STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055292	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shields Richmond Nursing Center	1919 Cutting Blvd Richmond, CA 94804

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40968 Based on observation, interview, and record review, the facility failed to ensure four of four sampled residents (Resident 18, 33, 14 and 7), received activities of daily living (ADL) care when the following was noted: 1. Resident 18 had long fingernails with black matter underneath both hands. 2. Resident 33 had long fingernails with black matter underneath both hands. 3. Resident 14 had overgrown fingernails. 4. Resident 7, who was dependent on staff, was not turned and repositioned every two hours as indicated in the care plan. Findings: 1. During a review of Resident 18's admission record, printed on 4/15/25, indicated Resident 18 was admitted to the facility on [DATE] with multiple diagnoses that included primary osteoarthritis (joint disease) and motor and sensory neuropathy (damage or dysfunction of nerves that control movement). During a review of Resident 18's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated, 2/15/25, indicated Resident 18 had a Brief Interview for Mental Status (BIMS -an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 05, meaning Resident 18 was cognitively impaired. The MDS also indicated, Resident 18 required set up or clean up assistance with personal hygiene. During a concurrent observation and interview on 4/15/25, at 9:40 a.m., in Resident 18's room, Resident 18 had thick and black matter underneath fingernails on left and right hand. Resident 18 stated, he did not like long and dirty nails. Resident 18 further stated, Certified Nursing Assistant (CNA) 2 did not offer to clean and trim his nails for a long time. During an interview on 4/15/25, at 9:48 a.m., with CNA 2, CNA 2 acknowledged Resident 18's nails were dirty. CNA 2 stated, even though Resident 18 had diabetes (a disease that occurs when your blood sugar is too high), it was not an excuse to not keep Resident 18's fingernails clean. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/15/25, at 10:03 a.m., with CNA 2 in the presence of Registered Nurse (RN) 1, CNA 2 stated, Resident 18 refused nail care. Resident 18 said, that's not true. CNA 2 then acknowledged, she did not offer to trim or clean Resident 18's fingernails. RN 1 stated, it was important to keep fingernails clean because Resident 18's fingernails on his left hand had fungal infection and there was risk to spread infection to other parts of his body. 2. During a review of Resident 33's admission record, printed on 4/15/25, indicated Resident 33 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with multiple diagnoses that included delirium (change in mental state characterized by confusion, difficulty paying attention, and a fluctuating level of alertness). During a review of Resident 33's MDS dated [DATE], indicated Resident 33 had a BIMS score of 01, meaning Resident 33's cognition was severely impaired. The MDS also indicated, Resident 33 required partial/moderate assistance with personal hygiene. During a concurrent observation and interview on 4/15/25, at 9:53 a.m., in Resident 33's room, with CNA 2, Resident 33's fingernails on both hands were long and had thick black matter underneath. CNA 2 stated, she knew Resident 33's nails were dirty but did not clean or trim his nails. CNA 2 also added, Resident 33 had a band aid on his forehead because Resident 33 liked to scratch his wound with his fingernails. During a concurrent observation and interview on 4/15/25, at 10:15 a.m., in Resident 33's room with RN 1, RN 1 stated Resident 33 was at risk for infection due to tendency to scratch his head. RN 1 further added, keeping Resident 33's fingernails clean and trimmed was important to prevent infection. 3. During a review of Resident 14's admission record, printed on 4/15/25, indicated Resident 14 was admitted on [DATE] with multiple diagnoses that included cataract (blurry or hazy vision), primary angle closure glaucoma (vision loss), low vision right eye and blindness left eye. During a review of Resident 33's MDS dated [DATE], the MDS indicated, Resident 33 had a BIMS score of 06, meaning Resident 33 had severely impaired cognition. The MDS also indicated, Resident 33's vision was severely impaired. The MDS revealed, Resident 33 required partial/moderate assistance with personal hygiene. During a concurrent observation and interview on 4/15/25, at 9:57 a.m., in Resident 14's room, with CNA 2, Resident 14 stated, he cannot see but he can feel his fingernails were long because fingernails felt heavy and uncomfortable. Resident 14 also stated, CNA 2 did not offer to trim his fingernails. During a concurrent observation and interview on 4/15/25, at 10:17 a.m., in Resident 14's room, with RN 1, RN 1 acknowledged Resident 14 hand overgrown fingernails and stated the nails had been long for a while. RN 1 stated, she told CNA 2 prior to today, to trim Resident 14's nails but CNA 2 did not do it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/25, at 9:52 a.m., with the Director of Nursing (DON), DON stated, there was risk for possible infection or skin tears due to Resident 18, 33, and 14's long and dirty fingernails. DON added, Resident 18 had diabetes but there was no excuse for CNA 2 not to keep nails clean. During a review of the facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of, dated 2/2018, indicated; The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. The P&P also indicated, under General Guidelines: 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed.' 50474 4. During a record review of Resident 7's Admission Record, printed on 4/18/25, the record indicated Resident 7 was admitted to the facility in July 2023 with multiple diagnoses of Alzheimer's disease (A progressive disease that destroys memory and other important mental functions.), muscle weakness, and chronic pain. During a record review of Resident 7's MDS, dated [DATE], the MDS assessment Section G (Functional Abilities and Goal) indicated Resident 7 was dependent on facility's staff to roll from lying on back to left and right side, and to return to lying on back on the bed. The MDS assessment section C indicated Resident 7's BIMS score was zero out of 15 which indicated severe cognitive impairment. During a record review of Resident 7's Care Plan, dated 3/25/25, the Care Plan indicated Resident 7 was at risk for fall and had to be checked and repositioned every 2 hours. During an observation on 4/16/25, at 9:49 a.m., with Resident 7, Resident 7 was awake and lying on her back on the bed. During an interview on 4/16/25, at 10:08 a.m., with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 7 was dependent to all Activities of Daily Living (ADLs, are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating) including repositioning every two hours. CNA 3 stated there were no records that Resident 7 was being repositioned every two hours on a daily basis because it was not included in their daily tasks for Resident 7. CNA 3 stated if the turning and repositioning task was included in their daily task for Resident 7, the CNAs would have been reminded to reposition Resident 7. CNA 3 stated it was important to provide repositioning every two hours to Resident 7 to prevent pneumonia (an inflammatory condition of the lung primarily affecting the small air sacs known as alveoli) and skin breakdown. During a follow up observation on 4/16/25, at 12:23 p.m., with Registered Nurse (RN) 4, Resident 7 was in the same position and was observed still lying on her back on the bed. RN 4 stated Resident 7 should have been turned and repositioned every two hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 4/16/25, at 2:52 p.m., with the DON, Resident 7's electronic health record (EHR, an electronic version of the patient's medical history that include all of the key clinical data) for CNA's daily task was reviewed. The DON stated and confirmed that there was no turning and repositioning task included in Resident 7's EHR. The DON stated the facility should have included the turning and repositioning task for Resident 7. The DON stated Resident 7 was at risk for developing pressure injury (develops when one or more layers of skin and tissue are damaged from continuous pressure to the area). During a record review of the facility's P&P, titled, Repositioning, dated March 2018, the P&P indicated, The purpose of this procedure is to provide guidelines for the evaluation of resident needs .to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents .General Guidelines .Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .Documentation .The following information should be recorded in the resident's medical record .1. The position in which the resident was placed. This may be in a flow sheet .2. The name and the title of individual who gave the care . During a review of the facility's P&P, titled, Activities of Daily Living (ADL), Supporting, dated March 2018, the P&P indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the plan of care, including appropriate support and assistance with . b. mobility .Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32717 Based on interview and record review, for three of 22 sampled residents (Resident 41, 20 and 5), the facility failed to provide treatment and care in accordance with professional standards of practice when: 1. Resident 41 did not receive multiple medications that included anti-hypertensives (blood pressure lowering medications), stool softeners and phosphate binders, according to physician's orders. This failure had the potential for complications that included hypertensive emergency (a severe and immediate medical condition characterized by dangerously high blood pressure and signs of end-organ damage, such as to the brain, heart, or kidneys), and hyperphosphatemia (or high phosphorus levels in the blood, a common and serious complication in patients with end-stage renal disease (ESRD). 2. Resident 20's elevated blood pressure (circulating volume of the blood on the walls of the arteries, veins, and chambers of the heart) was not addressed multiple times and the physician was not notified of Resident 20's change of condition. This failure had the potential to result in stroke or death. 3. Resident 5's refusal to take oral medications multiple times was not addressed in a timely manner. This failure had the potential to result in delayed treatment and management of medical condition. Definition: Daily Med is a nationally recognized publication of the National Institute of Health in the U. S. National Library of Medicine and includes references to drug information submitted to the Food and Drug Administration [Reference: dailymed.nlm.nih.gov]. Findings: 1. During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was admitted to the facility in April 2023 with diagnoses that included hypertensive emergency, end stage renal disease (a serious condition where the kidneys can no longer function properly), dependence on renal dialysis (a person relies on dialysis as a life-sustaining treatment for kidney failure, where their kidneys can no longer adequately filter blood and remove waste), essential hypertension (a chronic condition characterized by sustained high blood pressure with no identifiable underlying cause), pulmonary hypertension (a condition where the blood pressure in the lungs becomes abnormally high), anemia (a condition where the blood doesn't carry enough oxygen to the body's tissues) and atherosclerotic heart disease of native coronary artery (the buildup of fats, cholesterol and other substances in and on the artery walls). During a review of Resident 41's Medication Review Report (MRR), dated 4/16/25, the MRR indicated Resident 41 was to have dialysis (a life-sustaining treatment for individuals with kidney failure or injury, removing waste and excess fluid from the blood when the kidneys cannot do so themselves) every Monday, Wednesday, and Friday from 8:30 a.m.-11:30 a.m. The MRR indicated Physician's Orders for the following blood pressure and heart disease management medications: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Aspirin Oral Tablet Delayed Release 81 MG (milligrams) Give 1 tablet by mouth one time a day related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (a type of chest pain or discomfort caused by reduced blood flow to the heart muscle). Aspirin is used to treat pain and reduce fever or inflammation. b. Isosorbide Mononitrate ER Oral Tablet Extended Release 24 Hour 120 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION Hold if SBP <125. Isosorbide mononitrate tablets, USP are indicated for the prevention and treatment of angina pectoris (a type of chest pain or discomfort caused by reduced blood flow to the heart muscle) due to coronary artery disease. [Reference: dailymed.nlm.nih.gov]. c. Minoxidil Oral Tablet 10 MG Give 0.5 tablet by mouth two times a day for HTN (hypertension). Hold for SBP (systolic BP, the top number in a blood pressure reading) <110. d. Nifedipine ER Oral tablet Extended Release 24 Hour 60 MG (Nifedipine) Give 2 tablet by mouth one time a day related to HYPERTENSIVE EMERGENCY (I16.1); ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold for SBP <110. Nifedipine Extended-release Tablet is indicated for the treatment of hypertension, to lower blood pressure. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions. [Reference: dailymed.nlm.nih.gov]. e. Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350) Give 17 gram by mouth one time a day for bowel regularity mix with 4-8 oz of liquid and take by mouth. Hold for loose stools. Polyethylene Glycol is a laxative to relieve constipation. f. Renal-Vite Oral Tablet (B-Complex with C & Folic Acid) Give 1 tablet by mouth one time a day for supplement related to END STAGE RENAL DISEASE. Multivitamins for patients on dialysis. g. Renvela Oral Tablet 800 MG (Sevelamer Carbonate) Give 2 tablet by mouth three times a day related to END STAGE RENAL DISEASE. Renvela is indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis. [Reference: dailymed.nlm.nih.gov]. h. Iron (Ferrous Sulfate) Oral Tablet 325 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day related to ANEMIA IN CHRONIC KIDNEY DISEASE (D63.1) on empty stomach. Ferrous Sulfate is a dietary supplement for anemia. During a review of Resident 41's hypertension care plan initiated 9/14/23, the care plan indicated for licensed staff to give all medications for hypertension as ordered. During a review of Resident 41's Medication Administration Records (MAR) for March 2025 and April 2025, the MARs indicated the following medications were documented as omitted (not given as prescribed) by licensed staff with the reason as Other/See Progress Notes: a. The 9 a.m. dose of Aspirin Oral Tablet on 3/7, 3/12, 3/14, 3/17, 3/19, 3/21, 3/24, 3/26, 3/28, 3/31, 4/2, 4/4, 4/7, 4/8, 4/9, 4/11, 4/14, and 4/16. b. The 9 a.m. dose of Isosorbide Mononitrate ER Oral Tablet on 3/7, 3/12, 3/14, 3/17, 3/19, 3/21, 3/24, 3/26, 3/28, 3/31, 4/2, 4/4, 4/7, 4/8, 4/9, 4/11, 4/14, and 4/16. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. The Minoxidil Oral Tablet 10 MG on 3/12, 3/14, 3/17, 3/19, 3/21, 3/24, 3/26, 3/28, 3/31, 4/2, 4/4, 4/7, 4/8, 4/9, 4/11, 4/14, and 4/16. d. The 9 a.m. dose of NIFEdipine ER Oral tablet on 3/7, 3/12, 3/14, 3/17, 3/19, 3/21, 3/24, 3/26, 3/28, 3/31, 4/2, 4/4, 4/7, 4/8, 4/9, 4/11, 4/14, and 4/16. e. The 9 a.m. dose of Polyethylene Glycol 3350 Oral Powder on 3/12, 3/14, 3/17, 3/19, 3/21, 3/24, 3/26, 3/28, 3/31, 4/2, 4/4, 4/7, 4/8, 4/9, 4/11, 4/14, and 4/16. f. The 9 a.m. dose of Renal-Vite Oral Tablet on 3/7, 3/12, 3/14, 3/17, 3/19, 3/21, 3/24, 3/26, 3/28, 3/31, 4/4, 4/7, 4/8, 4/9, 4/11, 4/14, and 4/16. g. The Renvela Oral Tablet on 3/12, 3/14, 3/17, 3/19, 3/21, 3/24, 3/26, 3/28, 3/31, 4/2, 4/4, 4/7, 4/8, 4/9, 4/11, 4/14, and 4/16. h. The 11 a.m. dose of Iron (Ferrous Sulfate) Oral Tablet 325 on 3/14, 3/19, 3/21, 3/24, 3/26, 3/28, 3/31, 4/4, 4/7, 4/11, 4/14, and 4/16. During an interview on 4/14/25, at 1:10 p.m., with Registered Nurse (RN) 5, RN 5 stated, For Resident 41, except for hydralazine (used to treat high blood pressure (hypertension), all scheduled medications in the morning were On hold on dialysis days. During an interview and concurrent record review on 4/16/25, at 2:26 p.m., with RN 6, RN 6 stated sometimes blood pressure medications were on hold if blood pressure readings met parameters that was ordered (e.g. SBP <110). RN 6 stated the clinical record did not indicate a physician's order to hold medications when Resident 41 went to dialysis. During a review of Resident 41's Dialysis Communication Record, the following blood pressure readings were documented by facility staff before and after dialysis treatments: -On 3/12/25, pre-dialysis BP was 157/65, post-dialysis BP was 156/63. -On 3/14/25, pre-dialysis BP was 138/65, post-dialysis BP was 174/73. -On 3/17/25, pre-dialysis BP was 146/78, post-dialysis BP was 163/70. -On 3/19/25, pre-dialysis BP was 129/61, post-dialysis BP was 163/70. -On 3/21/25, pre-dialysis BP was 170/70, post-dialysis BP was 149/63. -On 3/24/25, pre-dialysis BP was 152/64, post-dialysis BP was 158/76. -On 3/26/25, pre-dialysis BP was 147/56, post-dialysis BP was 124/68. -On 3/31/25, pre-dialysis BP was 159/71, post-dialysis BP was 152/61. -On 4/2/25, pre-dialysis BP was 147/59, post-dialysis BP was 168/75. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/14/25, at 10:39 a.m., with Resident 20, Resident 20 stated he did not receive his BP medication on the night of 4/13/25. Resident 20 stated Licensed Vocational Nurse (LVN) 1 informed Resident 20 that if he wanted his BP medication, Resident 20 needed to get it from LVN 1. Resident 20 stated it was important that he received his BP medications because he was a dialysis (a procedure that removes waste and excess fluid from the blood when kidneys can no longer function properly) patient. Resident 20 further stated he needed his BP medications because of his high BP. During an interview on 4/15/25, at 2:40 p.m., with LVN 1, LVN 1 stated Resident 20 had a history of refusing medications. LVN 1 stated she did not notify the physician that Resident 20 refused the BP medications multiple times because the Director of Nursing (DON) told her to just document the refusals and inform them about it. LVN 1 stated the physician should have been notified of Resident 20's refusal to take the BP medications because Resident 20 could have had an elevated BP. During a concurrent record review and interview on 4/16/25, at 10:19 a.m., with the DON, Resident 20's electronic health record (EHR, an electronic version of the patient's medical history that include all of the key clinical data), was reviewed. The DON stated their policy for elevated BP included notifying the physician if the SBP was more than 160 mmHg. The DON stated there was no documentation from the licensed nurses that the physician was notified when Resident 20's BP was elevated multiple times. The DON stated on 4/11/25, when Resident 20's BP reached to 197/87 mmHg, there was no documentation that the licensed staff provided appropriate care, and the physician was not notified. The DON stated Resident 20 could have had a stroke due to very high BP. During a review of the facility's policy and procedure (P&P), titled, Blood Pressure, measuring, revised in September 2010, the P&P indicated, Hypertension is usually defined as BP over 140/90 mmHg . Hypertension should be reported to the physician . During a review of the facility's P&P, titled, Change in Resident's Condition or Status, revised in February 2021, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .1. The nurse will notify the resident's attending physician or physician on call when there has been a .d. significant change in the resident's physical/emotional/mental condition .2. A significant change of condition is a major decline or improvement in resident's status that .a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider . 3. During a record review of Resident 5's Admission Record, printed on 4/16/25, the record indicated Resident 5 was admitted to the facility in March 2025 with multiple diagnoses of urinary tract infection (UTI, an infection in any part of the urinary tract, the system of organs that makes urine), Alzheimer's disease (a progressive brain disorder that primarily affects memory, thinking, and behavioral abilities), neuromuscular dysfunction of bladder (urinary bladder problems caused by damage or disease to the nerves that control urination), pressure injury (develops when one or more layers of skin and tissue are damaged from continuous pressure to the area) of right and left heel. During a record review of Resident 5's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 3/8/25, Resident 5's assessment on Section C - Cognitive Patterns indicated Resident 5's cognitive skills for daily decision making was severely impaired. (continued on next page)

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Shields Richmond Nursing Center	1919 Cutting Blvd Richmond, CA 94804

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's record, titled, Medication Administration Record, dated 4/1/25 to 4/30/25, the MAR indicated the following medications were not administered to Resident 5: a. Tamsulosin (helps relax the smooth muscles in prostate and bladder improving the flow of urine) oral capsule 0.4 milligrams (mg) Give 1 capsule by mouth at bedtime for prostate was not administered on 4/11/25, 4/12/25, 4/13/25 at 9:00 a.m. and 4/7/25, 4/8/25, 4/11/25, 4/13/25, and 4/14/25 at 9:00 p.m. b. Zinc sulfate (supplement for low levels of zinc, a mineral that helps immune system, wound healing and cell growth) Give 1 capsule by mouth one time a day for supplement was not administered on 4/11/25, 4/12/25, and 4/13/25. c. Melatonin (helps regulate sleep) oral tablet 3 mg Give 1 tablet by mouth at bedtime for circadian rhythm (a natural, roughly 24-hour cycle that regulates sleep-wake cycles and other bodily functions, influenced by light and dark) was not administered on 4/7, 4/8/25, 4/11/25, 4/13/25, and 4/14/25. During a concurrent observation and interview on 4/16/25, at 10:09 a.m., with Certified Nurse Assistant (CNA) 3, Resident 5 was sleeping in his bed. CNA 3 stated Resident 5 had cognitive impairment, unable to verbalize needs, and was totally dependent to staff with all the activities. During an interview on 4/16/25, at 12:18 p.m., with Registered Nurse (RN) 4, RN 4 stated Resident 5 refused to take his oral medications multiple times that included the tamsulosin. RN 4 stated Resident 5 had the risk of urinary retention when he had missed the tamsulosin multiple times. RN 4 stated Resident 5's medical record indicated licensed nurses explained the risks and benefits of the tamsulosin medication to Resident 5. RN 4 stated Resident 5 would have not understood the risks and benefits because Resident 5 had cognitive impairment. During a record review and interview on 4/16/25, at 2:52 p.m., with the DON, Resident 5's Progress Notes were reviewed. The DON stated there were no documentations that Resident 5's physician and responsible family members were notified when Resident 5 refused multiple times to take the oral medications. The DON stated the physician should have been notified because missing the tamsulosin medication could have caused Resident 5 bladder pain. During a concurrent observation and interview on 4/17/25, at 12:01 p.m., with Resident 5's Responsible Party (RP) 1, in Resident 5's room, Resident 5 was sitting in the wheelchair. RP 1 stated she visited Resident 5 almost every day. RP 1 stated she was not aware that Resident 5 had been refusing to take his oral medications. RP 1 stated Resident 5's refusal of treatment was not a normal behavior for Resident 5. During a review of the facility's P&P, titled, Change in Resident's Condition or Status, revised in February 2021, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .1. The nurse will notify the resident's attending physician or physician on call when there has been .f. refusal of treatment or medications two or more consecutive times .

