STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055459	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vista Care Center	1440 S Euclid Avenue Anaheim, CA 92802

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, medical record review, and P&P review, the facility failed to ensure the medications were safely administered for one of 20 final sampled residents (Resident 35) and one nonsmapled resident (Resident 69) to self- administer medications. * Resident 69 was observed to have two bottles of Nerve Shield Pro (used as supplement for Brain & Nervous System Health, Neuropathy, Nerve Pain) at the bedside and had self-administered the medication. * Resident 35 was observed to have Tums (medication to relieve heartburn/stomach upset) tablet at bedside. These failures had the potential to negatively impact the residents' physiological well-being and administer the medications inaccurately. Findings: Review of the facility's P&P titled Self-Administration of Medications revised 2/2021 showed the residents have the right to self-administer medications if the Interdisciplinary Team has determined that is clinically appropriate for the resident. 1. Medical record review for Resident 69 was initiated on 10/30/24. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's Quarterly MDS dated [DATE], showed a BIMS score of 15 (cognitively intact). On 10/29/24 at 0857 hours, Resident 69 was observed to have two bottles of Nerve Shield Pro. One bottle had multiple capsules inside and the other bottle was empty. On 10/29/24 at 1510 hours, an interview was conducted with Resident 69. Resident 69 stated he was taking the Nerve Shield Pro capsules twice a week or more and stated his family member brought the Nerve Shield Pro medications to the facility. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 1510 hours, an interview and concurrent observation for Resident 69 was conducted with RN 2. RN 2 verified the Nerve Shield Pro capsules at bedside and stated any medication must have an order and it was not safe to keep the medications at bedside. RN 2 further verified there was no physician's order for Neuro Shield.Pro capsules. Review of Resident 69's medical record failed to show documented evidence of the following for Resident 69 to safely self-administer medications: - a physician's order; - IDT notes; - self-administration of medication assessment; and - a care plan addressing Resident 69's self- administration of medication. On 11/1/24 at 1525 hours, an interview and concurrent medical record review for Resident 69 was conducted with the DON. The DON was informed and verified the above findings. 50953 2. Medical Record Review for Resident 35 was initiated on 10/29/24. Resident 35 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 35's H&P examination dated 9/19/24, showed the resident had the capacity to understand and make decisions. Review of Residents 35's MDS dated [DATE], showed a BIMS score of 12 (meaning moderately cognitive impaired). On 10/29/24 at 0828 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with Resident 35. Three Tums tablets were observed at Resident 35's overbed table. Resident 35 stated she had been taking the Tums since she started having pain in the stomach two months ago, and the licensed nurses were the ones giving her the medication. On 10/29/24 at 0832 hours, an observation and concurrent interview for Resident 35 was conducted with RN 1. RN 1 was asked about the facility's process of self-administration of medication and leaving medication at bedside. RN 1 stated no medication should be left at the resident's overbed table and the facility needed to assess the residents if it was safe to self-administer medications, have an order from the physician, and a care plan. RN 1 verified Resident 35 had three Tums at her overbed table and was unable to verify who gave the medication to Resident 35. On 10/29/24 at 1219 hours, a concurrent interview and medical record review for Resident 35 was conducted with RN 2. RN 2 verified Resident 35's Order Summary Report did not show any order for the above medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 0852 hours, a follow-up interview and concurrent medical record review for Resident 35 was conducted with RN 2. RN 2 verified Resident 35's medical record failed to show documented evidence an assessment of self-administration of medication was conducted for Resident 35. On 11/1/24 at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of one final sampled resident (Resident 75) reviewed for Foley catheter care had a dignity bag to cover the urinary catheter drainage bag. This failure had the potential to compromise Resident 75's rights to be treated with respect and dignity. Findings: Review of the facility's P&P titled Dignity revised 2/2021, showed the following: - Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents, for example: a. helping the resident to keep urinary catheter bags covered; b. promptly responding to a resident's request for toileting assistance; and c. allowing resident unrestricted access to common areas, open to the public, unless this poses a safety risk for the resident. Medical record review for Resident 75 was initiated on 10/29/24. Resident 35 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 75's H&P examination dated 7/18/24, showed the resident was able to understand and make treatment decisions. Residents 75's MDS dated [DATE], showed a BIMS score of 15 (meaning cognitively intact). Review of Resident 75's Order Summary Report dated 10/30/24, showed a physician's order dated 7/16/24, for Foley catheter 16 Fr/10 cc to bedside drainage bag for the diagnosis of obstructive uropathy (a blockage in the urinary tract). On 10/29/24 at 1433 hours, an observatin was conducted for Resident 75. Resident 75 was observed lying in bed, with Foley catheter bag attached to the bed without a dignity bag. On 10/29/24 at 1441 hours, an observation and concurrent interview for Resident 75 was conducted with RN 1. RN 1 stated all residents with Foley catheter needed to have a covering on the urinary bag for the resident's dignity. RN 1 verified Resident 75 had no covering on the Foley catheter bag. On 11/1/24 at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to effectively respond to the repeated concerns of cold food brought up in the monthly Resident Council meetings. This failure resulted in the Resident Councils concerns of cold meals being an ongoing issue, putting the residents at risk of undesirable outcomes. Findings: Review of the facility's P&P titled Resident Council, revised February 2021 showed the purpose of Resident Council is for residents to discuss concerns and suggestions for improvement. The facility department related to any issues will be responsible for addressing the items of concern. Review of the facility's P&P titled Food Temperature Policy updated March 2019 showed foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures. Foods sent to the unit for distribution will be transported and delivered to the unit to maintain temperatures above 140 degreed Fahrenheit. Review of the Resident Council Minutes showed the following concerns: - On 11/8/23, food came out cold. The Dietary department's response was to monitor that meals were hot when they left the kitchen, and a weekly test tray audit would be done. - On 12/20/23, sometimes the food had been cold. The Dietary department's response was to monitor that meals were hot when they left the kitchen. - On 1/17/24, the food temperature was cold. The Dietary department's response was meals were hot when leaving the kitchen and dietary will discuss with the nursing to pass the meal tray to the residents quicker. - On 2/21/24, food temperature had been cold and lukewarm. The residents would like the order the tray carts came out from the kitchen to be rotated. The Dietary department's response was to speak with the nursing department about speeding up the process of passing out the residents' food trays. - On 3/26/24, food had come out lukewarm. The Dietary department's response was to continue to monitor the food trays to ensure the residents received their meals hot. - On 4/17/24, the residents requested meal tray delivery be rotated. The Dietary department's response was that they would speak to the nursing if they could rotate what the residents were served first. - On 5/15/24, the residents verbalized food coming out cold often. The Dietary department's response was to monitor the food temperatures when the food left the kitchen for each meal. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 6/19/24, the residents stated meals had been hit or miss and often came out warm and sometimes cold. The Dietary department's response was to monitor that meals were hot when they left the kitchen. - On 7/17/24, the residents stated sometimes meals are not hot enough. The Dietary department's response was to ensure meals were hot when they left the kitchen. - On 8/21/24, the food was hit and miss for the temperature. The Dietary department's response was to monitor that meals were hot when they left the kitchen and would continue to do weekly test trays. - On 9/18/24, the lunch trays had been cold. The Dietary department's response was for the meals to be hot when they left the kitchen, and they would discuss with the nursing department to pass the trays quicker. - On 10/16/24, the meals were arriving cold. The Dietary department's was to speak to the nursing department about delivering the trays in a shorter amount of time. Review of the Test Tray Worksheets showed the following: - On 6/14/24, for Station 1's meal tray delivery, the tray cart left the kitchen at 1701 hours, was delivered to the unit at 1702 hours, with the last tray being passed at 1734 hours (32 minutes later), with only one CNA passing out the trays. - On 8/8/24, for Station 1's meal tray delivery, the tray cart left the kitchen at 1702 hours, was delivered to the unit at 1703 hours, with the last tray being passed at 1731 hours (28 minutes later), with only one CNA passing out the trays. - On 9/5/24, for Station 1's meal tray delivery, the tray cart left the kitchen at 1703 hours, was delivered to the unit at 1704 hours, with the last tray being passed at 1729 hours (19 minutes later), with only one CNA passing out the trays. - On 9/12/24, for Station 2's meal tray delivery, the tray cart left the kitchen at 1713 hours, was delivered to the unit at 1714 hours, with the last tray being passed at 1740 hours (19 minutes later), with only one CNA passing out the trays. - On 10/4/24, for Station 2's meal tray delivery, the tray cart left the kitchen at 1212 hours, was delivered to the unit at 1214 hours, with the last tray being passed at 1233 hours (26 minutes later), with only one CNA passing out the trays. Medical record review for Resident 27 was initiated on 10/19/24. Resident 27 initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 27's MDS dated [DATE], showed the resident was cognitively intact. On 10/29/24 at 0959 hours, an interview was conducted with Resident 27. Resident 27 stated he attended the Resident Council and meals being delivered cold was a recurring issue in the meetings, and his food still being delivered cold. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 1201 hours, a meal tray cart was observed being brought to Unit 1. The tray cart was a wheeled cart, with slots to hold the trays. It was an open cart, with not sides. On 10/30/24, during a Resident Council meeting, Resident 27 stated food being delivered cold was still an issue and the resident had to ask staff to reheat their food. On 10/31/24 at 1222 hours, a meal tray cart was observed being brought to Unit 1. The tray cart was a metal cart with all sides enclosed. On 10/31/24 at 1245 hours, an interview was conducted with the CDM. The CDM stated they had been using the open tray carts up until this Tuesday when the surveyor asked about the open tray carts. The CDM stated they had four enclosed tray carts but had not used them for approximately a year. On 10/31/24 at 1448 hours, a follow-up interview was conducted with the CDM. The CDM stated the enclosed metal tray carts were not being used because they were time consuming to put the meal trays in. He stated the enclosed carts were supposed to help keep meal trays warm, but it took the kitchen staff longer to load the meal trays into the carts. The CDM was asked about the recurring Resident Council concerns about food temperature, and they had these enclosed meal trays carts available to use, why they did not utilize them since their other interventions to keep the food warm were not resolving the issue. The CDM stated because it took longer to load the enclosed tray carts. The CDM stated they had four enclosed tray carts, plus with one open side, and three enclosed sides. On 11/1/24 at 1758 hours, a concurrent interview and facility document review was conducted with the Activities Director. The Activities Director stated the concerns brought up during Resident Council were brought up with the appropriate department head for follow-up, then they gave their follow-up action to the Activities Director. The Activities Director stated the most common complaint from the Resident Council meeting was for the meals being cold. On 11/1/24 at 0817 hours, an interview was conducted with the Administrator. The Administrator stated she was aware of the repeated concerns about meals being cold, and they were monitoring it monthly in their QA/QAPI meetings. The Administrator stated she purchased the metal carts more than a year ago and was not aware that the dietary department was using the open tray carts to deliver the resident meals. On 11/1/24 at 1021 hours, a concurrent interview and facility document review was conducted with the DON. When asked if the facility had following up with other residents to determine if the Resident Council complaint about food temperatures was widespread, the DON stated all department heads did daily rounds on their assigned room, and were asked at standup if any residents had concerns. The DON retrieved a blank copy of the Room/Facility Rounds tool and stated this was the tool that the departments heads used. Review of the tool failed to show the residents were asked about any dietary concerns including meal temperatures, which was verified by the DON. Review of the untitled form dated 10/2021 showed the Assigned Rooms Rounds and the corresponding Room numbers. The following staff were assigned room rounds: Infection Preventionist, DSD, Business Office, Case Manager, Medical Records, MDS, Social Services, Admissions, Activities, Maintenance and Dietary. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/1/24 at 1026 hours, an interview was conducted with the MDS Nurse. The MDS Nurse stated all department heads and herself conducted daily room rounds on their assigned room. When asked what her assigned rooms were, the MDS Nurse was unable to state the rooms. The MDS Nurse stated she had not done daily room rounds in five months. On 11/1/24 at 1028 hours, an interview was conducted with the Medical Records Director. The Medical Records Director stated she was responsible for doing room rounds with other department heads. When asked what rooms she made round on, the Medical Records Director stated she had to check, and retrieved the untitled room rounds assignment sheet. The Medical Records Director stated they had not done the assigned daily room rounds since they started working at the facility back in 2023. On 11/1/24 at 1029 hours, an interview was conducted with the SSD. The SSD stated she was supposed to perform daily room rounds on her assigned rooms. The SSD stated she could not recall the last time she did their assigned room rounds, but it had been a while. The SSD stated she did not ask the residents about food specifically. On 11/1/24 at 1034 hours, an interview was conducted with the Case Manager. The Case Manager stated they did not have assigned rooms for daily rounds, nor a tool to use. The Case Manager stated they did rounds on the residents with a HMO, just to see how they were doing, any medication concerns, appointments, and to follow-up on discharge planning. They did ask about food on admission. On 11/1/24 at 1036 hours, an interview was conducted with the Admission Coordinator. The Admission Coordinator stated they were the Admissions department head, had been at the facility three years, and were not assigned and did not do daily room rounds. On 11/1/24 at 1039 hours, an interview was conducted with the Business Office Manager. The Business Office Manager stated they did not have assigned daily room rounds, but approximately twice a week they did meet with the residents who had trust accounts with the facility. On 11/1/24 at 1043 hours, an interview was conducted with the DSD. The DSD stated he did daily room rounds on his assigned rooms. The DSD stated he asked about meals; for example, how the food tasted, if they wanted more food and if needed, he would give them an alternate food menu. On 11/1/24 at 1047 hours, an interview was conducted with the Activity Director. The Activity Director stated she did her assigned daily room rounds using the checklist on her computer. The Activity Director stated the residents on her assigned area were not able to communicate so she just did the checklist. The Activity Director stated any concerns with room rounds would be discussed in the morning stand-up meeting. On 11/1/24/at 1053 hours, an interview was conducted with the Infection Preventionist. The Infection Preventionist stated she did daily room rounds on her assigned rooms, completed the check list and asked the residents if they were okay, in pain or needed anything. The Infection Preventionist went over any concerns with the room rounds in Stand-up when the Administrator asked if there were any room rounds concerns. On 11/1/24/at 1057 hours, an interview was conducted with the CDM. The CDM stated he did the daily assigned room rounds, however his assigned residents were not very responsive so he did the check list. The CDM stated the room rounds concerns were discussed in the morning stand-up meeting. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/1/24 at 1138 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated they completed their daily room rounds, but only completed the checklist when things were wrong, and he did not turn in the check list. The Maintenance Supervisor stated every morning at the stand-up meeting, the Maintenance Supervisor asked if there were any concerns from room rounds, and if anyone had concerns, they just spoke up. Medical record review for Resident 22 was initiated on 10/29/24. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's MDS dated [DATE], showed the resident was cognitively intact. On 11/1/24 at 1140 hours, an interview was conducted with Resident 22. Resident 22 stated cold meals had been an issue a long time. A cold hot dog or hamburger was yuck and a reheated hamburger was not good either.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to maintain a comfortable temperature level for one of 20 final sampled residents (Resident 33). This failure had the potential to negatively affect the resident's health and well-being. Findings: Review of the facility's P&P titled Environment - Temperatures - Test and Log Air Temperature revised 11/2/18, showed all buildings are required to maintain an ambient temperature throughout resident and patient areas in a temperature range of 71 to 81 degrees Fahrenheit or at a more restrictive range required by state or local requirements. Exceptions to this range may be available for brief periods of unseasonably warm or cold temperatures; however, the variance in temperatures must not adversely affect resident or patient health and safety. Medical record review for Resident 33 was initiated on 10/29/24. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Residents 33's MDS dated [DATE], showed Resident 33 had a BIMS score of 15 (meaning cognitively intact). On 10/29/24 at 0906 hours, during an initial tour of the facility, an observation and concurrent interview was conducted with Resident 33. Resident 33 was observed sitting in his wheelchair, wearing a hooded jacket and shivering. Resident 33 stated the room temperature in his room was always cold. On 10/31/24 at 0908 hours, an observation and concurrent interview was conducted with Resident 33. Resident 33 stated the room temperature was still cold. Resident 33 was observed wearing a hooded jacket and shivering. On 10/31/24 at 0921 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified Resident 33's room (Room B) was cold and the thermostat reading was 68 degrees Fahrenheit. 10/31/24 at 0936 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified Resident 33's room (Room B) was cold. The Maintenance Director checked the room temperature using a digital thermometer and the room temperature was 68.9 Fahrenheit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and medical record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of 20 final sampled residents (Resident 67) and one nonsampled residents (Resident 41). * Resident 41's care plan failed to address the use of a bedside commode. * Resident 67's care plan failed to address the resident's psychosocial needs and failed to implement non-pharmacological interventions attempted for his behaviors were documented for risperidone use. These failures posed the risk of the residents not receiving services that were person-centered to meet the specific needs of each resident. Findings: 1. On 10/29/24 at 1418 hours, a strong constant urine odor was in the hallway outside the facility's conference room. On 10/29/24 at 1545 hours, a concurrent observation and interview was conducted with the IP. The IP identified the urine odor coming from Resident 41's bedside commode. The IP verified the bedside commode needed to be emptied. On 10/30/24 0904 hours, a concurrent observation and interview was conducted with the IP. The IP verified the odor of urine coming out into hallway was from Resident 41's bedside commode. The IP verified Resident 41's bedside commode had a plastic bag inside half filled with urine. The IP also verified a towel on the floor between Resident 41's bed and bedside commode was observed with yellow stains on it. When asked about Resident 41's bedside commode, the IP verbalized the staff were expected to empty the bedside commode every two hours or as notified by Resident 41. On 10/31/24 at 1152 hours, an interview was conducted with CNA 1. When asked about Resident 41's bedside commode, CNA 1 stated she checked Resident 41's bedside commode every two hours or when notified by Resident 41. When asked why Resident 41 had a towel on the floor, CNA 1 stated Resident 41 used the towel because sometimes she would not be able to self transfer to the bedside commode and the towel would be used to catch Resident 41's urine or bowel movement while she transferred herself onto the bedside commode. Per CNA 1 she used disinfectant wipes to clean Resident 41's bedside commode. When asked when she replaced or washed Resident 41's bedside commode, CNA 1 stated she would change or wash the bedside commode when soiled or ever one to two days with soap and water. When asked about the urine or bowel movement odors, CNA 1 acknowledged would be coming from Resident 41's bedside commode. When asked about following up when the odor of urine was coming out of Resident 41's bedside commode, CNA 1 was unable to explain. Medical record review for Resident 41 was initiated on 10/29/24. Resident 41 was readmitted to the facility on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 41's ADL for bladder and bowel continence for October 2024, showed Resident 41 was sometimes continent and sometimes incontinent of both bladder and bowel. Review of Resident 41's plan of care failed to show a care plan problem to address Resident 41's toileting needs specifically her use of a bedside commode. On 11/01/24 at 1415 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 verified there was no care plan problem to address Resident 41's use of a bedside commode. 2. On 10/29/24 at 1049 hours, a concurrent observation of Resident 67 and interview was conducted with Resident 67's roommate, Resident 66. Resident 67 was observed lying in bed on his right side. Resident 66 stated Resident 67 screamed all evening, verbalizing wanting to go to the gym. Resident 66 further stated Resident 67 did not allow him to sleep. During this observation, Resident 67 kept repeating he wanted to go to the gym. Resident 67 then started whining, he wanted to go to the gym. Medical record review for Resident 67 was initiated on 10/29/24. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's H&P exam dated 9/28/24, showed Resident 67's diagnoses included developmental delay and psychosis. Resident 67 did not have capacity to understand and make decisions. Review of Resident 67's MAR showed Resident 67 was administered risperidone (antipsychotic medication) twice daily for psychosis manifested by aggressive behavior, yelling towards staff. The MAR also showed an area to document nonpharmacological interventions for Resident 67's risperidone, which was blank. Per this MAR, Resident 67 had behaviors of yelling. On 10/29/24 at 1149 hours, an interview was conducted with Resident 67's RP. Per the RP, prior to being admitted to the facility, Resident 67 would attend a day program for persons with developmental delay. On 10/30/24 at 0807 hours, an interview was conducted with the Activities Director. Per the Activities Director, Resident 67 liked looking at pictures of himself and his family. Review of Resident 67's plan of care showed a care plan problem addressing Resident 67's activities needs as being withdrawal from activity of interest or little interest, trouble falling asleep, and trouble concentrating. Interventions for Resident 67's activities care plan included attempt to determine cause of upset and resolve if possible. On 11/01/24 at 0852 hours, an interview was conducted with RN 1. When asked about documenting nonpharmacological interventions attempted for Resident 67's behaviors, RN 1 stated the staff did not attempt nonpharmacological behaviors for Resident 67's risperidone because it was a routine medication. On 11/01/24 at 0924 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 67's care plans for activities failed to show Resident 67's activities included attending a day program for developmental delay residents. Also, the DON verified Resident 67's medical record failed to show nonpharmacological interventions and their effectiveness were documented for Resident 67's risperidone. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross references to F679 and F757.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on interview and medical record review, the facility failed to ensure the comprehensive plan of care was revised to reflect the residents' current care needs and interventions for one of of 20 final sampled residents (Resident 67) and one nonsampled resident (Resident 41) . * Residents 41 and 67's care plan problem addressing their Covid-19 (Coronavirus disease- infectious disease caused by the SARS-CoV-2 virus) diagnoses and use of the antibiotic medication were not revised after the residents' Covid-19 symptoms resolved and were no longer on the antibiotic medication. This failure posed the risk of not providing the residents with individualized and person-centered care. Findings: 1. Medical record review for Resident 67 was initiated on 10/29/24. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's H&P examination dated 9/28/24, showed Resident 67 did not have capacity to understand and make decisions. Review of Resident 67's plan of care showed a care plan problem addressing Resident 67's Covid-19 diagnosis and his use of an antibiotic medication. On 11/1/24 at 1500 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 67's care plan still showed Resident 67 had the Covid-19 diagnosis and was on an antibiotic medication. RN 2 verified Resident 67 no longer had symptoms of Covid-19 and was not on an antibiotic medication. RN 2 verified Resident 67's plan of care was not revised to reflect the changes. 2. Medical record review for Resident 41 was initiated on 10/29/24. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's plan of care showed a care plan problem addressing Resident 41's Covid-19 diagnosis and her use of an antibiotic medication. On 11/1/24 at 1405 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 41's care plan still showed Resident 41 had the Covid-19 diagnosis and was on an antibiotic medication. RN 2 verified Resident 41 no longer had symptoms of Covid-19 and was not on an antibiotic medication. RN 2 verified Resident 41' plan of care was not revised to reflect the changes.