STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055446	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Creek Care Center	260 Racetrack Street Auburn, CA 95603

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49933 Based on observation, interview, and record review, the facility failed to ensure resident needs were accommodated for two of 25 sampled residents (Resident 17 and Resident 25), when the call light was not within reach. This failure had the potential to result in the residents not attaining their highest practicable physical, psychosocial, and emotional well-being. Findings: A review of an Admission Record indicated Resident 17 was admitted to the facility in late 2024 with multiple diagnosis of Parkinson's disease (a brain disease marked by tremor, muscular rigidity, and slow, imprecise movements) and muscle weakness. A review of Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/28/24, indicated Resident 17 had severely impaired cognition. Further review of the MDS indicated that Resident 17 required a helper to lift trunk or limbs during activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 10/8/24 at 1:43 p.m., Resident 17 was in bed and call light was not within reach. Licensed Nurse 1 (LN 1) searched the bed and could not find the call light. LN 1 confirmed that Resident 17 will use the call light if it was available and in their hand. LN 1 acknowledged call light should be within reach. A review of Resident 17's Care Plan, dated 9/9/24, indicated as interventions .Call light in reach and answered timely. A review of an Admission Record indicated Resident 25 was admitted to the facility in August 2024 with multiple diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (loss of muscle function of the body after blood flow to the brain is reduced or blocked). A review of MDS, dated [DATE], indicated Resident 25 had severely impaired cognition. Further review of the MDS indicated that Resident 25 required substantial/maximal assistance (requires a helper) with activities of daily living. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/8/24 at 10:16 a.m., Resident 25 was in bed laying on left side. Call light was located behind Resident 25 wrapped around side rail. Resident 25 stated he could not turn and wanted to use the call light to ask for coffee. Director of Staff Development (DSD) came into room and confirmed and acknowledged that Resident 25's call light was not within reach. During a concurrent observation and interview on 10/8/24 at 1:00 p.m. Resident 25 was sitting in a reclining seat next to the left side of the bed. Resident 25's call light was on the opposite side wrapped around siderail of bed. Resident 25 was unable to reach the call light. LN 2 confirmed call light was not within reach and near the resident. A review of Resident 25's fall risk Care Plan, revised 9/26/24, indicated as interventions .Keep call light within reach. During an interview on 10/11/24 at 10:30 a.m., with Director of Nursing (DON), the DON stated her expectation was to have all call lights within reach of the residents. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light revised May 2024, the P&P indicated .When the resident is in bed or confined to a chair be sure the light is within easy reach of the resident .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49821 Based on observation, interview, and record review, the facility failed to ensure accurate assessment was performed for one resident (Resident 22) of 25 sampled residents when Resident 22's dental/oral assessment was inaccurate. This failure resulted in Resident 22 not receiving care reflective of the residents' status and needs. Findings: A review of Resident 22's ADMISSION RECORD indicated an admitted to the facility of 4/4/24 with multiple diagnoses which included adult failure to thrive (significant weight loss, functional decline, and an inability to maintain adequte nutrition and physical health), and malnutrition. Resident 22's Minimum Data Set (MDS, a comprehensive assessment tool) dated 4/10/24, indicated no memory problem. During an observation on 10/9/24 at 10:25 a.m., in Resident 22's room, Resident 22 was observed with all teeth missing. During an interview on 10/10/24 at 3:31 p.m., Resident 22 stated she has no teeth at all, both top and bottom. During an interview on 10/10/24, at 3:45 p.m., Resident 22 stated she had all her teeth pulled before being admitted to the facility. A review of Resident 22's MDS, dated [DATE], indicated, .No natural teeth or tooth fragment(s) (edentulous) [all teeth missing] . was not marked. During an interview on 10/11/24 at 8:23 a.m., with MDSLN (MDS Licensed Vocational Nurse), the MDSLN confirmed Resident 22's MDS was inaccurate. The MDSLN stated, It was a mistake. I should have checked [marked] that one (edentulous) . During an interview on 10/11/24 at 8:47 a.m., Resident 22 stated her responsible party informed the staff during admission about her need for dentures. The facility was asked for policies on accuracy of assessment but none were provided.