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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. 40968 Based on observation, interview, and record review the facility did not provide proper supervision to one of two Residents (Resident 1) during transfer from bed to wheelchair using Hoyer Lift [(a mechanical assistive device used by caregivers to safely transfer patients with limited mobility from one place to another (i.e. bed to wheelchair)]. This failure placed Resident 1 at risk for fall and injury. Findings: During a review of Resident 1's Admission Record, printed on 4/14/25, the admission record indicated Resident 1 was originally admitted to the facility in 1999 and was readmitted in 2022. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 2/21/25, revealed Resident 1 had multiple diagnoses that included, muscle weakness and personal history of traumatic brain injury. MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 00, meaning Resident 1 had severely impaired cognition. MDS also indicated, Resident 1 was dependent on the assistance of two or more helpers with transfer from bed to chair. During a concurrent observation and interview on 4/14/25, at 11:49 a.m., with Certified Nursing Assistant (CNA) 1, in Resident 1's room, CNA 1 transferred Resident 1 from bed to wheelchair using Hoyer Lift by himself. When asked why he was operating the Hoyer lift without proper supervision, CNA 1 stated, I made a mistake. I'm not supposed to do it alone. It's supposed to be two person. CNA 1 also stated, there was risk to drop Resident 1 from Hoyer lift without support from another staff. During an interview on 4/14/25, at 2:42 p.m., with the Director Of Nursing (DON), DON stated, Hoyer lift with sling like the ones used for Resident 1, required two person to assist with the transfer. DON further added, there was increased risk for fall when CNA 1 transferred Resident 1 by himself using the Hoyer lift. During a review of Resident 1's care plan (a document that outlines the specific needs, goals, and services required for a resident's well-being and care), dated 9/4/24, indicated Resident 1 had self-care performance deficit that included impaired balance. The care plan also indicated, the resident was dependent on staff with transfer. During a concurrent interview and review of the facility's policy and procedure (P&P) titled, Lifting Machine, Using a Mechanical, dated 7/2017, on 4/14/25, at 3:20 p.m., with the DON, the DON confirmed, at least two nursing assistants are needed to safely move a resident with mechanical lift which included transferring a resident from bed to chair;

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 50474 Based on observation, interview and record review, the facility failed to assist in maintaining a sufficient food and fluid intake for one of three sampled residents (Resident 5) when Resident 5's poor meal and fluid intake were not addressed in a timely manner to maintain proper nutrition and hydration. This failure resulted in dehydration (dangerous loss of body fluid causes by illness or inadequate fluid intake) and potential for malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients it needs to maintain healthy tissues and organ function) and further decline in Resident 5's health condition. Findings: A review of Resident 5's Admission Record, printed on 4/16/25, indicated Resident 5 was admitted to the facility in March 2025 with multiple diagnoses of Alzheimer's disease (a progressive brain disorder that primarily affects memory, thinking, and behavioral abilities), severe protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and pressure injury (develops when one or more layers of skin and tissue are damaged from continuous pressure to the area) of right and left heel. During a record review of Resident 5's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 3/8/25, Resident 5's assessment on Section C - Cognitive Patterns indicated Resident 5's cognitive skills for daily decision making was severely impaired. During a record review of Resident 5's Care Plan, initiated on 3/2/25, the Care Plan indicated Resident 5 had a goal to meet more than 75% of meal intake to promote wound healing and prevent further skin breakdown. During a review of Resident 5's record, titled, Nutrition - Amount Eaten (NAR), dated 4/16/25, the NAR record indicated the following percentage of the meal eaten by Resident 5: 4/9/25 9:03 a.m.- Resident refused to eat 1:38 p.m. - 26% - 50% 7:28 p.m. - 0% - 25% 4/10/25 1:35 p.m. - 26% - 50% 1:36 p.m. - 26% - 50% (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6:39 p.m. - Resident refused to eat 4/11/25 11:04 a.m. - 26% - 50% 12:56 p.m. - 0% - 25% 6:00 p.m. - 0% - 25% 4/12/25 8:47 a.m. - Resident refused to eat 1:30 p.m. - 26% - 50% 6:29 p.m. - 0% - 25% 4/14/25 9:20 a.m. - 0% - 25% 1:29 p.m. - 0% - 25% 6:22 p.m. - 26% - 50% 4/15/25 11:30 a.m. - Resident refused to eat 1:36 p.m. - 26% - 50% 4/16/25 10:30 a.m. - Resident refused to eat 1:16 p.m. - Resident refused to eat During a review of Resident 5's Progress Notes documented by Registered Dietician (RD), dated 3/27/25, the Progress Notes indicated RD recommended Resident 5's estimated needs for fluids was between 1,830 ml to 2,140 ml per day. During a review of Resident 5's record, titled, Nutrition - Fluids, dated 3/18/25 to 4/16/25, the Nutrition - Fluids record indicated the following daily total amount of fluid that was consumed by Resident 5: 4/1/25 - 720 milliliters (ml) 4/9/25 - 480 ml (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/2/25 - 540 ml 4/10/25 - 480 ml 4/3/25 - 920 ml 4/11/25 - 720 ml 4/4/25 - 640 ml 4/12/25 - 720 ml 4/5/25 - 860 ml 4/13/25 - 180 ml 4/6/25 - 680 ml 4/14/25 - 300 ml 4/7/25 - 770 ml 4/15/25 - 480 ml 4/8/25 - 480 ml During a record review of Resident 5's document, titled, Laboratory Results Report, dated 4/17/25, the Laboratory Results Report indicated Resident 5 had the following result: a. Blood Urea Nitrogen (BUN, measures the amount of urea nitrogen, a waste product formed when body breaks down protein, in the blood. High levels may indicate kidney damage.) result of 47 milligrams (mg)/dilution (dL). The Laboratory Results Report indicated the reference range for normal BUN was between 7 - 25 mg/dL. b. Creatinine (a test that measures creatinine levels, a waste product produced by muscle metabolism, in the blood or urine to assess kidney function) result of 1.86 mg/dL. The Laboratory Results Report indicated the reference range for normal creatinine was 0.70 - 1.30 mg/dL. c. Sodium (a mineral that helps regulate fluid balance, nerve function, and muscle activity in the body. A high sodium concentration in the blood can be due to insufficient fluid intake, excessive water loss, or combination of both) result was 156 milliequivalent (mEq)/liter (L). The Laboratory Results Report indicated the reference range for normal sodium level was 136-145 mEq/L. During a concurrent observation and interview on 4/14/25, at 12:38 p.m., with Certified Nurse Assistant (CNA) 5, CNA 5 assisted and fed Resident 5 during lunch time in the dining room. Resident 5's eyes were closed and was observed not eating when CNA 5 tried to feed Resident 5. CNA 5 stated for Resident 5 there were incidents when Resident 5 would fall asleep during mealtimes. CNA 5 stated Resident 5 only consumed 10% of his meals and only drank half a cup of his drink. During an interview on 4/16/25, at 2:10 p.m., with RN 6, RN 6 stated CNAs were responsible for reporting to licensed nurses if a resident refused to eat or had poor meal intake. RN 6 stated licensed nurses were responsible for assessing and determining the root cause of why a resident would have a poor meal and fluid intake. RN 6 stated an RD should have been alerted first to discuss the poor meal and fluid intake of a resident. RN 6 stated after three consecutive incidents of poor meal and fluid intake, RN 6 stated it should have been considered a change of condition and should have been reported to the physician and responsible family members. RN 6 stated residents who were not eating and drinking had the potential to have dehydration that could have symptoms such as dry mouth, confusion, decreased urine output, and skin issues. RN 6 further stated residents who had skin issues such as wounds could have a delay in wound healing if they were not getting proper nutrition and hydration. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/25, at 10:12 a.m., with RD, RD stated she did not get a notification from the licensed nurses that Resident 5 recently experienced poor meal and fluid intake. RD stated she was also not informed that Resident 5 refused to eat or drink. RD stated the recommended amount of meal intake of 1, 830 to 2,140 kcal (kilocalorie, which is a unit of energy commonly used to measure the amount of energy in food) and 1,830ml - 2,140ml of fluids were based on Resident 5's current height and body weight. RD stated Resident 5 was not meeting the recommended fluid intake per day. RD stated Resident 5 had a recent abnormal laboratory result with high levels of BUN and sodium. RD stated the laboratory result indicated Resident 5 was severely dehydrated. RD further stated Resident 5's poor nutrition and hydration was a risk for delayed wound healing. During an interview on 4/16/25, at 2:52 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses should have notified the physician when Resident 5 had signs of poor meal and fluid intake so interventions could have been provided to prevent the dehydration. The DON stated Resident 5 started an intravenous (IV, into the vein) hydration therapy on 4/17/25 because Resident 5's recent weekly laboratory result indicated Resident 5 was dehydrated. The DON stated there were no interventions documented by the licensed nurses to address Resident 5's poor meal and fluid intake. During a concurrent observation and interview on 4/17/25, at 12:01 p.m., with Resident 5's Responsible Party (RP) 3, in Resident 5's room, Resident 5 was sitting in the wheelchair with an ongoing IV administration. RP 3 stated she visited Resident 5 almost every day. RP 3 stated she was only notified on 4/14/25 that Resident 5 ate less than 25% of his lunch. RP 3 stated she was not aware Resident 5 had also poor fluid intake. RP 3 stated prior to 4/14/25, the facility had not informed her personally of Resident 5's recent poor meal and fluid intake. RP 3 stated Resident 5 must have had an ongoing infection or illness because Resident 5 usually had a good appetite. During a record review of the facility's policy and procedure (P&P), titled, Resident Hydration and Prevention of Dehydration, revised in October 2017, the P&P indicated, This facility will strive to provide adequate hydration and to prevent dehydration .6. Nurses' Aides will provide and encourage intake at bedside, snack, and meal fluids, on a daily and routine basis as part of daily care .b. Aides will report intake of less than 1, 200ml/day to nursing staff .7. If potential intake/and or signs and symptoms of dehydration are observed .b. The physician will be notified .9. The dietician, nursing staff, and the physician will assess factors that may be contributing to inadequate fluid intake . During a record review of the facility's P&P, titled, Nutritional Assessment, revised in October 2017, the P&P indicated, 1. The dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident .and as indicated by a change in condition that places the resident at risk for impaired nutrition .2. As part of the comprehensive assessment, the nutritional assessment will be systematic, multidisciplinary process that includes gathering and interpreting data to help define meaningful interventions for the resident at risk for or with impaired nutrition . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's P&P, titled, Food and Nutrition Services, revised in October 2017, the P&P indicated, Nursing personnel, with the assistance of the food and nutrition staff, will evaluate (and document as indicated) food and fluid intake of residents with, or at risk for, significant nutritional problems . a. Variations from usual eating or intake patterns will be recorded in the resident's medical record and brought to the attention of the nurse .b. A nurse will evaluate the significance of such information and report it, as indicated, to the attending physician or dietician . During a review of the facility's P&P, titled, Change in Resident's Condition or Status, revised in February 2021, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .1. The nurse will notify the resident's attending physician or physician on call when there has been .f. refusal of treatment or medications two or more consecutive times .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on interview and record review, the facility failed to ensure staff had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident when Registered Nurse (RN) 2, who failed to observe infection control procedures for contact precautions and identify a change in resident's bowel elimination status, did not complete annual competency/skills evaluation. This failure had the potential to result in unsafe resident care. Findings: During review of Resident 169's Admission Record, the Admission Record indicated Resident 169 was admitted to the facility on [DATE] with diagnoses that included enterocolitis (an inflammation of both the small and large intestines. It can be caused by various factors, including bacterial infections) due to Clostridium difficile (C. diff, a bacteria that can cause diarrhea and colitis, an inflammation of the colon) infection. During an observation on 4/15/25, at 12:34 p.m., Resident 169's room had Contact Plus Precaution sign tucked inside a fabric door organizer. During an interview on 4/16/25, at 11:43 a.m., with Registered Nurse (RN) 2, RN 2 stated, medical devices, like the blood pressure monitor, used for Resident 169 were also used for other residents after disinfecting them with Clorox wipes or Sani-Cloth disinfecting wipes, but most of the time used Clorox with the white top because Clorox is Pretty good with everything. During a concurrent observation and interview on 4/17/25, at 11:20 a.m., with IP, IP stated any disinfecting wipes that have bleach could be used to disinfect a contact precaution room. An observation of a tub of Sani-Cloth disinfecting wipes with orange top indicated it was effective against C. diff spores. During a concurrent observation and interview on 4/17/25, at 2:34 p.m., with Director of Nursing (DON), DON stated not being sure if the Clorox wipes with the white top contained bleach. A tub of Clorox wipes with the white top found in the housekeeping cart indicated Bleach-free. During a review of Resident 369's Admission Record, the Admission Record indicated Resident 369 was admitted to the facility in March 2024 with diagnoses that included hypertension (high blood pressure) and personal history of urinary tract infection. During a review of Resident 369's clinical record, Medication Review Report (MRR), dated 4/17/25, indicated an order dated 3/25/25 for Cephalexin (treats infection) oral capsule 250 mg 1 capsule by mouth once daily for personal history of urinary tract infections. The clinical record did not indicate a urinalysis or urine culture was done. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25, at 12:10p.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 369 had diarrhea in the morning and had to be taken to the bathroom because Resident 369 kept going. CNA 4 stated Resident 369 also had diarrhea/loose stools too on 4/15/25. CNA 4 also stated Resident 369 was feeling bad for the night shift CNAs for cleaning up after a big loose bowel movement. During a joint interview on 4/16/25, at 12:19 p.m., with RN 2 and CNA 4, RN 2 stated he did not know about Resident 369 having episodes of diarrhea. CNA 4 reminded RN 2 that he had been told Resident 369 had been having diarrhea for two days. RN 2 stated, having loose stools was less serious than watery stools and it was normal for residents to use the bathroom constantly. During an interview on 4/17/25, at 11:20 a.m., with Infection Preventionist (IP), IP stated not being happy with antibiotics used as prophylaxis. IP also stated if a resident had more than three episodes of diarrhea, a stool specimen should be sent for testing to prevent spread of a possible infection. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, last revised December 2016, the P&P indicated, training and education of staff will include emphasis on the relationship between antibiotic use and gastrointestinal disorders, opportunistic infections like C. diff and evolution of drug-resistant pathogens. During a review of the facility's P&P titled, Antibiotic Stewardship-Staff and Clinician Training and Roles, last revised December 2016, the P&P indicated nurses will receive initial orientation and ongoing training on the facility's Antibiotic Stewardship Program, common clinical conditions treated at the facility. During a review of the Facility Assessment last revised 8/8/24, the Facility Assessment indicated the staff training necessary to provide the level of support and care for the resident population included infection control that includes written standards, policies, and procedures for the program, and such mandatory training should be provided to all staff upon hire, annual and as needed. The Facility Assessment also indicated residents with common diagnoses, conditions, and/or combinations of conditions that require complex care are admitted to the facility, including residents with infectious diseases such as C. diff, infections with multi-drug-resistant organisms, and urinary tract infections. During a concurrent interview and record review on 4/17/25, at 2:40 p.m., with Director of Nursing (DON), RN 2's Annual Skill Check dated 8/2023 was reviewed. DON stated RN 2 did not have annual Skills Check for 2024. DON stated if skills for licensed nurses were not evaluated, significant errors may happen.