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and medical record review, the facility failed to provide an ongoing program to provide activities designed to meet the specific needs of the residents and encouraging both independence and interaction in the community for two of 20 final sampled residents (Residents 66 and 67). This failure posed the risk of not supporting the residents' psychosocial well-being. Findings: 1. On 10/29/24 at 1049 hours, a concurrent observation of Resident 67 and interview was conducted with Resident 67's roommate, Resident 66. Resident 67 was observed lying in bed on his right side. Resident 66 stated Resident 67 screamed all evening, verbalizing wanting to go to the gym. Resident 66 further stated Resident 67 did not allow him to sleep. During this observation, Resident 67 kept repeating he wanted to go to the gym. Resident 67 then started whining, and stated he wanted to go to the gym. Medical record review for Resident 67 was initiated on 10/29/24. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's H&P examination dated 9/28/24, showed Resident 67's diagnoses included developmental delay and psychosis. Resident 67 had no capacity to understand and make decisions. On 10/29/24 at 1149 hours, an interview was conducted with Resident 67's RP. Resident 67's Responsible Party stated prior to being admitted to the facility, Resident 67 would attend a day program for persons with developmental delay. 10/30/24 at 0807 hours, an interview was conducted with the Activities Director. When asked about assessing Resident 67 for his activities needs, the Activities Director stated Resident 67 was in a confused state, more child-like. According to the Activities Director, Resident 67's activities included staying in his room, looking at family pictures on his tablet, and family visits. Review of Resident 67's admit MDS modified 9/19/24, showed Resident 67 had unclear speech, cognitive impairment, and activities that were important to Resident 67 included fresh air, favorite activities, pets, and music. On 10/30/24 at 1339 hours, a follow-up interview was conducted with the Activities Director. When asked if she attended Resident 67's care plan meetings, the Activities Director verbalized during Resident 67's care plan meeting, the Activities Director introduced herself and informed Resident 67's RP about the facility's activities. When asked if she had contacted Resident 67's previous residence or the day program where Resident 67 attended to inquire about what activities Resident 67 participated in, the Activities Director stated she did not contact those places. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/24 at 1100 hours, a telephone interview was conducted with Day Program Staff 1. When asked what activities Resident 67 participated in, Day Program Staff 1 stated Resident 67 could read and write, played bingo, could follow instructions, enjoyed history and geography, enjoyed puzzles and matching games, would use walker to exercise, participated in dancing, and would sit with older residents to converse. 2. On 10/29/24 at 1101 hours, concurrent observation and interview was conducted with Resident 66. Resident 66 stated he was blind in both eyes. When asked about activities provided to Resident 66, Resident 66 verbalized his family member brought him a radio about one week prior so he could listen to music. Resident 66 verbalized the music helped drown the sound of his roommate (Resident 67) screams. Resident 66 verbalized he used to be involved in a vision institute for his blindness. On 10/29/24 at 1555 hours, an interview was conducted with CNA 8. When asked about Resident 66, CNA 8 stated Resident 66 was visually impaired. When asked about Resident 66's activities, CNA 8 stated Resident 66 liked listening to music. On 10/31/24 at 1044 hours, during an observation with RN 1, Resident 66 verbalized there was not a lot of staff to resident social interaction. Resident 66 verbalized he would be interested in getting involved again with the Braille Institute. On 10/31/24 at 1621 hours, an interview was conducted with the Activities Director. When asked about the activities for Resident 66, the Activities Director stated Resident 66 got room visits which included ensuring his music was on and family visits. When asked if she had contacted the agencies such as the Braille Institute for the blind to provide activities designed for Resident 66, she stated no. The Activities Director was informed Resident 67 verbalized he used to go to the Braille Institute for the blind.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 20 final sampled residents (Resident 12) and one nonsampled resident (Resident 57) were free from the accident hazards. * The facility failed to store the razors in a secure area when not in use. This failure had the potential to place Residents 12 and 57 at risk for serious injury. Findings: Review of the facility's P&P titled Safety Information - Illness and Injury Prevention Program (undated) showed the facility does everything within reason to prevent injury and illness to employees, residents, and guests which includes supply and material handling: any sharp objects are put away when not in use. On 10/30/24 at 900 hours, during a follow-up observation in Residents 12 and 57's room, an opened pack of razors was observed in Residents 12 and 57's drawers at their bedsides. CNA 5 verified the the pack of razors from Residents 12 and 57's bedside drawer and removed the razors. a. Medical record review on Resident 12 was initiated on 10/31/24. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's H&P examination dated 7/29/24, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's ADL care plan initiated on 7/27/24, showed self-care deficit as evidenced by Resident 12 requiring assistance or dependent in personal hygiene. b. Medical record review of Resident 57 was initiated on 10/30/24. Resident 57 was admitted on [DATE]. Review of Resident 57's medical progress note dated 11/21/24, showed the resident was oriented x 1 (a person knows who they are but not where they are, what time it is, or what is happening to them) and confused. Review of the Order Summary Report - active orders dated 10/30/24, showed Resident 57 was being monitored for tremors, rigid muscle, shaking, etc. On 10/30/24 at 0945 hours, a concurrent interview with CNA 5 was conducted. CNA 5 stated the razors were kept in the supply room and the unused razors were placed back to the storage. On 10/30/24 at 0955 hours, a concurrent interview with LVN 3 and RN 1 was conducted. LVN 3 stated the razors were not kept at the bedside. RN 1 stated the razors were kept in the supply room and should not be left at the bedside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/24 at 1525 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access for one of one final sampled resident (Resident 66) reviewed for IV care. * The facility failed to to ensure the IV catheter site for Resident 66 was labeled. This failure had the potential to delay the identification of catheter related complications for Resident 66. Findings: Review of the facility's P&P titled Peripheral Venous Catheter Insertion dated March 2023 showed IV sites are to have date, time, and initials on the dressing label. On 10/29/24 at 1101 hours, Resident 66 was observed in bed with his IV site unlabeled, with no date, time, or staff initials. Medical record review for Resident 66 was initiated on 10/29/24. Resident 66 was admitted to the facility on [DATE]. Resident 66 was admitted to the facility with diagnoses including UTI. On 10/31/24 at 1044 hours, an observation and concurrent interview was conducted with RN 1. When asked about the labeling of Resident 66's IV site, RN 1 verified Resident 66's IV site was not labeled with the date, time, and initials of staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the respiratory care orders were properly maintained and administered as ordered for two of 20 final sampled residents (Residents 1 and 83). * The facility failed to follow the physician's order for Resident 83's oxygen therapy. * The facility failed to ensure Resident 1's oxygen tubing was dated. These failures had the potential for the residents to not receive oxygen as ordered and adequate respiratory care. Findings: Review of the facility's P&P titled Oxygen Administration revised on 10/2010, showed to verify that there is a physician's order for this procedure, and to review the physician's orders or facility protocol for oxygen administration. 1. On 10/29/24 at 0906 hours, during the initial tour observation, Resident 83 was observed lying in bed with oxygen on via nasal cannula which was attached to the oxygen machine concentrator setting at 4 liters per minute. On 10/29/24 at 1603 hours, during an observation, Resident 83 was observed lying in bed with oxygen via nasal cannula which was attached to the oxygen machine concentrator setting at 4 liters per minute. Medical record review for Resident 83 was initiated on 10/29/24. Resident 83 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 83's H&P examination dated 7/9/24, showed Resident 83 had the capacity to understand and make decisions. Review of Resident 83's Order Summary Report showed a physician's order dated 7/9/24, for oxygen administration at 2 liters per minute via nasal cannula continuously every shift. Review of Resident 83's care plan showed the resident had oxygen therapy related to COPD and an intervention dated 7/11/24, was to administer oxygen at 2 liters per minute via nasal cannula continuously every shift. On 10/29/24 at 1621 hours, a concurrent observation and interview was conducted with LVN 6. LVN 6 verified the oxygen machine concentrator was set at 4 liters per minute and the physician's order for the oxygen was to administer at 2 liters per minute continuously for Resident 83. LVN 6 stated the physician's order should be followed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 1635 hours, a concurrent observation and interview was conducted with RN 2. RN 2 was informed and verified the above findings. RN 2 stated the physician's order should be followed, and only the licensed nurses could change oxygen setting with the physician's order. 