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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** 44946 Based on observation, interview and record review, the facility failed to ensure that nursing staff had the necessary competencies and skill sets to meet the care and services for one of 25 sampled residents (Resident 378) when one Certified Nursing Assistant (CNA) transferred Resident 378 by herself using a Hoyer lift (an electronically operated mechanical lift used to transfer a patient from place to place). This failure had the potential for Resident 378 to receive unsafe care. Findings: Review of Resident 378's Admission Record, indicated, Resident 378 was admitted to the facility on [DATE], with diagnoses that included fracture of upper end of right leg, muscle weakness, abnormalities in gait and mobility, and hemiplegia and hemiparesis following cerebral infarction (paralysis and weakness on one side of the body after stroke.) During a review of Resident 378's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/7/24, the MDS indicated, Resident 378 needed the assistance of two or more staff for chair/bed-to-chair transfer (transfer to and from a bed to a chair or wheelchair.) During a review of Resident 378's Order Summary Report (OSR), dated 10/10/24, the OSR indicated Resident 378 is non-weight bearing (NWB-can't put any weight or pressure) on his right lower extremity (entire right leg.) During a review of Resident 378's Physical Therapy Evaluation & Plan of Treatment (PT Eval) dated 10/2/24, the PT Eval indicated, Resident 378 is NWB on his right leg and needed total assist with mechanical lift for transfers. During an observation on 10/8/24 at 10:56 a.m. in Resident 378's room, Resident 378 was in bed and a Hoyer lift sling was on the bed. CNA 1 was providing care to Resident 378 by herself. During a concurrent observation and interview on 10/8/24 at 11:12 a.m. in Resident 378's room, Resident 378 was observed to be on his motorized wheelchair. CNA 1 confirmed that she did the transfer by herself without additional staff assistance using the Hoyer lift. CNA 1 stated that Hoyer lift transfers should be done by two persons. During an interview on 10/10/24 at 3:04 p.m. with Director of Staff Development (DSD), DSD stated, Hoyer lift transfers were always done by 2 persons, it was part of training and what was taught in school. DSD stated that 2 persons were needed for the safety of the residents. During a review of the facility's policy and procedure (P&P) titled, Lifting Machine, Using a Mechanical, dated, May 2024, the P&P indicated, .At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 40830 Based on interview and record review, the facility failed to ensure two food service personnel were able to safely and effectively carry out the functions of the food and nutrition services when: 1. Dietary Aides (DA) 1 and DA 2, were unable verbalized the process of manual dishwashing by using three-compartment sinks correctly (cross refer to F812, #6), and 2. DA 2 was unable to verbalize the concentration of sanitizer solution for the sanitation (red) bucket (a red color-coded bucket with sanitizer solution for food service staff to sanitize food contact surfaces) (cross refer to F812, #7). These failures had the potential to place 75 out of 75 highly susceptible residents who received food from the kitchen at risk for food-borne illness. Findings: 1. During an interview on 10/8/24, at 11 a.m. with DA 1, DA 1 verbalized the process of manual dishwashing by using the three-compartment sink. She was not able to verbalize the immersion time of the dishes for the sanitizing step with the sanitizer. DA 2 joined the interview and stated the immersion time should be 20 seconds. A concurrent review of the directions for the sanitizer (Quaternary Ammonium - a sanitizer agent) indicated the immersion time was 60 seconds. Dietary Supervisor (DS) confirmed and stated the immersion time should be 60 seconds. During an interview with Registered Dietitian (RD) on 10/10/24, at 11:29 a.m., she acknowledged the issue and stated the staff should know the correct procedure of the manual dishwashing, if not may put the residents at risk for food-borne illness. A review of the facility policy and procedure (P&P), titled 3-Compartment Procedure for Manual Dishwashing, dated 2023, it indicated, the third compartment is for sanitizing .immerse all washed items for 60 sec . A review of DA 1's employee file with hire date of 7/18/19, and a competency audit of DA 1, titled Verification of Job Competency Demonstration & Equipment Competency, completed on 9/20/24 and checked off by DS, indicated DA 1 was competent in the procedure of three-compartment sink manual dishwashing by demonstration. A review of DA 2's employee file with hire date on 9/11/24, showed there was no competency audit completed due to DA 2 did not work at facility for a year per DS. A review of facility document, titled Food & Nutrition Services In-Service, Topic: Sanitation, completed on 6/11/24 by the pervious DS, it indicated DA 1 attended the in-service which included the procedure of three-compartment sink dishwashing. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility document titled, Job Description: Dietary Aide, dated 9/1/16, it indicated the dietary aide job functions include, .clean food preparation utensils, dishes .practice infection control policies and procedures . 2. During an interview regarding the sanitation (red) bucket on 10/8/24, at 11:06 a.m. with DA 2 and DS, DA 2 was not able to verbalize the correct concentration range for the sanitizer solution (Quaternary Ammonium - a chemical agent for sanitation). DS confirmed and stated the concentration range should be at 200-400 ppm (part per million - a measurement of concentration). During an interview with RD on 10/10/24, at 11:29 a.m., she stated the staff needed to have a good knowledge how to test and the correct concentration range for the sanitizer solution. If not may put the residents at risk for food-borne illness. A review of the facility P&P titled, Quaternary Ammonium Log Policy dated 2023, it indicated, .the quaternary solution, use for sanitizing clean work surfaces in the kitchen, will be made according to the instructions .the solution will be replaced when the reading is below 200 ppm . A review of DA 2's employee file with hire date of 9/11/24, there was no competency audit completed due to DA 2 did not work at facility for a year per DS. There was no indication of DA 2 attended any in-service for sanitation. A review of the facility document titled, Job Description: Dietary Aide, dated 9/1/16, it indicated the dietary aide job functions include, .clean food preparation utensils, dishes .practice infection control policies and procedures of the department .practice infection control .attend in-service education . A review of facility document titled, Job Description: Dietary Manager, dated 2/2024, it indicated, .primary purpose .provide supervision for the Dietary Department .monitor work assignments, provide feedback, evaluate performance .conduct .training, in-service education activities .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49950 Based on observation, interview, and record review, the facility failed to ensure that the menu was being following for the therapeutic diet for lunch on 10/9/24 when: 1.Three residents (Resident 30, 49, and 64) were on modified texture diets, Dysphagia Mechanical (diet is for people with mild to moderate chewing and/or swallowing difficulty) and Pureed (diet is for people with trouble chewing, swallowing, or fully breaking down food and usually ground, pressed, or strained to pudding like consistency) who received no wheat roll for bread instead of receiving pureed roll (for Pureed diet) or chopped and milk-soaked wheat roll (for Dysphagia Mechanical diet) as indicated on the menu; 2. Two residents (Resident 18 and 23) with NCS (No Concentrated Sweets)/CCHO (Consistent or Controlled Carbohydrate) diet (diet is for people that need to control their blood sugar or diabetes) received wheat roll for bread instead of no roll as indicated on the menu; 3. Two residents (Resident 15 and 39) with 60 grams (g) Protein Renal diet (diet is for people to manage chronic kidney disease) received vanilla wafers as dessert instead of a cookie as indicated on the menu; 4. Three residents (Resident 31, 60, and 63) received mashed potato and green beans for vegetables instead of rice and carrot as indicated on the menu; 5. Resident 64 with Dysphagia Mechanical diet received mousse with chocolate chips for dessert instead of mousse without chocolate chips as indicated on the menu; 6. Resident 71 with 60 g Protein Renal, NCS/CCHO diet received mousse without chocolate chips for dessert instead of diet cookie as indicated on the menu; and 7. 75 out 75 meals were served without garnish instead of receiving garnish as indicated on the menu. These failures had the potential to result in compromising the medical and nutrition status of those 75 residents. Findings: During an observation of lunch meal service on 10/9/24 beginning at 12:05 p.m., it was noted as followed: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Residents 30, 49, and 64 who were on dysphagia mechanical and pureed diets did not receive chopped and milk-soaked wheat roll and puree wheat roll respectively. A concurrent review of the facility spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) titled, Fall Menus, Week 2 Wednesday, indicated that dysphagia mechanical diet should have received wheat roll as chop 1/2, mashable, soak and drain and pureed diet should receive wheat roll as P (Pureed) #16 (1/4 cup). 