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Shields Richmond Nursing Center	1919 Cutting Blvd Richmond, CA 94804

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 27194 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than 5 percent for three out of eight sampled Residents (Resident 25, 57, and 270). This failure had the potential for negative health outcomes. Findings: 1. During a concurrent observation and interview on 4/15/25, at 8:32 a.m., with Registered Nurse (RN) 2, outside of Resident 57's room, RN 2 was observed pouring 1 tablet of the multi-vitamin into a small medication cup and then administered it along with all other morning medications scheduled for Resident 57. During a concurrent interview and record review on 4/15/25, at 1:11 p.m., with RN 2, Resident 57's medication orders for the observed medication pass were reviewed. Resident 57 was noted as having an order for multi-vitamin tablet with minerals and to be administered daily in the morning. Review of the ingredients on the multi vitamin bottle that RN 2 had used earlier for Resident 57 revealed the multi-vitamin tablets contained no minerals in them. When RN 2 was asked if there was another type of multi vitamin tablets available in his medication cart (med cart), RN 2 looked through the med cart and found a bottle of multi-vitamin with minerals deep in the top drawer. RN 2 stated he did not see this bottle of multi-vitamin with minerals, and he also acknowledged the packaging of both bottles (the multi-vitamin and the multi-vitamin with minerals) looked almost the same. 2. During a concurrent observation and record review on 4/15/25, at 10:05 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 270 was noted as having an order for chlorhexidine gluconate solution (a prescription mouthwash for oral care). This medication was not observed as being passed to Resident 270 for oral care treatment during the morning medication pass. During a concurrent interview and record review on 4/15/25, at 10:59 a.m., with LVN 2, she confirmed that the chlorhexidine gluconate solution was not given to Resident 270 in the morning. And LVN 2 also stated she was about to prepare it now for oral use by the Resident. 3. During a concurrent observation and interview on 4/15/25, at 9:29 a.m., with Licensed Vocational Nurse (LVN) 1, she was observed getting a blood sugar reading from Resident 25. LVN 1 stated Resident 25's blood sugar was 302 and the resident would be getting 8 units of Humulin R (a short acting form of insulin that starts working in 30 minutes after injection to lower blood sugar). During a concurrent interview and record review on 4/15/25, at 10:59 a.m., with LVN 1, Resident 25 was noted as having an order to obtain his blood sugar at 7 a.m. And when LVN 1 was asked as to why she did not get the blood sugar from Resident 25 at 7 a.m. or at least before his breakfast time to get an accurate measurement of his blood sugar control, LVN 1 stated she missed it and did not know that Resident 25 had an insulin order this morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Administering Medications dated 4/2019, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame .Medications areadministered with one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 27194 Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices when two expired medications in a medication cart were available for use. These failures had the potential to result in Residents receiving expired and ineffective medications. Findings: During a concurrent observation and interview on 4/14/25, at 2:50 p.m., with Registered Nurse (RN) 7, in the hallway of nursing station 2, medication storage cart (2A) was audited, and observed there were a bottle of 2. 5 ml Rocklatan (medication used to treat high pressure inside the eye) eye drop and a vial of 10 ml Humalog (a short acting form of insulin that starts working in 15 minutes after injection to lower blood sugar) insulin inside the medication cart (med cart) with an expiration date of 4/7/25 and 4/8/25 respectively. RN 7 confirmed both of these medications were expired. She also stated this med cart was not my regular one, I was here just helping out with med pass today. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage dated 2/2023, the P&P indicated, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 40968 Based on observation, interview, and record review, the facility failed to employ a qualified Dietary Services Manager (DSM) in the absence of a full-time Registered Dietitian (DC) for 64 Residents who received food from the kitchen. This failure had the potential for the residents' nutritional needs not to be met; and dietary staff were not supervised by a qualified person. Findings: During the initial kitchen tour on 4/14/25, at 9:38 a.m., with the Dietary Service Supervisor (DSS), the tour revealed improper food preparation, improper storage of food items, and un-maintained kitchen equipment. (Cross-reference F812). During concurrent interview and record review on 4/14/25, at 10:37 a.m., with the DSS, in the DSS office, the DSS revealed she was not a certified Dietary Manager. DSS also stated she took the dietary manager course but failed to complete the course. During an interview on 4/14/25, at 10:42 a.m., with Registered Dietician (RD), RD stated the facility did not have a qualified Dietary Manager. RD added she worked part time in the facility because she had other facilities to supervise. During an interview on 4/16/25, at 8:35 a.m., with the Administrator (ADM), ADM confirmed there was no qualified dietary manager. ADM added, RD worked two to three days per week. ADM further added, RD and Nutrition Support Specialist (NSS) shared the responsibility to ensure there was full coverage of qualified Registered Dietician. During a telephone interview on 4/16/25, at 9:45 a.m., with NSS, NSS stated she had not passed the exam to be a qualified Registered Dietician. NSS also stated she was responsible to oversee the kitchen and staff when RD was not in the facility. During an interview on 4/16/25, at 11:56 a.m., with DSS, DSS confirmed RD came to the facility part time and NSS came and worked the rest of the week to cover RD's role. (Cross-reference F800). A review of facility's document titled, Nutrition Therapy Essentials - Registered Dietician Consultant Services Agreement, dated, 2/1/23, the agreement indicated, .V. COMPENSATION .2. Contracted hours for the Facility will be 16 hours a week as negotiated with Consultant and Facility's appointed person of contact. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the California Code, Health and Safety Code - HSC S 1265.4 (HSC), the HSC indicated, (a) A licensed health facility .shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. The dietetic services supervisor shall receive frequently scheduled consultation from a qualified dietitian. (b) The dietetic services supervisor shall have completed at least one of the following educational requirements: (1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility. (2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration. (3) A graduate of a dietetic assistant training program approved by the American Dietetic Association. (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. (5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. (6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision. (7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40968 Based on observation, interview, and document review, the facility failed to store, prepare, and serve food under sanitary conditions when: 1. [NAME] 1 prepared food in the emergency three compartment sink. 2. Open package pasta was not stored in airtight container. 3. 12 Quart clear container stored multiple sprouted, soft, and wrinkled red potatoes. 4. Powdered sugar in tin can labeled with used by 4/10/25. 5. One and half pint cherry tomatoes was not labeled and dated with used by. 6. 12 Quart full container with wrinkled, mushed, liquified cherry tomatoes were stored. 7. Unlabeled 12 ounce (oz - unit of measurement) clear plastic container contained; a. four green bell peppers that were extremely soft with white fuzzy matter and discoloration; b. three wrinkled red bell peppers had caked in black matter and white fuzzy discoloration, two yellow peppers were wrinkled. 8. Two 16 oz containers had mushy strawberries with liquid juice was labeled with delivery date 4/7/25. 9. One dented can good was stored with ready to use cans. 10. Mounted can opener had a reddish and brown flaky coating on surface near the blade. These failures had the potential to cause food borne illness to residents who receive food from the kitchen out of a facility census of 64. Findings: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the initial tour of the kitchen on 4/14/25, at 9:38 a.m., in the presence of Dietary Service Supervisor (DSS) and Registered Dietician (RD), the following was observed; 1. [NAME] (CK) 1 prepared food in the emergency three compartment sink. 2. Open package of pasta was not stored in airtight container. 3. 12 Quart clear container stored multiple sprouted, soft, and wrinkled red potatoes. 