination .Store cooked or ready to eat food above raw meat, poultry, and fish if these items re stored in the same unit. This will prevent raw- product juices from dripping onto the raw prepared food causing food borne illness . A review of a facility provided document titled, Employee Personal Items, dated 2023, indicated, .POLICY: Personal items brought in by staff from outside will not be kept in the kitchen. PROCEDURE: Employees bringing in personal items from outside . will not be kept in the kitchen area. These items will be kept in the corner outside the storeroom . A Review of The Food and Drug Administration (FDA) Food Code 2022, under section 6-305.11 Designation, indicated, .personal belongings can contaminate food, food equipment, and food-contact surfaces. Proper storage facilities are . (https://www.fda.gov/media/164194/download) A Review of The Food and Drug Administration (FDA) Food Code 2022, under section 6-403.11 Designated Areas, indicated, .Because employees could introduce pathogens to food by hand-to-mouth-to-food contact and because street clothing and personal belongings carry contaminants, areas designated to accommodate employees' personal needs must be carefully located. Food, food equipment and utensils, clean linens, and single-service and single-use articles must not be in jeopardy of contamination from these areas . (https://www.fda.gov/media/164194/download) A Review of The Food and Drug Administration (FDA) Food Code 2022, under section 6-501.110 Using Dressing Rooms and Lockers indicated, .personal belongings can contaminate food, food equipment, and food preparation surfaces and consequently must be stored in properly designated areas or rooms . (https://www.fda.gov/media/164194/download) 5. During a concurrent observation and interview, during the initial kitchen tour on 2/18/25, at 8:49 AM, the CK confirmed the following items located on the floor in the dry storage area: one box of coffee covers, one box of roasted coffee placed, one box of 24 pack of pepper soda, one box of 24 pack of lemon-lime soda, three cases of water stacked on top of one another, and two cases of 24 pack of cola soda placed on top of the 24 pack of pepper soda. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the RD on 2/21/25 at 1:18 PM, the RD stated the facility did not allow food or food items to be placed on the floor and food items must be at least 6 inches off of the ground for safety and risk of insects and pests. The RD stated her expectations was for all items in the dry storage room to be placed at least 6 inches from the floor. A review of a facility provided document titled, Storage of Food Supplies, dated 2023, indicated, .All food and food containers are to be stored 6 [inches] off the floor and on a clean surface in a manner that protects it from contamination . A review of The Food and Drug Administration (FDA) Food Code 2022, under section 4-903, indicated, . Storing (D) Items that are kept in closed PACKAGES may be stored less than 15 cm (6 inches) above the floor on dollies, pallets, racks, and skids that are designed as specified under S 4-204.122 . (https://www.fda.gov/media/164194/download) 6. During a concurrent observation and interview, during the initial kitchen tour in the dry storage room on 2/18/25, at 8:49 AM, the CK confirmed the findings of one kids blue chair, one black chair with four wheels, one plastic foot stool, one black space heater, one black round house fan, and one blue personal lunch pail. During an concurrent observation and interview with Dietary Aide (DA) 3 on 2/18/25 at 8:49 AM, DA 3 stated the items were being used by staff who took their breaks in the dry storage room. During a concurrent interview and observation in the dry storage with the CDM on 2/18/25 at 12:30 PM, the CDM confirmed the personal items present belonged to staff. The CDM also stated the items found were utilized by staff while taking their breaks in the dry storage room. During an interview with the RD on 2/21/25 at 1:21 PM, the RD stated the employees have access to breakrooms. The RD stated the items found in the dry storage room did not appear to be clean or safe to use for staff. The RD stated the facility was unaware of where the items came from and how often they were cleaned. The RD stated the facility aims to minimize the amount of human contact wherever food is stored and these items that was found in the dry storage room goes against the facility food storage policy. The RD stated only food was to be stored in the dry storage room. The RD stated her expectations were for the staff to take breaks in their designated break rooms and for only food to be stored in the dry storage room. A review of a facility provided document titled, Employee Personal Items, dated 2023, indicated, .POLICY: Personal items brought in by staff from outside will not be kept in the kitchen. PROCEDURE: Employees bringing in personal items from outside . will not be kept in the kitchen area. These items will be kept in the corner outside the storeroom . A Review of The Food and Drug Administration (FDA) Food Code 2022, under section 6-305.11 Designation, indicated, . personal belongings can contaminate food, food equipment, and food-contact surfaces . (https://www.fda.gov/media/164194/download) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Review of The Food and Drug Administration (FDA) Food Code 2022, under section 6-403.11 Designated Areas, indicated, .Because employees could introduce pathogens to food by hand-to-mouth-to-food contact and because street clothing and personal belongings carry contaminants, areas designated to accommodate employees' personal needs must be carefully located. Food, food equipment and utensils, clean linens, and single-service and single-use articles must not be in jeopardy of contamination from these areas . (https://www.fda.gov/media/164194/download) A review of The Food and Drug Administration (FDA) Food Code 2022, under section 7-209.11, titled, Storage indicated, .Employee personal care items may serve as a source of contamination and may contaminate food, food equipment, and food-contact surfaces if they are not properly labeled and stored . (https://www.fda.gov/media/164194/download) A review of the facility provided document titled, storage of food and supplies, dated 2023, indicated, Storage areas should be used for food only . 