2. Residents 18 and 23 who were on NCS/CCHO diet received wheat roll instead of no roll. A concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, indicated that CCHO diet should have received no wheat roll. A review of the facility document titled, Diet Manual for Long Term Care and Residential Facilities, dated 2020, it indicated, .CCHO diet .carbohydrates are controlled through portion control and avoiding some concentrated sweets . 3. Residents 15 and 39 who were on 60 g Protein Renal diet received six pieces of vanilla wafers instead of a cookie. A concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, it indicated 60 g Protein Renal diet should have received two small sugar cookies or one large sugar cookie for dessert. A review of the facility document titled, Diet Manual for Long Term Care and Residential Facilities, dated 2020, it indicated, .Protein Restricted Diet .a diet high in simple sugars and fat is used to spare protein . desserts: one serving = 2 small sugar cookies . 4. Residents 31, 60, and 63 received mashed potatoes and green beans instead of carrots and rice. A concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, it indicated regular diet should have received brown rice and carrots. 5. Resident 64 who was on a Dysphagia Mechanical diet received mousse with chocolate chips instead of mousse without chocolate chips. A concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, indicated Dysphagia Mechanical diet should have received mousse dessert with no chocolate chips. A review of the facility document titled, Diet Manual for Long Term Care and Residential Facilities, dated 2020, it indicated, .Dysphagia Mechanical .this diet consists of foods that are moist, mechanically altered, or easily mashed .foods must not be sticky or bulky increasing the risk of airway obstruction . 6. Resident 71 who was on a 60 g Protein Renal diet and NCS/CCHO diet received mousse with no chocolate chips instead of a diet cookie. A concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, it indicated Renal CCHO diet should have received two small diet sugar cookies. 7. All meals delivered did not have parsley garnish. A concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, it indicated all diets should have received a parsley garnish. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the DS (Dietary Supervisor) on 10/9/24 at 1:56 p.m., the DS acknowledged and confirmed the observation findings during lunch meal service. The DS stated that some puree and dysphagia mechanical diet trays did not get the wheat roll. The DS further stated the vanilla wafers for the 60 g Protein Renal diet with and without NCS/CCHO was used because the kitchen did not prepare the cookies. The DS further stated the last few meals were served with mashed potato and green beans because they were running out of rice and carrots. DS further stated the Registered Dietitian (RD) approved the substitution of mashed potatoes and green beans during meal service, but residents had not been notified of the changes. The DS further stated all meals should have garnish with parsley. The DS stated the menu and spreadsheet should be followed. During an interview with the RD on 10/10/24 at 11:29 a.m., the RD acknowledged issues that were found during meal service. The RD stated residents should receive the food items that were reflected on the menu. The RD further stated the kitchen did not prepare enough rice and carrots because the cook did not follow the standardized recipe. The RD further stated the substitute for rice and carrots needed to be approved by the RD and the residents should be informed of the change. The RD further stated, kitchen staff needed to follow the menu and spreadsheet. During a review the facility's policy and procedure (P&P) titled, Menu Planning dated 2023, indicated, .menu changes should be noted on menus on the consumers board and any other menus which may be posted . menus are planned to meet nutritional needs of residents in accordance with established national guidelines . the facility's diet manual and diets are ordered by the physician should mirror the nutritional care provided by the facility .menus are written for regular and therapeutic diets in compliance with the diet manual . standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation . During a review of facility document, titled Job Description: Cook, dated 2/2024, it indicated, .essential duties .ability to follow prepared menus and portion control guides .ability to prepare special diets accurately .