4. Powdered sugar in tin can labeled with used by 4/10/25. 5. One and half pint cherry tomatoes was not labeled and dated with used by. 6. 12 Quart full container with wrinkled, mushed, liquified cherry tomatoes were stored. 7. Unlabeled 12 ounce (oz - unit of measurement) clear plastic container contained; a. four green bell peppers that were extremely soft with white fuzzy matter and discoloration; b. three wrinkled red bell peppers had caked in black matter and white fuzzy discoloration; c. two yellow peppers were wrinkled and soft. 8. Two 16 oz containers had mushy strawberries with liquid juice was labeled with delivery date 4/7/25. 9. One dented can good was stored with ready to use cans. 10. Mounted can opener had a reddish and brown flaky coating on surface near the blade. During a concurrent observation and interview on 4/14/25, at 9:43 a.m., with RD, the RD acknowledged CK 1 prepared food in the three-compartment sink. RD stated, the sink should not have been used as food preparation area due to risk of cross contamination with food and pathogen from sink. During an interview on 4/14/25, at 9:45 a.m., with DSS, DSS stated staff were used to using the three-compartment sink as food preparation area and it was hard to undo. DSS further stated, staff needed re-training to not use the sink for food preparation. During a review of facility's policy and procedure (P&P) titled, FOOD PREPARATION, dated 2023, the P&P indicated, Employees will prepare food in a clean and safe manner to protect residents and staff from foodborne illness. During a review of facility's P&P titled, SANITATION AND INFECTION CONTROL, dated 2023, the P&P indicated, Food preparation should not occur in two or three compartment sinks. During a concurrent observation and interview on 4/14/25, at 9:50 a.m., with DSS, DSS attempted to seal the open package of pasta with plastic wrap. DSS stated, staff forgot to put the open package of pasta in airtight container. DSS added, there was potential for pest to get inside unsealed package. During a review of facility's P&P titled, SANITATION AND INFECTION CONTROL, dated 2023, the P&P indicated, under PROCEDURES: .9. Metal, plastic containers (with tight fitting lids and NSF approved), or resealable plastic bags will be used for staples and opened packages of items such as pastas, rice, dry cereals, etc. During a concurrent observation and interview on 4/14/25, at 9:54 a.m., with DSS, DSS discarded the unlabeled container of cherry tomatoes and stated the tomatoes may possibly be stored beyond used by. DSS added, kitchen staff would not know when the tomatoes could be used and discarded because it was not labeled. During a concurrent observation and interview on 4/14/25, at 10:11 a.m., with RD, RD stated the sprouted tomatoes and wrinkled, soft cherry tomatoes were compromised and should have been discarded. RD also stated, there was potential for the residents in the facility to get sick if compromised food items were ingested. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's PRODUCE STORAGE GUIDELINES, dated 8/15, on 4/14/25, at 10:19 a.m., with DSS, the guidelines indicated, strawberries are to be stored in the refrigerator for 3-5 days. During an observation on 4/14/25, at 10:25 a.m., in the presence of DSS, one dented can of six-pound sweet potatoes was stored in the rack along with ready to use can goods. During a review of facility's P&P titled, SANITATION AND INFECTION CONTROL, dated 2023, the P&P indicated, under PROCEDURES: .10. Canned food items should be routinely inspected for damage such as dented, bulging or leaking cans. These items should be set aside in a designated area for return to the vendor or disposed of properly. During a concurrent observation and interview on 4/14/25, at 10:45 a.m., with RD, RD removed the can opener shaft from the mount and inspected the can opener. RD stated the can opener should not be used because of the rust. RD further stated rust could transfer toxin to food ingested by residents and residents could get sick. During a review of facility's P&P titled, SANITATION AND INFECTION CONTROL, dated 2023, indicated under policy, Equipment will be cleaned and sanitized to prevent food borne illness.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32717 Based on observation, interview and record review, the facility failed to ensure infection prevention and control procedures were followed when: -Housekeeping Aide (HA) did not disinfect Resident 169's room, a contact precaution (a set of infection control practices used to prevent the spread of germs through direct or indirect contact. These precautions are implemented when a patient has a disease that can be transmitted by touching the patient, contaminated surfaces, or objects in their environment) room, with appropriate disinfectant. -Registered Nurse (RN) 1 did not disinfect medical device with appropriate disinfectant in between resident use. This failure had the potential to result in spreading Clostridium difficile (C. diff, a bacteria that causes diarrhea and colitis (inflammation of the colon). It's a serious infection that can be life-threatening, especially in vulnerable populations like older adults in healthcare settings) infection to other residents. Findings: During a review of Resident 169's Admission Record, the Admission Record indicated Resident 169 was admitted to the facility on [DATE] with diagnoses that included enterocolitis (an inflammation of both the small and large intestines. It can be caused by various factors, including bacterial infections) due to C. diff infection. During an observation on 4/15/25, at 12:34 p.m., Resident 169's room had Contact Plus Precaution sign tucked inside a fabric door organizer. During an interview on 4/16/25, at 10:01 a.m., with Housekeeping Aide (HA), HA stated, when entering Resident 169's room, she made sure to wear Personal Protective Equipment (PPE, a variety of equipment designed to protect the wearer from injury or illness, including clothing, helmets, gloves, face shields). HA stated she used the pink Ecolab Smartpower Sink and Surface sanitizer to clean the tables, doorknobs, cabinets, night stand, bed and bed frame, and left the sanitizer on for five minutes. HA stated she used the purple Oasis 499 Disinfectant Cleaner to clean the bathroom and the floor. HA stated these two chemicals came in pre-mixed. During an interview on 4/16/25, at 10:12 a.m., with Infection Preventionist (IP), IP stated, for contact precaution rooms, housekeeping staff are supposed to use the orange top disinfectant wipes (Sani-Cloth Germicidal Disposable Wipe/Bleach), not the purple cleaner spray as it is only a cleaner and not a disinfectant. During a follow-up interview on 4/16/25, at 10:30 a.m., with HA, HA stated she only used the spray solution, either the pink or purple, and wiped with cleaning towel. HA stated she did not use the Sani-Cloth disinfecting wipes and did not have any of those in the cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25, at 11:43 a.m., with Registered Nurse (RN) 2, RN 2 stated they used the wrist BP cuff on all the residents and disinfected it with Clorox wipes and the Sani-Cloth disinfecting wipes, but most of the time used Clorox with the white top because Clorox was pretty good with everything. During an observation on 4/16/25, at 11:46 a.m., HA cleaned room [ROOM NUMBER] by spraying a wash towel with the pink solution and wiped down the door, a walker that was at the bedside, cabinet, walls, overhead light, bed rails and overbed tables. During a concurrent observation and interview on 4/17/25, at 11:20 a.m., with IP, IP stated any disinfecting wipes that has bleach could be used to disinfect a contact precaution room. An observation of a tub of Sani-Cloth disinfecting wipes with orange top indicated it is effective against Clostridium difficile spores. During a concurrent observation and interview on 4/17/25, at 2:34 p.m., with Director of Nursing (DON), DON stated not being sure if the Clorox wipes with the white top contained bleach. Clorox wipes was found in the housekeeping cart that indicated Bleach-free. During a review of the facility's policy and procedure (P&P) titled, Clostridium Difficile, last revised October 2018, the P&P indicated, the primary reservoir for C.difficile are surfaces, spores can persist on resident-care items and surfaces for several months and are resistant to some common cleaning and disinfection methods. Environmental cleaning in rooms of residents with C. difficile is done with a disinfecting agent recommended for C.difficile (e.g. household bleach and water solution or an EPA registered germicidal agent effective against C.difficile spores). Steps toward prevention and early intervention include disinfection of items with potential fecal soiling (e.g. commode chairs, bed rails, etc.) with a disinfecting agent recommended for C. diff. During a review of the manufacturer's information of the Sani-Cloth Bleach Germicidal Disposable Wipe with EPA registration number 9480-8, the manufacturer's information indicated the wipes are effective against 52 microorganisms and is ideal for disinfecting high-risk areas contaminated with Clostridioides difficile spores.