7. During a concurrent observation and interview during the the initial kitchen tour on 2/18/25, at 8:49 AM, the CK confirmed the findings of two dented cans of pineapple, one dented can of ripe olives, two dented cans of fruit salad, one dented can of shredded sauerkraut, and one dented can of pork and beans. These cans were stocked and stored in a ready to serve area. During an interview with the RD on 2/21/25 at 1:11PM, the RD stated having dented cans on the shelves ready to serve did not meet the facility's expectations. The RD stated the facility's process and her expectations were when dented cans were discovered the staff should place the cans in a separate area and have them returned to the vendor for a credit. The RD stated the dented cans posed a serious risk because the integrity of the can was compromised and presented the ability of bacteria growth that could become deadly. A review of a undated facility provided document titled, FOOD STORAGE-DENTED CANS OR ALTERATION IN PACKAGING OF ANY FOOD ITEM POLICY AND PROCEDURES, indicated, .Policy: Food in unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents or swells shall not be retained or used by the facility .Update: Do not use any food item, canned or in any form that has altered packaging .dented cans .If a food item has a dent or crumpled carton, separate the item DO NOT USE. Return to the vendor for credit . 8. During a concurrent observation and interview during the initial kitchen tour on 2/18/25 at 9:08 AM, the CK confirmed twelve tray line pans were found stocked and stored wet with visible drops of liquid. During an interview with the RD on 2/21/25 at 11:11 PM, the RD stated the tray line pans should be allowed to air dry prior to storing them. The RD stated the pans being stocked and stored wet placed a risk for bacteria growth and contamination of the residnets food and posed a food borne illness risk. The RD stated her expectations were for the pans to be fully air dry prior to being stored. A review of a facility provided document titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, indicated, .Step 1. Clean and sanitize all work surfaces. Set up area for air drying .Step 6. All items are air dried, which means no water or droplets are present . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of The Food and Drug Administration (FDA) Food Code 2022, under section 4-901.11 Equipment and Utensils, Air-Drying Required, indicated, .Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils . (https://www.fda.gov/media/164194/download) 9. During a concurrent observation and interview during the initial kitchen tour on 2/18/25 at 9:09 AM, the CK confirmed that the stove was found with layers of a black greasy substance, layers of black hard flaky debris in the range area, and the oven was found to have layers of splattered liquid of various colors on the inside of the door of the oven and on the base of the oven. During a concurrent record review and interview with the CDM on 2/18/25 at 3:45 PM, the CDM stated the stove was to be cleaned after each shift to be prepared for the next shift on duty. The CDM stated the cleaning of the oven and stove was the cook on duty responsibility. The CDM stated maintenance cleans only the hood to the oven and the other duties belong to the cook. When shown the picture of the stove. the CDM confirmed the cooks need to scrub it with a scrubber and the chemicals provided by the vendor to get the stove and oven to meet her expectations. During an interview with the RD on 2/21/25 at 12:51 PM, the RD stated the stove and oven have a cleaning schedule and the expectations were for the cleaning schedule to be followed. The RD stated the purpose for the stove to be cleaned appropriately is to maintain the temperature along with fire safety and if it was not cleaned properly there could be gaps in the temperature when cooking food. The RD stated that her expectations was for the stove to be cleaned after every use by the cook. A review of a facility provided document titled, Ranges and Ovens, dated 2023, indicated, .CLEANING PROCEDURE: 1 .Immerse grills in a solution of water and grease solvent to soak. Remove encrusted material with a blunt scraper . 2 .Clean clogged burner posts with a stiff wire brush .5.Grills must be cleaned after each use .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 .5. Clean the exterior of the oven according to the manufacture's instructions . Review of The Food and Drug Administration (FDA) Food Code 2022, under section 4-501.14 Warewashing Equipment, Cleaning Frequency, indicated, .During operation, warewashing equipment is subject to the accumulation of food wastes and other soils or sources of contamination. In order to ensure the proper cleaning and sanitization of equipment and utensils, it is necessary to clean the surface of warewashing equipment before use and periodically throughout the day . (https://www.fda.gov/media/164194/download) Review of the FDA 2022 Food Code, under section 4-601.11, indicated, .Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, version 1/23, indicated, .