50953 2. Review of the facility's undated P&P titled Oxygen Equipment showed tubing should be replaced every week and as needed. Medical Record Review for Resident 1 was initiated on 10/29/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's Order Summary Report dated 10/31/24, showed a physician's order dated 10/5/24, for oxygen at two liters per minute via nasal cannula as needed for shortness of breath. Resident 1's H&P examination dated 9/23/24, showed the resident did not have the capacity to understand and make decisions. Residents 1's MDS dated [DATE], showed a BIMS score of 9 (meaning moderately cognitive impaired). On 10/29/24 at 0816 hours, during an initial tour of the facility, Resident 1 was observed in bed with oxygen being administered at two liters per minute via nasal cannula. There was an oxygen concentrator next to Resident 1's bed. There was no date observed on the oxygen tubing, and the oxygen tubing bag was dated 10/21/24. On 10/29/24 at 1008 hours, an observation and concurrent interview for Resident 1 was conducted with RN 2. RN 2 was asked about the facility's process when changing the oxygen tubing. RN 2 stated the oxygen tubing was changed every week by the licensed nurse and should be dated. RN 2 verified Resident 1's oxygen tubing bag from the concentrator was dated 10/21/24, and the oxygen tubing was not dated. RN 2 further stated the oxygen bag should have been changed on 10/28/24. On 11/1/24 at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0698 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on interview and medical record review, the facility failed to ensure a sack lunch was provided to one of 20 final sampled residents (Resident 33) during dialysis days. This failure posed the risk for possible medical complications for Resident 33. Findings: Medical Record Review for Resident 33 was initiated on 10/29/24. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Residents 33's MDS dated [DATE], showed a BIMS score of 15 (meaning cognitively intact). Review of Resident 33's Order Summary Report 10/31/24, showed an order dated 1/3/24, may bring sack lunch at dialysis center. On 10/31/24 at 1436 hours, an interview was conducted with Resident 33. Resident 33 stated he never received any sack lunch during dialysis days. On 10/31/24 at 1447 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 verified Resident 33 had an order for sack lunch during dialysis days. RN 2 was asked the process of how the dietary department was aware that Resident 33 needed a sack lunch during dialysis days. RN 2 stated they provided a diet order form. RN 2 was unable to provide documented evidence a diet order form was provided to the dietary department to provide the resident a sack lunch during dialysis days.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, record review and the facility P&P, the facility failed to ensure pharmaceutical procedures were followed for one of one final sampled residents (Resident 27) investigated for pain and one of two residents (final sampled resident, Resident 35) reviewed for self-administration of medication * Resident 27's Percocet (an opioid based pain reliever) was removed from the supply but not documented as administered in the MAR on six occasions. * Resident 35 was observed with the medications at bedside. Resident 35 did not have a physician's order, assessment, and care plan for the self-administration of medications. These failures had the potential to put the resident at risk of unsafe pharmaceutical practices. Findings: 1. Review of Resident 27's Order Summary Report dated 10/30/24, showed a physician's order for Percocet 7.5-325 mg every six hours as needed for severe pain. Review of Resident 27's Antibiotic or Controlled Drug Record form initiated 9/14/24, showed one tablet of Percocet 7.5-325 mg tablet was removed from the supply on the following dates: On 9/16/24 at 0950 hours. On 9/24/24 at 1100 hours. On 9/25/24 at 0930 hours On 9/26/24 at 0930 hours. On 9/30/24 at 1000 hours On 10/23/24 at 1000 hours. Review of Resident 27's MAR for September and October 2024 failed to show the Percocet was administered to the resident when it was removed from the supply on the above dates and times. On 10/30/24 at 1403 hours, an interview and concurrent record review was conducted with LVN 1. LVN 1 stated the process for the controlled medications was to sign out the medication on the controlled drug record when it was removed from the drug supply, and to sign the MAR once it was administered. LVN 1 reviewed Resident 27's Antibiotic or Controlled Drug Record form and MAR and verified the above doses were removed from the supply and not documented as administered. 50953 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical Record Review for Resident 35 was initiated on 10/29/24. Resident 35 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 35's H&P examination dated 9/19/24, showed the resident had capacity to understand and make decisions. Residents 35's MDS dated [DATE], showed the resident had a BIMS score of 12 (meaning moderately cognitive impaired). On 10/29/24 at 0828 hours, during an initial tour of the facility, concurrent observation, and interview was conducted with Resident 35. Three Tums (medication for indigestion/upset stomach) tablets were observed at the overbed table on middle right side of Resident 35's bed. Resident 35 stated she had been taking the Tums medication since she started having pain in the stomach two months ago, and the licensed nurses were the one giving her the medication. On 10/29/24 at 0832 hours, an observation and concurrent interview with RN 1 was conducted. RN 1 was asked about the process of self-administering of the medication and leaving the medication at bedside. RN 1 stated no medication should be left at bedside table of the resident and the facility needed to assess the resident if it was safe to self-administer medication, have an order from the physician, and a care plan. RN 1 verified Resident 35 had three Tums at her overbed table and was unable to state who gave the medication to Resident 35. On 10/29/24 at 1219 hours, a concurrent interview and medical record review was conducted with RN 2. Review of Resident 35's Physician Order Summary did not show any order for the above medication. Review of the Physician Order Summary dated 1/16/24, showed an order for Gerilanta oral suspension 200-200-20 mg 30 ml by mouth six hours as needed for upset stomach. On 10/31/24 at 0852 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was unable to show documented evidence of Resident 35 was assessed for self-administration of the medication. On 11/1/24 at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and medical record review, the facility failed to ensure the following was completed for two of 20 final sampled residents (Residents 66 and 67): * Non-pharmacological interventions for Resident 67's risperidone were not documented * There was no clear indication for Resident 67's risperidone * The valproic acid level was not completed for Resident 67's use of valproic acid * There was no montioring and no documentation for discoloration related to Resident 66's use of humalog These failures posed the risk of inadequate monitoring. Findings: 1. Review of the facility's P&P Psychotropic Medication Use effective 6/21, showed facility staff should document the resident's response to staff interventions for residents' behaviors. Medical record review for Resident 67 was initiated on 10/29/24. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's H&P examination dated 9/28/24, showed Resident 67's diagnoses included developmental delay and psychosis. Resident 67 did not have capacity to understand and make decisions. a. On 10/29/24 at 1049 hours, a concurrent observation of Resident 67 and interview was conducted with Resident 66, roommate of Resident 67. Resident 67 was observed lying on his right side in bed. Per Resident 66, Resident 67 screamed he wanted to go to the gym in the evening. During this observation, Resident 67 kept repeating he wanted to go to the gym. Resident 67 then started whining he wanted to go to the gym. On 11/01/24 at 0924 hours, a concurrent interview and medical record review was conducted with the DON. The DON verbalized she was familiar with Resident 67. The DON stated Resident 67's behaviors were mostly from Resident 67 did not like being touched. Resident 67 would exhibit this behavior when the staff tried to change his disposable underwear. The DON stated she would do a follow-up to clarify the behavior monitoring indication for Resident 67's risperidone. Review of Resident 67's medical record failed to show documented evidence non-pharmacological interventions were attempted for the resident. The DON verified non-pharmacological interventions attempted for Resident 67's behaviors were not documented. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of Resident 67's MAR for October 2024 showed Resident 67 was being administered risperidone 1 mg twice daily for psychosis manifested by aggressive behavior yelling toward staff and valproic acid 500 mg every 12 hours for epilepsy. Review of the area designated to document the number of behaviors for Resident 67's risperidone showed Resident 67 had one behavior on 11/2/24, and two behaviors on 11/3/24. Review of the area designated to document non-pharmacological interventions attempted to alleviate Resident 67's behaviors was blank. In addition, review of Resident 67's medical records failed to show documented evidence a baseline valproic acid level was obtained for Resident 67's use of valproic acid. On 11/01/24 at 1411 hours, the Medical Records Director verified there was no valproic acid level result on file for Resident 67's use of valproic acid. 2. On 10/29/24 at 1101 hours, an interview was conducted with Resident 66. When asked if the resident received insulin, Resident 66 verified he was administered insulin twice daily. Medical record review for Resident 66 was initiated on 10/29/24. Resident 66 was admitted to the facility on [DATE], with diagnoses including diabetes and blindness. Resident 67 was able to verbalize his needs. Further review of the medical record showed no documented evidence of change of condition related to skin discoloration. On 10/31/24 at 1029 hours, a concurrent observation, interview, and medical record review was conducted with LVN 1. Resident 66's left upper abdominal area was observed with purple fading discoloration. When asked about documenting this change in condition for Resident 66, LVN 1 verbalized she did observe Resident 66's purple discoloration but did not document this change in condition. LVN 1 was unable to explain why she did not document this change in Resident 66's skin condition.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five residents (one final sampled resident, Resident 30) reviewed for unnecessary medications was free from unnecessary psychotropic (medications which affect the brain and the nervous system to treat mental illness and conditions which impact behavior and emotions) drugs. * The facility failed to ensure Resident 30 was properly monitored for orthostatic blood pressures (measure the blood pressure while laying down or sitting and again upon standing up) as ordered by the physician for the use of the olanzapine (a medication for mental disorders including schizophrenia and bipolar disorder). This failure had the potential for Resident 30 to experience adverse consequences from the psychotropic medication. Findings: Review of the facility's P&P titled Psychotropic Medication Use dated 7/2022 showed the residents receiving psychotropic medications are monitored for adverse consequences, including cardiovascular effects: irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath, diaphoresis, chest/arm pain, increased blood pressure and orthostatic hypotension. Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed the documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Medical record review for Resident 30 was initiated on 10/31/24. Resident 30 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 30's SOAP Note dated 4/22/24, showed the resident was confused but able to make needs known. Review of Resident 30's Psychiatric Evaluation Note dated 5/17/24, showed the diagnosis of bipolar disorder. Review of Resident 30's Order Summary Report dated 10/31/24, showed the following physician's orders: - dated 4/27/24, to monitor orthostatic hypotension blood pressure (BP) when lying, sitting, standing. One time a day every Sunday for olanzapine (a medication for mental disorders including schizophrenia and bipolar disorder) use when lying. - dated 4/27/24, to monitor orthostatic hypotension BP when lying, sitting, standing. One time a day every Sunday for olanzapine use when sitting, call physician if systolic BP drops by 20 mmHg. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 4/27/24, to monitor orthostatic hypotension blood pressure when lying, sitting, standing. One time a day every Sunday for olanzapine use when standing, call physician if systolic BP drops by 20 mmHg. Review of Resident 30's MAR for September and October 2024 showed orthostatic hypotension (lying, sitting, and standing) BP were scheduled to be monitored every Sunday. However, Resident 30's BP readings for lying, sitting, and standing were the same as follows: - On 9/1/24, the BP readings were 112/64 mmHg for lying position, 112/64 mmHg for sitting position, and 112/64 mmHg for standing position. - On 9/15/24, the BP readings were 140/88 mmHg for lying position, 140/88 mmHg for sitting position, and 140/88 mmHg for standing position. - On 10/13/24, the BP readings were 124/66 mmHg for lying position, 124/66 mmHg for sitting position, and 124/66 mmHg for standing position. - On 10/20/24, the BP readings were 122/74 mmHg for lying position, 122/74 mmHg for sitting position, and 122/74 mmHg for standing position. - On 10/27/24, the BP readings were 122/62 mmHg for lying position, 122/62 mmHg for sitting position, and 122/62 mmHg for standing position. On 11/1/24 at 0944 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 verified the above orthostatic BP for the month of September and October 2024 had the same BP readings for lying, sitting, and standing position. LVN 4 stated normally, the BP should change slightly when the resident changed position. LVN 4 stated Resident 30's BP should be taken separately for lying, sitting, and standing position. On 11/1/24 at 1151 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 30's orthostatic BP were all the same for lying, sitting, and standing position on 9/1, 9/15, 10/13, 10/20, and 10/27/24. RN 1 stated the licensed nurse did check the BP but just copied Resident 30's last BP for sitting position and standing position. RN 1 further stated the licensed nurse should have done it in three positions: lying position, sitting position, and standing position. RN 1 stated the licensed nurse should follow the physician's order. On 11/1/24 at 1532 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 7.69 %. * The facility failed to ensure LVN 3 administered Resident 75's metformin HCl (medication to lower blood sugar) and cholecalciferol (vitamin D supplement) as ordered. This failure had the potential to cause negative outcome for Resident 75. Findings: Review of the facility's P&P titled Administrating Medications dated 4/2019 showed the medications are administered in accordance with prescriber orders, including any required time frame. Medical record review for Resident 75 was initiated on 10/29/24. Resident 75 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 75's Order Summary Report 10/31/24, showed the following physician's orders: - dated 7/15/24, to administer cholecalciferol 50 mcg one tablet by mouth one time a day. - dated 8/2/24, to administer metformin HCl 500 mg one tablet by mouth two times a day and administer with meals. On 10/30/24 at 0841 hours, a medication administration observation for Resident 75 was conducted with LVN 3. LVN 3 administered one tablet of metformin HCl 500 mg without meals and/or food and did not administer cholecalciferol 50 mcg as ordered. On 10/30/24 at 1459 hours, an interview was conducted with LVN 3. LVN 3 verified the cholecalciferol medication and the metformin medication were not administered to Resident 75 as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper medication storage when: * The facility failed to ensure the expired medications were removed from Medication Cart C. * The facility failed to store internal and external medications separately. These failures had the potential to negatively impact the residents' well-being, and medication errors. Findings: 1. Review of the facility's P&P titled Disposal of Medications and Medication-Related Supplies dated 12/2018, showed the following: - When medications are expired, discontinued by a prescriber, a resident is transferred or discharged and does not take medication with him/her, or in the event of a resident's death, the medications are marked as discontinued or stored in a separate location and later destroyed. - If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified or shall be stored in a separate location designated solely for this purpose. The date the medication was discontinued shall be indicated on the medication container. - Medication awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed. Internal and External medications shall be stored separately. Medications are removed from the medication cart or storage area prior to expiration, and immediately upon receipt of an order to discontinue. On 10/30/24 at 1359 hours, a medication cart inspection for Medication Cart C was conducted with LVN 2. During the inspection of Medication Cart C, the following was observed: - one individual pack of Cutimed Epiona (natural collagen to aid in healing wounds), sealed, with an expiration date of 10/2021. - three individual pack of Manukahd Superlite honey coated absorbent dressing (use for wound care), sealed, with an expiration date og 8/2024. - two individual pack of Hydrogel saturated gauze (used to treat wounds) 2x2 (5 cm x 5 cm), sealed with an expiration date of 7/2023. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- one individual pack of Skintegrity Hydrogel impregnated gauze (used to treat wounds), sealed, with an expiration date of 8/2022. - two individual pack of Aquaderm hydrogel sheet wound dressing, sealed, with an expiration date of 4/23/20. On 10/30/24 1431 hours, an interview was conducted with LVN 2 and verified all the findings, LVN 2 stated all expired medications needed to be removed from Medication Cart C. 48332 2. Review of the facility's P&P titled Medication Storage in the Facility, ID1: Storage of Medications, dated 4/2008, showed orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. On 10/31/24 at 0905 hours, an observation of Medication room [ROOM NUMBER] and concurrent interview was conducted with the Central Supply Designee. The over the counter medications/house supplies medications were stored on the shelves. During the observation, two boxes of acetaminophen (medication to treat pain and fever) suppositories and two boxes of bisacodyl (medication to treat constipation) suppositories were stored on the bottom shelf, side by side with the two bottles of Miralax (medication to treat constipation) liquid and one bottle of Pepto Bismol (medication to treat diarrhea, hearburn, nausea, and upset stomach) liquid. The Central Supply Designee stated there was no space to separate the oral medications from the externally used medications. The Central Supply Designee verified the findings and stated orally administered medications and suppositories were supposed to be stored separately.