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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. 49950 Based on observation, interview, and facility document review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety when: 1. Several various metal sheet pans in clean and ready-to-use storage areas: a. Were stacked wet while stored away b. Had food debris; 2. There were opened bags of food items in dry storage and freezer with issues: a. One opened bag of elbow noodles was not tightly closed b. One opened bag of croutons was not labeled with an open or use by date c. One opened package of hamburger meat patties was not labeled with an open or use by date; 3. The thawing process system did not effectively identify when food was pulled from the freezer and used by date; 4. The ice machine was not clean; 5. The hot food cool down was not practiced correctly; 6. Two dietary aides were not able to verbalize the process of manual dishwashing by using the 3-compartment sinks correctly; 7. One dietary aide was not able to verbalize the concentration of the sanitizer solution for the sanitation (red) bucket (a color coded bucket contain sanitizer for the food service staff to sanitize the food-contact surfaces); and, 8. The microwave for resident's food located in dining room was not clean. These failures had potential to cause food-borne illness in a highly susceptible population of 75 out of 75 residents who received food from the kitchen. Findings: 1. During a concurrent observation and interview with Dietary Supervisor (DS) and Registered Dietician (RD) on 10/8/24 at 9:40 a.m. at the kitchen's initial tour, several metal sheet pans stored at the clean and ready-to-use storage areas were observed stacked wet and had food debris. The metal pans included: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-9 of full sheet pans (wet) -5 of full sheet pans (food debris inside) -4 of 1/4 sheet pans (wet) -10 of 1/6 sheet pans (wet) -1 of 1/6 sheet pan (food debris inside) The DS confirmed the metal sheet pans were wet and had food debris inside. The DS stated the dishes, pans and pots needed to be completely air-dried and clean before stored away. The RD stated dishes, pans and pots should be dried before being stored away to prevent mold and bacteria growth. During a review of the facility's policy and procedure (P&P) titled, Dishwashing, dated 2023, it indicated, . dishes are to be air dried in racks before stacking and storing . During a review of the facility's P&P titled, Sanitation dated 2023, it indicated, .All utensils .shall be kept clean . 2. During a concurrent observation and interview with the DS on 10/8/24 at 9:52 a.m. at the kitchen's initial tour, one opened bag of elbow pasta was not tightly closed, and one opened bag of croutons did not have an opened or used by date. The DS confirmed and stated opened packages of food should be wrapped and closed tightly. The DS further stated opened packages of food need to have labels with opened or used by dates. During a concurrent observation and interview with the DS on 10/8/24 at 10:06 a.m., at the kitchen's initial tour, one opened package of hamburger meat patties was not tightly closed and did not have and open or use by date. The DS confirmed and stated the opened package should have been wrapped tightly and labeled with opened or used by dates. During a review of the facility's P&P titled, Storage of Food and Supplies dated 2023, it indicated, .dry food items which have been opened .will be tightly closed, labeled, and dated . During a review of the facility's P&P titled, Labeling and Dating of Foods dated 2023, it indicated, .newly opened food items will need to be closed and labeled with an open date and used by date . 3. During a concurrent observation and interview with DS on 10/8/24 at 10:16 a.m., at the kitchen's initial tour, two boxes of fish and one box of chicken were sitting on the bottom rack in the refrigerator for thawing. The boxes of fish and chicken were not labeled with a pulled or used by date. The DS confirmed the thawing boxes of fish and chicken did not have labels indicating when the food was pulled from the freezer and when the food should be used by date. The DS stated she pulled the two boxes of fish from the freezer yesterday. The DS further stated she did not know when the box of chicken was pulled from the freezer. The DS further stated verbal communication was used to indicate when the meat items were being thawed. The DS further stated verbal communication was not effective. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Thawing of Meats dated 2023, it indicated, .label defrosting meat with pull and use by date . 4. During a concurrent observation and interview with the DS and the RD on 10/8/24 at 10:35 a.m., at the kitchen's initial tour, an orange slimy substance was on the ice chute (the passageway that allows ice to fall into an ice storage bin) inside the top machinery part of the ice machine. Also observed the water was dripping through the orange slimy substance onto the ice in the ice storage bin. The DS and the RD confirmed the ice machine chute had an orange slimy substance. The DS stated an outside vendor was responsible for deep cleaning the ice machine every three months. During a review of the outside vendor invoice, it indicated the last deep cleaning service was on 5/31/24 and it had passed the three month mark as stated. During a review of the facility's P&P titled, Ice Machine Cleaning Procedures dated 2023, it indicated, .ice machine needs to be cleaned and sanitized monthly .clean inside of ice machine .per manufacturer's instructions . During a review of the ice machine's service manual, dated 12/8/2021, the service manual indicated the icemaker should be cleaned every 6 months and .more frequent maintenance may be required depending on water quality and appliance's environment . According to 2022 FDA (Food and Drug Administration) Food Code, on section 4-602.11 Equipment Food-Contact Surface and Utensils, it stated equipment like ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms (a living thing that is so small it must be viewed with a microscope, such as bacteria or algae). 