(A) Equipment Food-Contact Surfaces and utensils shall be clean to sight and touch. (B) The Food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris . (https://www.fda.gov/media/164194/download)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 51485 Based on interview and record review, the facility failed to provide Physical Therapy (PT- the treatment of disease, injury, or deformity by physical methods such as message, heat treatment, and exercise) and Occupational Therapy (OT- treatment that helps improve the ability to perform daily tasks) services to one of twenty one sampled residents (Resident 81), when Resident 81 did not receive a PT/OT evaluation and treatment as ordered. This failure had the potential for Resident 81 not to attain, maintain, or restore his highest practicable level of physical, mental, functional, and psycho-social well-being. Findings: A review of Resident 81's ADMISSION RECORD indicated Resident 81 was admitted to the facility with diagnoses which included generalized muscle weakness, repeated falls, and other symptoms and signs involving cognitive functions and awareness. A review of Resident 81's physician orders dated 1/10/25, indicated Resident 81 had orders for OT Evaluation and Treatment as indicated and PT Evaluation & Treatment as indicated. Further review of Resident 81's record failed to show PT/OT evaluations or treatments were provided. During an interview on 2/18/25, at 11:13 AM, Resident 81 stated he was supposed to be on therapy because he was admitted for balance problems. Resident 81 further stated his balance problems were not being addressed. Resident 81 confirmed he was not provided with physical and occupational therapy since the day he was admitted to the facility. During an interview on 2/19/25, at 4:06 PM, the Occupational Therapist (OT) 1 stated Resident 81 was not receiving therapy services. OT 1 stated she did not receive a referral for him. Resident 81's medical record was reviewed with OT 1 and OT 1 confirmed Resident 81 had an order to receive a PT/OT evaluation and treatment on 1/10/25. OT 1 confirmed Resident 81 did not receive rehabilitation services. During a concurrent interview and record review on 2/20/25, at 2:33 PM, Physical Therapist (PT) 1 stated as per facility protocol, resident should be seen and receive rehabilitation services within 72 hours from the time when ordered. PT 1 stated that the importance of the rehabilitation evaluation was for safety purposes like providing recommendations on activities of daily living and safe transfers which included getting in and out of bed. PT 1 further stated that they also recommended assistive devices for residents such as walkers, wheelchairs, and RNA services (Restorative Nursing Aide; provides skill practice to residents with activities such as walking and mobility, dressing, grooming, and eating), or ongoing PT/OT. PT 1 stated that he did not receive a referral for PT/OT services for Resident 81. Resident 81's medical record was reviewed with PT 1 and PT 1 confirmed Resident 81 had an order for PT/OT evaluation and treatment dated 1/10/25. PT 1 stated he was not aware of it. PT 1 stated Resident 81 was placed at risk of decline and fall when rehabilitation services were not provided as ordered. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/21/25, at 12:03 PM, with the Director of Nursing (DON), the DON confirmed that Resident 81 had physical therapy and occupational therapy orders upon admission. The DON confirmed that the facility did not have rehabilitation services from the beginning of December through January 14, 2025, during the transition period. The DON stated that the facility wanted an in-house rehabilitation service, and the negotiations to renew the contract took some time. The DON stated that if there was an order for PT/OT evaluation, it must be done within 24 hours. The DON stated if a resident was not provided PT/OT evaluation and treatment as ordered then it placed residents at risk of physical deterioration. A review of Resident 81's undated BASELINE CARE PLAN, indicated, .OTHER SPECIAL CARE INSTRUCTIONS .Therapy service: PT OT .PHYSICIAN ORDER FOR THERAPY .PT Evaluation Treatment . OT Evaluation Treatment . A review of Resident 81's care plan dated 1/10/25, indicated, .LONG TERM GOAL: To maintain/improve physiological and psychosocial functions daily .Concerns & Problems Extensive assist with ADL's [Activities of Daily Living] d/t[due to] weakness 2[secondary to] health issues . A review of Resident 81's care plan dated 2/7/25, indicated, CLIENT PROTECTION PLAN: SAFETY/FALL . Approach Plan .Physical therapy as ordered or range of motion during ADL care to help improve movement & strength & decreases pain . A review of an undated facility policy and procedure titled, [Facility Name] Policy and Procedure for Rehabilitation Program, indicated, .Policy Statement [Facility Name] is committed to providing evidence-based rehabilitation services tailored to the individual needs of residents. The rehabilitation program shall be designed to maximize functional abilities, promote safety, and facilitate resident's return to their highest level of independence .Procedure 1. Admission to Rehabilitation Program .Residents requiring rehabilitation services will be identified through physician referrals, nursing assessments, and interdisciplinary team evaluations. A comprehensive evaluation will be conducted by a licensed therapist to determine the resident's rehabilitation needs and goals. The rehabilitation plan of care will be developed based on assessment findings, physical recommendations, and resident preferences .