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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. 32717 Based on interview and record review, for one randomly selected resident (Resident 369), the facility failed to establish and implement infection prevention and control program that included antibiotic stewardship program when: -Resident 369 was administered antibiotics without adequate indication. -Resident 369's possible symptoms of antibiotic side effects were not monitored. This failure had the potential to result in the development of antibiotic-resistant infections (occur when bacteria develop the ability to withstand the effects of antibiotics, making them difficult or impossible to treat, can be serious and even life-threatening, often requiring longer hospital stays, more expensive treatments, and potentially toxic medications). Findings: During a review of Resident 369's Admission Record, the Admission Record indicated Resident 369 was admitted to the facility in March 2024 with diagnoses that included hypertension (high blood pressure) and personal history of urinary tract infection. During a review of Resident 369's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 3/31/25, the MDS indicated a Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 13. A BIMS score of thirteen to fifteen is an indication of intact cognitive status. During a review of Resident 369's clinical record, Medication Review Report (MRR), dated 4/17/25, indicated an order dated 3/25/25 for Cephalexin (treats infection) oral capsule 250 mg 1 capsule by mouth once daily for personal history of urinary tract infections. The clinical record did not indicate a urinalysis or urine culture was done. During an interview on 4/16/25, at 12:10 p.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 369 had diarrhea in the morning and had to be taken to the bathroom because Resident 369 kept going. CNA 4 stated Resident 369 also had diarrhea/loose stools too on 4/15/25. CNA 4 also stated Resident 369 was feeling bad for the night shift CNAs for cleaning up after a big loose bowel movement. During a joint interview on 4/16/25, at 12:19 p.m., with RN 2 and CNA 4, RN 2 stated he did not know about Resident 369 having episodes of diarrhea. CNA 4 reminded RN 2 that he had been told Resident 369 had been having diarrhea for two days. RN 2 stated, having loose stools was less serious than watery stools and it was normal for residents to use the bathroom constantly. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25, at 12:20 p.m., with Resident 369, Resident 369 stated having diarrhea for a few days, and a big portion of the bed being soiled made her feel like she might have gone so many times. Resident 369 also stated having diarrhea this bad was a new thing and felt bad for the staff who had to clean up. During a review of Resident 369's clinical record, Skilled Evaluation (written and signed by licensed staff) and Bowel and Bladder Elimination record (completed by assigned CNAs) indicated the following: - Skilled Evaluation dated 4/6/25 indicated, genitourinary: Urine yellow. Denies urinary complaints., gastrointestinal: Abdomen is flat. Abdomen is non-tender; Bowel sounds present x 4 .Bowel movement appearance: WNL [within normal limits]. Bowel and Bladder Elimination dated 4/6/25 indicated Resident 367 had diarrhea in the day shift. - Skilled Evaluation dated 4/7/25 indicated, under genitourinary; No urinary complaints .New onset incontinence; No. under gastrointestinal; Abdomen flat, non-tender, Bowel sounds present x 4 [all four quadrants, divides the abdomen into four quadrants], Denies indigestion, nausea, vomiting, diarrhea, constipation or bowel incontinence. Bowel and Bladder Elimination dated 4/7/25 indicated Resident 369 had diarrhea. - Skilled Evaluation dated 4/11/25 indicated, genitourinary: Resident continent of bladder. Urine clear yellow. Denies urinary complaints., gastrointestinal: Abdomen flat, non-tender. Bowel sounds present x 4, Denies indigestion, nausea, vomiting, diarrhea, constipation or bowel incontinence. Bowel and Bladder Elimination dated 4/11/25 indicated Resident 369 had diarrhea. - Skilled Evaluation dated 4/12/25 indicated genitourinary: Resident continent of bladder. Urine clear yellow. Denies urinary complaints., gastrointestinal: Abdomen flat, non-tender. Bowel sounds present x 4, Denies indigestion, nausea, vomiting, diarrhea, constipation or bowel incontinence. Bowel and Bladder Elimination dated 4/12/25 indicated Resident 369 had diarrhea. - Skilled Evaluation dated 4/16/25 indicated genitourinary: Resident continent of bladder. Urine clear yellow. Denies urinary complaints., gastrointestinal: Abdomen flat, non-tender. Bowel sounds present x 4, Denies indigestion, nausea, vomiting, diarrhea, constipation or bowel incontinence. Bowel and Bladder Elimination dated 4/16/25 indicated Resident 369 had diarrhea. During an interview on 4/17/25, at 11:20 a.m., with Infection Preventionist (IP), IP stated being unhappy with antibiotics that were used as prophylaxis. IP stated, for urinary tract infections, the following needed to be present before starting antibiotics; symptoms such as fever, burning sensation and signs of infection such as increased heart rate AND a culture and sensitivity to determine what organism and what antibiotic needed to be used, otherwise, if a resident was prescribed an antibiotic that was not going to work, it could mess up their immune system. IP also stated if a resident had more than three episodes of diarrhea, a stool specimen should be sent for testing to prevent spread of a possible infection. IP stated, for Resident 36, a discussion with nursing was done about having to re-do urinalysis and culture, but there was no update as to when this was going to be done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055292	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shields Richmond Nursing Center	1919 Cutting Blvd Richmond, CA 94804

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, last revised December 2016, the P&P indicated the facility will provide training and education with emphasis on the relationship between antibiotic use and gastrointestinal disorders, opportunistic infections like C. difficile and evolution of drug-resistant pathogens. During a follow-up interview on 4/17/25, at 3:01 p.m., with IP, IP stated the facility was using McGeer Criteria (a set of clinical and laboratory findings used to define and track infections in long-term care facilities. They help identify potential infections, such as urinary tract infections (UTIs), respiratory tract infections, and skin and soft tissue infections, and monitor their incidence and trends). A review of Revised McGeer Criteria for LTC (Long Term Care) indicated, for urinary tract infections without an indwelling catheter, an infection is present when either 1a, 1b or 1c AND 2 are present: Criteria 1a- acute dysuria, or acute pain, swelling or tenderness on the suprapubic area (the region of the abdomen located directly above the pubic bone) Criteria 1b-fever or increased white blood cell count AND one or more of the following; suprapubic pain, gross hematuria (visible blood in the urine), new or marked increase in incontinence, urgency and frequency. Criteria 1c- two or more of the following- suprapubic pain, gross hematuria, new or marked increase in incontinence, urgency and frequency. AND 2- one of the following must be present; at least 100,000 colony forming units (cfu/ml) of no more than 2 species of microorganisms in a voided urine sample, or at least 100 cfu/ml of any number of organisms in a specimen collected by in-and-out catheter (a temporary tube inserted into the urethra to drain urine from the bladder and then removed).

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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 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** 50474 Based on observation, interview, and record review, the facility failed to provide 80 square foot of space per resident for 31 residents who occupied 12 multi-bed bedrooms. This deficient practice had the potential to result in lack of sufficient space for the provision of care both routine and emergency and for residents to have their personal belongings at bedside. Findings: During multiple room observations on 4/14/25 through 4/17/24, there were three residents in Rooms 22, 26, 27, 30, 32, 33, 34, and 35; two residents occupying three-bedroom rooms in rooms [ROOM NUMBER]; and one resident occupying three-bedroom room in room [ROOM NUMBER]. 1. room [ROOM NUMBER] measured 11.3 feet by 19 feet which equaled 71.56 square feet per resident. 2. room [ROOM NUMBER] measured 19 feet by 11.4 feet which equaled 72.2 square feet per resident. 3. room [ROOM NUMBER] measured 19.3 feet by 11.4 feet which equaled 73.34 square feet per resident. 4. room [ROOM NUMBER] measured 19.1 feet by 11.3 feet which equaled 71.94 square feet per resident. 5. room [ROOM NUMBER] measured 19.1 feet by 11 feet which equaled 70.03 square feet per resident. 6. room [ROOM NUMBER] measured 19 feet by 11.4 feet which equaled 72.2 square feet per resident. 7. room [ROOM NUMBER] measured 19 feet by 11.4 feet which equaled 72.2 square feet per resident. 8. room [ROOM NUMBER] measured 18.9 feet by 11.4 feet which equaled 71.82 square feet per resident. 9. room [ROOM NUMBER] measured 18.9 feet by 11.4 feet which equaled 71.82 square feet per resident. 10. room [ROOM NUMBER] measured 18.9 feet by 11.3 feet which equaled 71.19 square feet per resident. 11. room [ROOM NUMBER] measured 18.1 feet by 11.7 feet which equaled 70.59 square feet per resident. 12. room [ROOM NUMBER] measured 19.1 feet by 11.3 feet which equaled 71.94 square feet per resident. (continued on next page)

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	055292	A. Building B. Wing	04/17/2025

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During random observations of care and services from 4/14/23 to 4/17/25, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment in the rooms that might interfere with resident's care and each resident had adequate personal space and privacy. During an interview on 4/14/25, at 10:45 a.m., with Resident 10, Resident 10 stated the room was small for her. Resident 10 stated she preferred to be in a two-bed room. During an observation on 4/14/25, at 11:03 a.m., in room [ROOM NUMBER], a Certified Nurse Assistant (CNA) was observed providing care to Resident 25. The privacy and care of Resident 25 were not impacted by shortage of space. During a concurrent observation and interview on 4/14/25, at 11:21 a.m., with Resident 55, in room [ROOM NUMBER], Resident 55 stated she had no complaints in the room. Resident 55 was observed getting up from the bed with a use of walker with enough space to move around. There were no negative consequences resulted from decreased space. No safety concerns for residents in the 12 rooms. The Administrator requested a continuous room waiver for the above residents' rooms.