5. During a concurrent interview and record review with the DS on 10/8/24 at 10:47 a.m., at the kitchen's initial tour, the DS stated hot and ambient foods were documented on the same log. A review of the October 2024 cooling log indicated the last cooling temperature was not documented for all foods on the log. A review of the September 2024 cooling log indicated there was a hot food item that went through the cool down process for more than six hours. A review of the September 2024 and October 2024 cooling logs indicated several hot foods on the log started cool down above 140 degrees Fahrenheit (F). DS confirmed staff were not practicing cool down processes correctly. During a review of the facility's P&P titled, Cooling and Reheating of Potentially Hazardous or Time/Temperature Control for Safety Food dated 2023, it indicated cooked food that is not served right away will be cooled using the two-stage method. The P&P further indicated, .cool cooked from 140 degrees F to 70 degrees F within two hours .then cool from 70 degrees F to 41 degrees F or less in an additional four hours for a total cooling time of six hours .when cooling down food, use the Cool Down Log .to document with proper procedure . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055446	A. Building B. Wing	10/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. During a concurrent interview and review of manual dishwashing directions on 10/8/24 at 11:00 a.m. with the Dietary Aide 1 (DA 1), DA 2 and DS, The DA 1 stated they would switch to manual dishwashing with 3-compartment sink if dishwashing machine was not working. The DA 1 was not able to provide sanitizer immersion time for dishes. The DA 2 stated an incorrect immersion time of 20 seconds for the dishes. A review of the directions for sanitizer (Quat) indicated immersion time was 60 seconds. The DS confirmed the immersion time should be 60 seconds for dishes during the sanitizing process for the manual dishwashing procedure. During a review of the facility P&P titled, 3-Compartment Procedure for Manual Dishwashing dated 2023, it indicated, .the third compartment is for sanitizing .immerse all washed items for 60 sec . During a review of the facility's Job Description for Dietary Aide dated 9/1/16, the Job Description indicated the Dietary Aide job functions include, .clean food preparation utensils, dishes .practice infection control . 7. During a concurrent interview and review of red bucket sanitizer directions on 10/8/24 at 11:06 a.m. with the DA 2 and the DS, the DA 2 stated she did not know the right concentration range for red bucket sanitizer. The DS confirmed the DA 2 was not able to state correct concentration range. The DS further stated the concentration range for red bucket sanitizer should be 200-400 ppm (part per million - a measurement of concentration for the sanitizer). During an interview on 10/10/24, at 11:29 a.m. with the RD, the RD stated the staff should have good knowledge about how to test the concentration range for the sanitizer solution, and that would minimize the risk for the residents to get food-borne illness. During a review of the facility's P&P titled, Quaternary Ammonium Log Policy dated 2023 it indicated, .the quaternary solution, use for sanitizing clean work surfaces in the kitchen, will be made according to the instructions .the solution will be replaced when the reading is below 200 ppm . 8. During a concurrent observation and interview on 10/10/24 at 9:36 a.m. with the Director of Staff Development (DSD), noted the interior part of the microwave for resident's food in the dining room had black dry food splashes. The DSD confirmed the microwave was dirty and needed to be cleaned. During a review of the facility's P&P titled, Sanitation dated 2023, it indicated, .all equipment shall be kept clean .

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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** 44946 Based on observation, interview, and record review the facility failed to implement infection prevention and control practices for one of 25 sampled residents (Resident 379) when the Certified Nursing Assistant (CNA 2) did not wear the proper Personal Protective Equipment (PPE-gown, eye protection or face shield and gloves) upon entering Resident 379's room with an isolation precaution sign. This failure put the residents at increased risk for the spread of infection. Findings: During a review of Resident 379's Admission Record, the Admission Record indicated, Resident 379 was admitted on [DATE], with diagnoses that included but is not limited to COVID-19 (a highly contagious respiratory disease caused by the SARS-CoV-2 virus), moderate protein-calorie malnutrition, and muscle weakness. During a review of Resident 379's Result Details, dated 10/2/24, the Result Details indicated a positive result for COVID-19. During a review of Resident 379's Order Summary Report (OSR), dated 10/10/24, the OSR indicated Resident 379 had an order for Droplet Precaution in Place: Dx [diagnosis] covid positive until 10/12/24. During an observation on 10/8/24 at 12:43 p.m., outside Resident 379's room, there was a signage that indicated Resident 379 is on droplet precaution (a set of measures used to prevent the spread of organisms that cause disease through respiratory secretions.) During an observation on 10/8/24 at 12:48 p.m., inside Resident 379's room, the CNA 1 brought in the lunch tray, and asked the CNA 2 to help her reposition Resident 379. At 12:51 p.m. the CNA went in the room with gown, gloves, and a yellow surgical mask (disposable loose-fitting mask that covers the user's nose and mouth). During a concurrent observation and interview on 10/8/24 at 12:56 p.m., with the CNA 2, the CNA 2 confirmed wearing the yellow surgical mask inside Resident 379's room. The CNA 2 looked at the signage posted at the door and stated, I'm sorry, I'm sorry. During a review of the facility's P&P titled Categories of Transmission Based Precautions, dated May 2024, the P&P indicated, Droplet Precautions .masks are worn when entering the room. During a concurrent interview and record review on 10/11/24 at 10:59 a.m. with Infection Preventionist (IP), IP stated that for Covid-19 isolation staff should be wearing an N95 mask (a disposable face mask that covers the user's nose and mouth which offers protection from small solid or liquid droplets found in the air). IP stated that a sign was placed on the door indicating that staff should be wearing N95. The 'Droplet Precautions' signage at Resident 379's door was reviewed, and IP nurse confirmed that the picture 'Respiratory Protection' in that signage was the indicator that staff should be wearing N95.