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 51485 Based on observation, interview, and record review, the facility failed to maintain and obtain complete medical records for 1 out of 21 sampled residents (Resident 72), when Resident 72's medical record did not contain progress notes from the primary care provider. This failure resulted in an incomplete reflection of Resident 72's progress toward achieving her person-centered plan of care and potentially resulted in insufficient information for the staff to facilitate communication among the interdisciplinary team that provided care for Resident 72. Findings: During an observation on 2/18/25 at 11:23 AM, Resident 72 was observed scratching her chest and upper extremities. During an interview on 2/19/25 at 10:45 AM, License Nurse (LN) 5 stated that Resident 72 was under the care of an outside primary care provider who was treating her and prescribing her medications. A review of Resident 72's medical record failed to show progress notes from her outside primary care provider. During a concurrent interview and record review, on 2/20/25 at 4:04 PM, Resident 72's medical records were reviewed with the Director of Nursing (DON). The DON stated Resident 72 was under the care of an outside primary care provider who managed her care. The DON stated the outside primary care provider started providing services to Resident 72 in August of 2024. The DON confirmed Resident 72's outside primary care provider notes were not available in Resident 72's medical record at the facility. During an interview on 2/20/25 at 4:18 PM, Medical Records (MR) 1 stated she had not received medical records from Resident 72's outside primary care provider and had never requested them. During an interview on 2/20/25 at 4:22 PM, Resident 72's outside Primary Care Provider (PCP) stated that the progress notes were the communication between the PCP and the nurses for any new orders, updates, and for Resident 72's continuity of care. During an interview on 2/21/25 at 11:49 AM, the DON stated not having Resident 72's primary care provider's progress notes in her medical record at the facility would result in not knowing what measures or interventions the facility needed to do for the resident.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 50778 Based on interview, and record review, the facility failed to provide evidence of the ongoing efforts of a Quality Assurance and Performance Improvement (QAPI- a data driven and proactive approach used to continuously identify opportunities for improving the overall quality of life and quality of care and services to nursing home residents) program/plan for a resident census of 81. This deficient practice had the potential for the facility to miss efforts to identify, report, investigate, analyze, and prioritize identified concerns in the facility. Findings: During an interview with the Administrator (ADM) on 2/18/25 at 1:15 PM, the ADM stated she would provide the QAPI documents as requested that morning during the Entrance Conference held at 9:17 AM. During a concurrent interview and record review on 2/18/25 at 5 PM, with the ADM, the Entrance Conference Worksheet, dated 10/23 was reviewed.The Entrance Conference Worksheet indicated, QAPI plan was listed on the worksheet under the heading INFORMATION NEEDED FROM FACILITY WITHIN FOUR HOURS OF ENTRANCE and the worksheet was provided at the Entrance Conference. The ADM acknowledged the worksheet information and stated she would provide the QAPI plan documents as requested. Interviews with the ADMIN to request the facility's QAPI plan and names of its members were held on the following dates and times: 2/19/25 at 12:25 PM and at 4:15 PM 2/20/25 at 11:57 AM 2/21/25 at 2:15 PM During a concurrent interview and record review on 2/21/25 at 2:15 PM with the ADM and Director of Nursing (DON), a facility document titled, QUALITY ASSURANCE/ACTION PLAN, dated 2/19/25 was reviewed. The ADM stated this was the facility's current QAPI plan and that the document was created the week of the survey. The ADM stated she created the document after being told the survey team had identified the issue of F761 Expired Medications. The ADM was again asked for a QAPI plan initiated prior to the current survey week, and the DON provided document titled, QUALITY ASSURANCE/ACTION PLAN, which was signed and dated 1/21/25. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, FACILITY QUALITY ASSESSMENT & ASSURANCE AND QUALITY ASSURANCE IMPROVEMENT PROGRAM, dated 10/01/94, indicated, .is maintained in accordance with the Federal Requirements, all applicable State regulations .The function of such program will be the responsibility of the QAA [specifies who attends the QAPI meetings and how often] and QAPI committee .In coordination with QAA/QAPI Program governing body, the facility administrator is responsible to oversee the Quality Improvement [QI] Program in order to meet the needs, goals and objectives of the resident population that it serve[s] and meet the QI Standards of Care established through the QAPI Program .to work systematically in order to identify, analyze and evaluate quality issues . Review of an undated facility document titled, QAPI Written Plan: Introduction, indicated, .The QAPI plan will guide your organizations performance improvement efforts .The QAPI regulation requires a written plan . Your written plan will be made available to a state agency, federal surveyor, or CMS upon request .

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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. 49823 Based on observation, interview, and record review, the facility failed to provide an environment free from the risk of infection for a census of 81 when staff refilled an empty soda bottle from the water dispenser at Nurse Station #3 with the water dispenser spout touching the mouth of the soda bottle. These failures resulted in the potential for the spread of infection to residents, visitors, and staff in the facility. Findings: During a concurrent observation and interview, at Nursing Station #3, on 2/18/25, at 3:45 p.m., Medical Records Assistant (MR) 2 filled an empty plastic soda bottle with water from the resident water dispenser with the bottle mouthpiece touching the spout of the resident water dispenser. MR 2 confirmed that she refilled the empty plastic soda bottle with water from the resident water dispenser at the nurses' station with the mouth of the bottle touching the spout of the resident water dispenser. MR 2 stated that it was not acceptable to refill the soda bottle from the resident water dispenser with the mouth of the empty plastic soda bottle touching the spout of the resident water dispenser. MR 2 stated that the risk was if she was ill, the residents who drank water from the dispenser would be ill, too. During an interview on 2/21/25 at 12:45 p.m. with the facility Director of Nursing (DON), the DON stated that the water dispensers at the nurses' stations were cleaned every 24 hours and filled with fresh water. The DON stated that disposable cups were provided for drinking water next to the water dispensers. The DON stated that if staff used the drinking water for personal use, staff used the drinking cups or their personal refillable containers. The DON stated that if staff used their personal refillable containers, staff should not allow their personal reusable water containers to touch the spout of the water dispenser while refilling their personal containers. The DON stated that the risk was contamination (introducing germs into or on areas that are normally clean or sterile) and potential spread of infection (growth of germs in the body). The DON confirmed that facility policy was not followed. A review of an undated facility policy and procedure (P&P) titled, The Infection Control Program, indicated, . Policy: It is the policy of this facility to establish an Infection Control Program designed to provide a safe, sanitary and comfortable environment for residents and staff, visitors and the general public and to help prevent the development and transmission of disease and infection .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 50778 Based on interview and record review, the facility failed to ensure the Antibiotic Stewardship Program (ASP-a federally mandated program that includes a set of practices to ensure antibiotics are used appropriately) was followed for one of two sampled residents (Resident 42) on an antibiotic when: 1. Resident 42 developed signs and symptoms of a Urinary Tract Infection (UTI-an infection of the urinary system) and the facility's ANTIBIOTIC STEWARDSHIP GUIDELINE (a set of rules for identifying infections in long-term care facilities) used as part of ASP was not initiated for Resident 42; 2. The Infection Preventionist (IP) was not aware Resident 42 was prescribed antibiotics and did not add Resident 42 to the ANTIBIOTIC STARTS TRACKING log, the MONTHLY SURVEILLANCE REPORT FORM, or the ANTIBIOTIC LOG; and 3. An antibiotic time-out (an active reassessment of an antibiotic prescription 48-72 hours after the medication's first dose) was not done for Resident 42. These failures had the potential to contribute to unsafe antibiotic use and monitoring in the facility for a census of 81 and placed Resident 42 at higher risk of antibiotic resistance (when bacteria/germs change in some way that reduces or eliminates the effectiveness of drugs, chemicals, or other agents designed to cure or prevent infections). Findings: Review of Resident 42's PHYSICIAN ORDERS, dated 2/7/25, written by Medical Doctor (MD) 1, indicated, . New order for UA [urine analysis (UA test) is a medical examination of the urine to detect potential health issues] stat d/t [due to] resident c/o [complaint of] burning sensation during urination .6:40 PM .urine specimen collected [a sample of urine that's collected for analysis in a lab] . Review of Resident 42's PHYSICIAN ORDERS, dated 2/11/25, written by MD 1, indicated, .Ciprofloxacin [antibiotic medication] 500 mg [a unit of measurement] Q [every] day X [for] 5 days for UTI . Review of a facility document titled, MONTHLY SURVEILLANCE REPORT FORM, dated 2/25, indicated four residents were tracked for signs and symptoms of infection for the month of February. Further review indicated Resident 42 was not listed on the form. Review of a facility document titled, ANTIBIOTIC STARTS TRACKING, dated 2/25, indicated four residents were started on antibiotics for the month of February. Further review indicated Resident 42 was not listed on the form. Review of a facility document titled, ANTIBIOTIC LOG, dated 2/25, indicated five residents were started on antibiotics. Further review indicated Resident 42 was not listed on the form. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/21/25 at 9:28 AM with the Infection Preventionist (IP), the IP stated ASP guidelines were used as a tracking system for residents with signs and symptoms of infectious disease. During a review of the IP's ASP binder, the IP acknowledged Resident 42 was not listed on a spreadsheet titled MONTHLY SURVEILLANCE REPORT FORM, dated 2/2025. The IP confirmed Resident 42 was not listed on the tracking spreadsheets titled, ANTIBIOTIC STARTS TRACKING and ANTIBIOTIC LOG for February of 2025. The IP stated she was not aware Resident 42 was on antibiotics for a UTI in February of 2025 and she should have been listed on the forms so Resident 42 could have been tracked on both spreadsheets for antibiotic use. The IP stated the nurse should have filled out the form ANTIBIOTIC STEWARDSHIP GUIDELINE for Resident 42 when Resident 42 initially complained of signs and symptoms of a UTI and placed the form in the binder located in the