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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** 45718 Based on observation, interview and record review, the facility failed to ensure 28 multiple-resident rooms (rooms 1-8, 11, 12, 17-19, 21, 23-36) met the required 80 square feet (sq. ft.) per resident when the following rooms were measured as: room [ROOM NUMBER] at 71.4 sq. ft. per person room [ROOM NUMBER] at 71.45 sq. ft. per person room [ROOM NUMBER] at 71.4 sq. ft. per person room [ROOM NUMBER] at 75.5 sq. ft. per person room [ROOM NUMBER] at 71.4 sq. ft. per person room [ROOM NUMBER] at 74.5 sq. ft. per person room [ROOM NUMBER] at 74.5 sq. ft. per person room [ROOM NUMBER] at 76.9 sq. ft. per person room [ROOM NUMBER] at 74.67 sq. ft. per person room [ROOM NUMBER] at 72.1 sq. ft. per person room [ROOM NUMBER] at 74.67 sq. ft. per person room [ROOM NUMBER] at 73.83 sq. ft. per person room [ROOM NUMBER] at 78.93 sq. ft. per person room [ROOM NUMBER] at 70.47 sq. ft. per person room [ROOM NUMBER] at 70.8 sq. ft. per person room [ROOM NUMBER] at 71.4 sq. ft. per person room [ROOM NUMBER] at 70.47 sq. ft. per person room [ROOM NUMBER] at 71.4 sq. ft. per person room [ROOM NUMBER] at 70.8 sq. ft. per person room [ROOM NUMBER] at 71.9 sq. ft. per person (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] at 70.8 sq. ft. per person room [ROOM NUMBER] at 71.4 sq. ft. per person room [ROOM NUMBER] at 70.8 sq. ft. per person room [ROOM NUMBER] at 71.4 sq. ft. per person room [ROOM NUMBER] at 70.8 sq. ft. per person room [ROOM NUMBER] at 75.64 sq. ft. per person room [ROOM NUMBER] at 70.8 sq. ft. per person room [ROOM NUMBER] at 70.8 sq. ft. per person This failure had the potential to negatively affect the residents' quality of life and result in inadequate space for the provision of care. Findings: During observations made throughout the survey in the rooms with two and three resident occupancies, the space was adequate to store assistive devices in the rooms (such a wheelchair and/or walkers) and to facilitate provision of care and needs. During an interview on 10/8/24 at 10:19 a.m., a resident in room [ROOM NUMBER] stated, he did not have many things, so he had enough space in the room. During an interview on 10/8/24 at 10:16 a.m., Residents in room [ROOM NUMBER] stated they had no concerns or issues with the size of the room. During an interview on 10/8/24 at 12:29 p.m., a resident in room [ROOM NUMBER] stated he had no issues with the space in the room. During an interview on 10/9/24 at 11:13 a.m. a resident in room [ROOM NUMBER] stated there was not enough space in her room for assistance in getting out of bed. She had a Hoyer lift, and stated the Certified Nursing Assistants (CNAs) had a difficult time and sometimes had to maneuver furniture, such as her bedside table and items on her nightstand. Her roommate stated the CNAs often moved items past the dividing curtain into her space when they were transferring Resident 22 via the Hoyer lift, but she lets them do it because she wanted to respect her roommate's needs. The Department recommends continuation of the waiver for the above-mentioned rooms.