nursing station for the IP to retrieve to add Resident 42 to ASP tracking forms. The IP confirmed Resident 42 did not have the ANTIBIOTIC STEWARDSHIP GUIDELINE form initiated for her regarding her UTI that was diagnosed in February of 2025. The IP acknowledged antibiotic time-outs were not included on any of the facility's ASP forms and was not done for Resident 42 or the other residents listed on the form. The IP stated, an antibiotic time-out should have been conducted on day three from the start of antibiotic treatment to ensure effectiveness of the medication ordered and to notify the MD if new orders were needed. The IP further explained this process helped to ensure correct antibiotic treatment was used for susceptible organisms (bacteria that cannot grow in the presence of a specific drug), to prevent spread of infectious disease, and provide timely treatment to decrease duration of infection. The IP acknowledged antibiotic time-outs were not being conducted on residents receiving antibiotics in the facility and stated they should be conducted for the residents on the residents being tracked as part of the ASP. The IP stated if not following the facility's ASP policy and guidelines could lead to the facility not implementing an ASP program to its fullest effect and could lead to residents taking antibiotics for longer than necessary and not the shortest duration. A review of the facility's undated policy and procedure titled, ANTIBIOTIC STEWARDSHIP POLICY AND PROCEDURE, indicated, .Purpose .improving the use of antibiotics in healthcare to protect our residents and reduce the threat of antibiotic resistance .Components of this policy were developed by using evidence-based practice [a systematic approach to clinical decision-making that integrates the best available research] guidelines and are aligned with the Core Elements of Antibiotic Stewardship for Nursing home, published by the Centers for Disease Control and Prevention (CDC) .This facility will incorporate all seven (7) core elements .Utilize antibiotic-use and other data to ensure that Antibiotic Stewardship Policy Procedures and other best practices are followed .how to quantify [express or measure the quantity of] and assess appropriateness of antibiotics prescribed and how to identify adverse outcomes .Nurses will utilize the approved antibiotic stewardship guideline algorithm in identifying signs and symptoms specific to different systems .Antibiotic 'time-out.' At 72 hours after antibiotic initiation .each resident will be reassessed for consideration of antibiotic need, duration, selection, and de-escalation potential [a process whereby the delivery of effective initial antibiotic treatment is achieved while avoiding unnecessary antibiotic use] . completion of an antibiotic time-out must be recorded in the resident record .What will be measured/tracked . Antibiotic starts .Days of therapy .Antibiotic use .Stewardship actions .Outcomes .A monthly ASP Tracking Report will be compiled . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an online document published by the Centers for Disease Control and Prevention (CDC) in 2015 titled, Core Elements of Antibiotic Stewardship for Nursing Homes, indicated, . Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics [antibiotics that are taken to treat infections throughout the body] when followed over a year . studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate .Harms from antibiotic overuse are significant for the frail and older adults receiving care .These harms include risk of serious diarrheal infections from Clostridium difficile (a bacteria that causes diarrhea and inflammation of the colon-the longest part of the large intestines, which is an organ in the digestive system) increased adverse drug events (harm caused by appropriate or inappropriate use of a drug) and drug interactions (a change in the way a drug acts in the body when taken with certain other drugs), and colonization (when bacteria are present on or inside a person's body, growing and multiplying, but without causing any noticeable symptoms or illness) and/or infection with antibiotic-resistant organisms . Infection prevention coordinators have key expertise and data to inform strategies to improve antibiotic use .This includes tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections . practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process, also known as an antibiotic time-out, for all antibiotics prescribed . Perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices . (https://www.cdc.gov/antibiotic-use/media/pdfs/core-elements-antibiotic-stewardship-508.pdf)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 50598 Based on observation, interview and record review, the facility failed to maintain equipment in safe operating condition when: 1. The can opener was found with layers of metal shavings and food particles; and 2. The dishwashing machine remained below manufacture required temperature of 120 degrees. These deficient practices had the potential to compromise food safety for the 81 residents receiving food from the facility. Findings: 1. During the initial kitchen tour on 2/18/25 at 8:45 AM, in the presence of [NAME] (CK) 1, the can opener was found with paint chipped off, food debris, and layer of metal shavings behind the blade. CK 1 confirmed the findings. During an interview with the Registered Dietician (RD) on 2/21/25, the RD stated the can opener should be cleaned regularly. The RD stated, there was a cleaning schedule for the staff to follow. The RD stated the can opener was dirty and for all of the metal build up staff had been taught to use a wired brush to clean the can opener properly. The RD stated, this did not meet her expectations and posed a risk to the residents as a can opener in this condition could harbor pathogens that could be unsafe for the residents. 2. During a concurrent observation, interview and record review with the Certified Dietary Manager (CDM) and RD on 2/18/25 at 1:10 PM, after observing three complete dishwashing cycles it was found that the temperature on the machine did not exceed/reach 120 degrees. The CDM stated the reason for the temperature difference was because it was a low temperature washing machine. On the dishwashing machine was manufacture requirements and recommendations. The CDM confirm the minimum required temperature per manufacturer guldens was 120 Fahrenheit. The RD placed a handheld thermometer in a part of the dishwasher that allows external access during washing cycles. The handheld thermometer would not go above 117 degrees Fahrenheit during a full cycle of dish washing. During an interview with the RD on 2/21/25, the RD stated the chlorine works to sanitize the dishes at 120 degrees Fahrenheit at least and it had to be at 120 degrees Fahrenheit for safety. If not at 120 degrees Fahrenheit this poses a risk to the residents. No, the condition of the dishwasher did not meet my expectations. At 120 degrees Fahrenheit the dishes are not hygienically sanitized as that is completely necessary. During an interview with the Maintenance Supervisor (MS) on 2/21/25 at 3:34 PM, the MS stated the dishwashing machine needed to be calibrated to the correct temperature. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055039	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Rehab and Care Center	1630 N. Edison Street Stockton, CA 95204

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the FDA 2022 Food Code, under section 4-202.15, Tilted Can Openers Indicated, .Once can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized. Can openers must be designed to facilitate replacement. (https://www.fda.gov/media/164194/download) Review of the FDA 2022 Food Code, under section 4-501.15 , Titled Warewashing Machines, Manufacturers' Operating Instructions indicated, To ensure properly cleaned and sanitized equipment and utensils, warewashing machines must be operated properly. The manufacturer affixes a data plate to the machine providing vital, detailed instructions about the proper operation of the machine including wash, rinse, and sanitizing cycle times and temperatures which must be achieved. Review of the FDA 2022 Food Code, under section 4-501.110 titled. Mechanical Warewashing Equipment, Wash Solution Temperature indicated, The wash solution temperature in mechanical warewashing equipment is critical to proper operation. The chemicals used may not adequately perform their function if the temperature is too low. Therefore, the manufacturer's instructions must be followed. The temperatures vary according to the specific equipment being used. (https://www.fda.gov/media/164194/download) Review of the FDA 2022 Food Code, under section 4-601.11, .Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, version 1/23, indicated, (A) Equipment Food-Contact Surfaces and utensils shall be clean to sight and touch. (B) The Food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris . (https://www.fda.gov/media/164194/download)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51375 Based on observation and interview, four rooms (rooms 5, 18, 22, and 45) in the facility did not meet the required 80 square feet per resident. This failure placed the residents in rooms 5, 18, 22, and 45 at potential risk to impede their care and highest possible level of functioning due to smaller than required square footage. Findings: During an observation with the Maintenance Supervisor (MS), the following measurements were obtained for rooms 5, 18, 22, and 45. a. room [ROOM NUMBER], a 3-bed room, measured 237.37 square feet, rather than the required 240 square feet. b. room [ROOM NUMBER], a 3-bed room, measured 235.58 square feet, rather than the required 240 square feet. c. room [ROOM NUMBER], a 3-bed room, measured 233.21 square feet, rather than the required 240 square feet. d. room [ROOM NUMBER], a 2-bed room, measured 142.85 square feet, rather than the required 160 square feet. a. During a concurrent observation and interview with the MS, on 2/20/25, at 9:30 AM, the MS confirmed room [ROOM NUMBER] measured at 21 feet 5 inches x 11 feet 1 inch (237.37 square feet) for a 3-bed room, leaving 79.1 square feet per resident, less than the 80 square feet per resident required. During a concurrent observation and interview with Resident 40 in room [ROOM NUMBER], on 2/20/25, at 10:11 AM, Resident 40 stated that there was plenty of room and she was able to get the care that she needed without any issues. b. During a concurrent observation and interview with Resident 24 in room [ROOM NUMBER], on 2/18/25, at 11:30 AM, Resident 24 stated that he had no issues with the room or his care. Resident 24 stated the room had adequate space to keep his wheelchair in the room without hindering workable areas or access to the residents residing in the room. During a concurrent observation and interview with the MS, on 2/20/25, at 9:40 AM, the MS confirmed room [ROOM NUMBER] measured at 14 feet 3 inches x 17 feet (242.25 square feet), with a free-standing closet measuring 4 feet x 20 inches (6.67 square feet), leaving a total of 235.58 square feet for a 3-bed room or 78. 5 square feet per resident, less than the 80 square feet per resident required. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent observation and interview with Resident 34 in room [ROOM NUMBER], on 2/20/25, at 10:14 AM, Resident 34 stated that there was enough space in the room and that staff could get around with no problems to provide care to him. He further stated that he was happy with the room. c. During a concurrent observation and interview with the MS, on 2/20/25, at 9:35 AM, the MS confirmed room [ROOM NUMBER] measured at 14 feet 3 inches x 16 feet 10 inches (239.88 square feet), with a free-standing closet measuring 4 feet x 20 inches (6.67 square feet), leaving a total of 233.21 square feet for a 3-bed room or 77.7 square feet per resident, less than the 80 square feet per resident required. During a concurrent observation and interview with Resident 16 in room [ROOM NUMBER], on 2/20/25, at 10:12 AM, Resident 16 stated that the room was big enough and that there was enough room for her to get care with no issues. d. During a concurrent observation and interview with the MS, on 2/20/25, at 9:30 AM, the MS confirmed room [ROOM NUMBER] measured at 14 feet 2 inches x 10 feet 1 inch (142.85 square feet), leaving a total of 71.4 square feet per resident, less than the 80 square feet per resident required. During a concurrent observation and interview with Resident 288 in room [ROOM NUMBER], on 2/20/25, at 4:37 PM, Resident 288 stated that he did not have any problems moving around the room, even though it was a little smaller than other rooms. Resident 288 further stated that he could transfer into and out of the wheelchair without problems. Resident 288 added he could walk with the wheelchair to the bathroom and around the room without trouble. During an interview with licensed nurse (LN) 3, on 2/20/25, at 10:22 AM, LN 3 stated that he had provided treatments and care to the residents in the smaller rooms with no issues. LN 3 further stated there was enough room for him to safely provide care. During an interview with certified nursing assistant (CNA) 3, on 2/20/25, at 10:23 AM, CNA 3 stated that he had provided direct care in the smaller rooms. CNA 3 stated there was more than enough space for him to safely provide care to the residents and had no issues. During an interview with CNA 2, on 2/21/25, at 9:35 AM, CNA 2 stated she could take care of each resident in the rooms without any problems related to room space. CNA 2 further stated that she can move between beds and around each bed without difficulty. CNA 2 added the smaller rooms did not impact daily tasks. During an interview with LN 2, on 2/21/25, at 9:42 AM, LN 2 stated that the small room sizes did not have any negative effects on care provided to the residents. During an interview with the Administrator (ADM), on 2/21/25, at 12:17 PM, the ADM confirmed the room sizes of rooms 5, 18, 22, and 45. The ADM stated there were not any complaints from residents or staff that the room spaces were too small or that they were unable to accommodate the resident needs. Room waiver was recommended to continue, as contingent upon compliance with federal regulations at Resident Rights (481.10) and Physical Environment (483.90).

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 50598 Based on observation, interview, and record review, the facility failed to ensure the environment was free of pests for a census of 81 residents when roaches were found in front and beneath the microwave that was used to reheat foods for the residents. This failure had the potential for the cross-contamination of foods stored in the resident's refrigerator, and foods being reheated in the resident's microwave, resulting in food-borne illnesses. Findings: During a concurrent interview and observation with the Certified Dietary Manager (CDM) on 2/18/25 at 4:41 PM, The resident's microwave that was used to reheat the residents outside food, was found with layers of old food splatters. The CDM stated the house keeping were the ones cleaning the microwave. During a follow up observation on the microwave to reheat the residents' food on 2/21/25 at 9:13 AM, prior to opening the microwave, a roach was found walking in front of the microwave. During a concurrent interview and observation with the House Keeping Supervisor (HS) on 2/21/25 at 9:20 AM, the HS confirmed the splatters that were there three days ago remained with additional layers of food and stated the microwave was supposed to be cleaned twice a day. While observing the microwave, the microwave was moved, and multiple roaches began to run in various directions. The HS grabbed a paper towel and began to smash the roaches. The HS confirmed the bugs running away were roaches. During an interview with the Maintenance Supervisor (MS) on 2/21/25 at 1:40 PM, the MS stated the facility had regular pest control monthly. The MS confirmed the presence of roaches and stated, the roaches are bad and pose an infection control issue. During a concurrent interview and record review with the MS and the Physical Plant Supervisor (PPS) on 2/21/25 at 2:07 PM, the PPS stated, when there were reports of pests, they would inspect the issue and contact the contractor. The MS stated he had not seen roaches in the building ever. A record review of the pest control document titled, Work Order/ Invoice, service date 11/5/24, indicated, one resident reported sightings of roaches in their room and treatment was provided. The PPS stated the risk for having roaches in the facility were that they bring diseases, can make the residents sick, and they may swallow it. The PPS stated, it's important to have a pest control program because these roaches multiply fast. The PPS stated his expectation was the facility needs to be cleaned every day and [including] the counter tops. According to the 2022 Federal Food Code, section 6-501.111 stated . Controlling Pests .The premises shall be maintained free of insects, rodents, and other pests .by .routinely inspecting the premises for evidence of pests .Insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments. (https://www.fda.gov/media/164194/download)