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 39856 Based on observation, interview and facility document review, the facility failed to ensure the CDM was competent in managing the day-to-day functions of the food services department. In addition, the facility failed to ensure the RD had adequate oversight of the food service department. This failure to employ staff with the skills and abilities to effectively implement departmental processes in accordance with standards of practice had the potential to jeopardize the health and well-being of the 84 residents who received food prepared in the kitchen. Findings: Review of the facility's matrix showed 84 residents consumed food prepared in the kitchen. Review of the facility's document titled Dietary Manager signed and dated by the CDM on 4/16/20 showed, the purpose of job description is to organize, plan and supervise the dietary department functions in accordance with current applicable federal, state, and local standards that govern the facility and as directed by the Administrator and/or Dietitian. Under essential duties and responsibilities, monitoring staff to confirm they adhere to all sanitation, safety and procedural guidelines within the department, partnering with the Dietitian to ensure diet is in accordance with the residents' nutritional needs. Review of the facility's document titled Performance Evaluation signed and dated by the Administrator and CDM on 2/15/24, showed job knowledge; knowledge of techniques, processes, procedures, services, equipment, and materials required to do the job was good. There were no goals documented for the CDM. Review of the facility's document titled Dietetic Service Contract signed and dated by the Administrator on 9/16/19, showed the RD was responsible to provide management tools as needed to the food service supervisor to enhance the operation of the dietary department. Review of the facility document titled Dietary Consultant Report completed by both the RD and CDM for the months of June, July and August showed, the following were not concerns: appropriate food handling techniques were followed, food was not put on the steam table more than 30 minutes prior to meal service, meal spreadsheets were followed, recipes were followed, food consistencies were accurate, menu substitutions were approved by the RD, gloves worn by employees per facility P&P, staff had fingernails without nail polish, hairnets were worn, staff does not eat or drink in the food preparation area, vents were clean, food bins were clean, walls and ceiling were in good repair, no cool down log in place, items air-dried, drawers were clean, can opener was clean and free of metal shavings, pans and equipment were clean and not rusted, cleaning cloths were stored in a sanitizing solution, cutting boards has a smooth surface, brooms were store off the floor and indirect connection on all sink drains (>one inch air gap). (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the annual recertification survey from 10/29/24 to 11/1/24, multiple issues were found in the kitchen, including: lack of monitoring of time and temperature during the cool down process for TCS (time/temperature control for safety foods), food preparation surfaces were not sanitized, raw vegetables were not washed prior to service, a sanitizing solution was not available for manual ware washing in emergency situations, gloves were not used appropriately, facial hair was not covered, kitchen employees were drinking in the food preparation areas, one kitchen employee had artificial nails and wore jewelry during food preparation, food preparation equipment and utensils were not clean or in good working condition, meal preparation equipment was not air dried, the kitchen environment was not clean, cleaning equipment was not stored in a sanitary manner, a food preparation sink did not have an air gap, pureed recipes were not followed, meal portion size was incorrect, therapeutic diets were not followed, menu changes were not approved by the RD, nutritive value was not conserved for pureed vegetables, the appropriate meat texture was not made for mechanical soft ground diets, and flies were observed in the kitchen. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD confirmed she performed a monthly kitchen audit which was uploaded to the company website. The RD stated she also could email concerns to the corporate leadership as needed. When asked if she had any concerns in the kitchen, the RD stated the temperature of the kitchen was very high in the summer and the air curtain (a device that prevents flying insects from entering the kitchen) was not always working. The concerns found in the kitchen were reviewed with the RD and she stated she was not aware of the extent of the findings. On 11/1/24 at 1534 hours, the Administrator, RN Consultant, CDM, RD and DSD were informed of the findings. The Administrator confirmed the above findings. Cross references to F812 examples #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13; F803 examples #1, #2, #3, #4, #5; F804; F805, and F925.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 39856 Based on observation, interview, and facility document review, the facility failed to ensure the menus were followed for 20 of 84 residents (two final sampled residents, Residents 1 and 31; and 18 nonsampled residents, Residents 2, 4, 9, 13, 15, 17, 21, 24, 51, 57, 59, 65, 69, 74, 85, 86, 446, and 791) who received a pureed diet; and 27 of 84 residents (two final sampled residents, Residents 27 and 31; and 25 nonsampled residents, Residents 2, 4, 7, 9, 13, 14, 17, 24, 32, 37, 38, 41, 45, 46, 49, 51, 57, 59, 61, 60, 69, 70, 80, 85, 791) who received a fortified diet when: 1. The pureed green bean recipe was not followed, 2. The correct portion size was not utilized for the pureed meat, 3. Mashed potatoes were not served to pureed diets, 4. Menu changes were not documented or approved by the Registered Dietitian, and 5. Fortified diets were not followed. These failures had the potential to not meet the resident's nutritional needs. Findings: Review of the facility's matrix showed 84 of 88 residents consumed food prepared in the kitchen. 20 of 84 residents (two final sampled residents, Residents 1 and 31; and 18 nonsampled residents, Residents 2, 4, 9, 13, 15, 17, 21, 24, 51, 57, 59, 65, 69, 74, 85, 86, 446, and 791) who received a pureed diet. 27 of 84 residents (two final sampled residents, Residents 27 and 31; and 25 nonsampled residents, Residents 2, 4, 7, 9, 13, 14, 17, 24, 32, 37, 38, 41, 45, 46, 49, 51, 57, 59, 61, 60, 69, 70, 80, 85, 791) who received a fortified diet. 1. Review of the facility's P&P titled Standardized Recipes revised April 2007 showed a Standardized recipes shall be developed and used the in the preparation of foods. Review of the facility's document titled Puree [NAME] Beans undated showed 20 servings, two quarts and two cups seasoned green beans, 3/4 cup thickener, one cup hot liquid, water or low sodium vegetable broth. Method: Remove portions needed from regular prepared recipe; drain and reserve liquid. 2. Place drained portions into a food processor; process to a fine texture. 3. Add thickener and liquid. Process until smooth. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/31/24 at 0844 hours, an observation of the pureed preparation was conducted with [NAME] 1. [NAME] 1 stated he was preparing 19 portions of pureed green beans. Using a slotted spoon, [NAME] 1 measured 22 spoons of cooked green beans into a blender. [NAME] 1 added three cups of the liquid the green beans were cooked in, to the blender then blended the green bean/water mixture. [NAME] 1 poured the blended green bean/water mixture into a bowl. The product was a liquid consistency. [NAME] 1 added 3/4 cup thickener to the pureed green beans then whisked the mixture to a pudding consistency. [NAME] 1 did not refer to a recipe during the pureed process. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD confirmed pureed recipes should be followed. 2. Review of the facility's document titled Therapeutic Spreadsheets dated 10/31/24, showed puree diets should have received a #8 scoop (four ounces) of pureed baked chicken for the lunch meal. On 10/31/24 at 1124 hours, during the lunch meal tray line observation with [NAME] 1 and the CDM present, a #12 scoop (1/3 cup) was observed for the pureed baked chicken. [NAME] 1 confirmed the scoop size. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD confirmed therapeutic diet spreadsheets must be followed to ensure proper nutrition for the residents. 3. Review of the facility's document titled Therapeutic Spreadsheets dated 10/31/24, showed the puree diets should have received pureed baked chicken, puree green beans, mashed potatoes, puree bread and puree snickerdoodle cake with icing. On 10/31/24 at 1105 hours, a lunch meal tray line observation was conducted with Diet Aide (DA) 2, [NAME] 1, and the CDM. Resident 24's lunch meal tray ticket showed Resident 24 was on a Fortified/High Protein Pureed diet with thin liquids. Resident 24's lunch meal tray was observed with pureed chicken, pureed green beans, pureed bread, and applesauce. DA 2 was checking the lunch meal trays for accuracy. DA 2 was asked how he ensured the resident meal trays were accurate. DA 2 stated he followed the Therapeutic Spreadsheet. The Therapeutic Spreadsheet dated 10/31/24, was reviewed with DA 2. DA 2 confirmed Resident 24's lunch meal did not include mashed potatoes. The CDM was asked why puree diets did not receive mashed potatoes. The CDM then asked [NAME] 1 why puree diets did not receive mashed potatoes. [NAME] 1 stated mashed potatoes were a starch therefore pureed diets could not have mashed potatoes. The CDM confirmed mashed potatoes were not given to the residents on pureed diets. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD confirmed all therapeutic spreadsheets must be followed to ensure resident's nutritional needs were met. 4. Review of the facility's P&P titled HPSI Guidelines for the Food and Nutrition Services Department Section V. Menu Changes/Substitutes revised 2/4/20, showed 1. The Nutrition Services Manager initiates menu changes based on resident preferences making sure that substitutions selected are of equal nutritional value to the original food item on the menu. 3. The change along with the reason for the change is recorded on the menu and/or the form Menu Changes/Substitutions. 5. The Consultant/Registered Dietitian approves all changes and substitutions made. Review of the facility's document titled Therapeutic Spreadsheets dated 10/29/24, showed the puree diets should have received a #12 scoop of pureed pound cake for the lunch meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 1206 hours, during the lunch meal observation and concurrent interview with LVN 2 in the dining room Residents 17, 24, and 86's tray tickets showed all three residents were on pureed texture diets. All three residents received applesauce instead of puree pound cake. LVN 2 confirmed the findings. When asked what nursing's role in checking resident meal trays was, LVN 2 stated it was the kitchen's responsibility to ensure resident diets were accurate. LVN 2 added nursing only checked for correct texture of diets. Review of the facility's document titled Therapeutic Spreadsheets dated 10/31/24, showed the puree diets should have received a #12 scoop of pureed snickerdoodle cake with icing for the lunch meal. On 10/31/24 at 1105 hours, a lunch meal tray line observation was conducted with Diet Aide (DA) 2, [NAME] 1, and the CDM. Resident 24's lunch meal tray ticket showed Resident 24 was on a Fortified/High Protein Pureed diet with thin liquids. Resident 24's lunch meal tray was observed with pureed chicken, pureed green beans, pureed bread, and applesauce. DA 2 was checking the lunch meal trays for accuracy. DA 2 was asked how he ensured the resident meal trays were accurate. DA 2 stated he followed the Therapeutic Spreadsheet. The Therapeutic Spreadsheet dated 10/31/24, was reviewed with DA 2. DA 2 confirmed Resident 24 did not receive pureed pound cake. When asked why pureed diets did not receive pureed pound cake DA 2 asked the CDM why pureed diets got applesauce instead of pureed pound cake. The CDM asked DA 1 who was responsible to make the pureed desserts for the lunch meal why pureed diets received applesauce instead of pureed pound cake. DA 1 responded there was not enough pound cake available to puree, so she substituted applesauce. On 11/1/24 at 0931 hours, an interview was conducted with the CDM. The CDM was asked how he handled menu substitutions. The CDM stated he was not aware his staff were changing the menu. The CDM was asked if menu substitutes were recorded on a log and approved by the RD. The CDM stated he did not keep a log to record menu substitutions nor were menu substitutions approved by the RD. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD confirmed all menu substitutions should be documented and approved by herself. 5. Review of the facility's Diet Manual revised August 2023 showed for the Fortified/High Calorie Diet 2. This diet includes Fortification of two menu items per day with ingredients such as evaporated milk, butter, and sugar. 3. This diet features a Super Cereal given at breakfast and a Super Soup at the noon meal. Review of the facility's document titled Therapeutic Spreadsheets dated 10/29/24, showed the Fortified/High Protein diets should have received eight ounces of Super Soup. On 10/29/24 at 1206 hours, during the lunch meal observation and concurrent interview with LVN 2 in the dining room Residents 17, 24, and 36's tray tickets showed all three residents were on a Fortified/High Protein diet. All three residents did not receive Super Soup with their lunch meals. LVN 2 confirmed the findings. When asked what nursing's role in checking meal trays was, LVN 2 stated it was the kitchen's responsibility to ensure resident diets were accurate. LVN 2 added nursing only checked for correct texture of diets. a. Review of the facility's document titled Therapeutic Spreadsheets dated 10/31/24, showed the Fortified/High Protein diets should have received eight ounces of super soup. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/31/24 at 1105 hours, a lunch meal tray line observation was conducted with Diet Aide (DA) 2, [NAME] 1, and the CDM. Resident 24's lunch meal tray ticket showed Resident 24 was on a Fortified/High Protein Pureed diet with thin liquids. Resident 24's lunch meal tray was observed with pureed chicken, pureed green beans, pureed bread, and applesauce. No Super Soup was observed on Resident 24's lunch meal tray. DA 2 was checking the lunch meal trays for accuracy. DA 2 was asked how he ensured the resident meal trays were accurate. DA 2 stated he followed the Therapeutic Spreadsheet. The Therapeutic Spreadsheet dated 10/31/24, was reviewed with DA 2. DA 2 was asked to clarify what Fortified/High Protein diets should have received. DA 2 could not answer why Resident 24's lunch meal tray did not contain Super Soup. [NAME] 1 stated fortified (Super) soup was not made for Fortified/High Protein diets; only fortified oatmeal was made for breakfast. The CDM confirmed [NAME] 1's statement. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD confirmed the therapeutic diet spreadsheets must be followed and Super Soup should be made for Fortified/High Protein diets to ensure resident's nutritional needs were met.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39856 Based on observation, interview, and facility P&P review, the facility failed to ensure nutritive value was preserved when pureed vegetables were prepared two hours prior to meal service and held on a hot steam table. This failure had the potential for the resdients who received a pureed diet to not meet their nutritional needs. Findings: Review of the facility's matrix showed 84 of 88 residents consumed food prepared in the kitchen. 20 of 84 residents received a pureed diet. Review of the facility's P&P titled Guidelines for the Food and Nutrition Service Department revised 2/4/2020, showed F. Vegetable Preparation 2. Vegetables are high in nutritive value and contribute to the attractiveness and acceptability of the meal. Care should always be taken to prevent destroying their nutritive valve. Vegetables should be cooked in a small amount of water and only long enough to make them tender. On 10/31/24 at 0844 hours, during the lunch meal puree food preparation with [NAME] 1, [NAME] 1 stated he boiled the frozen green beans with water, vegetable broth, garlic and pepper. [NAME] 1 placed 22 spoons of cooked green beans and three cups of broth the vegetables were cooked in into the blender. The mixture was blended then transferred to a large bowl. The mixture was a liquid consistency. [NAME] 1 added 3/4 cup thickener to the mixture then stirred it with a wire whisk. [NAME] 1 transferred the green bean mixture to a steam table pan and placed the pan on the heated steam table. The temperature of pureed green beans was 129 degrees Fahrenheit (F). The green beans were held on the heated steam table until lunch tray line began at 1145 hours. The temperature of the green beans at 1145 hours was 207 degrees F. On 11/01/24 at 1120 hours, an interview was conducted with the RD. The RD confirmed all recipes should be followed.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 39856 Based on observation, interview and facility document review, the facility failed to ensure 20 residents of 84 (three final sampled residents, Residents 12, 30, and 47; and 17 nonsampled residents, Residents 11, 14, 16, 18, 29, 32, 41, 49, 50, 63, 66, 68, 71, 80, 84, 444, and 791) who were on mechanically altered diets received ground meat. This failure had the potential for these residents to be at risk for choking. Findings: Review of the facility's matrix showed 84 of 88 residents consumed food prepared in the kitchen. 20 of 84 residents (Residents 11, 12, 14, 16, 18, 29, 30. 32, 41, 47, 49, 50, 63, 66, 68, 71, 80, 84, 444, and 791) received a mechanical soft ground diet. Review of the facility's Diet Manual revised August 2023 showed the Mechanical Soft (Ground) diet should provide meat that is ground or chopped. Ground meat was defined as 1/8 or less. Review of the facility's document titled Therapeutic Spreadsheet dated 10/31/24, showed the Mechanical Soft diets should have received two ounces of ground chicken and Soft Bite Sized diet should have received two ounces of bite sized chicken. Review of the IDDSI (International Diet Dysphagia Standardization Initiative) defined Soft and Bite Sized Diet as 1/2 inch by 1/2 inch bite sized pieces. https://cms.iddsi.org/media/publications-iddsi/patienthandouts/english/adults/6_soft_bite_sized_adult_consumer_handout_30jan2019.pdf. On 10/31/24 at 1142 hours, during an observation of the lunch meal tray line with [NAME] 1 and the CDM present, chopped chicken approximately 1/2 inch in size was observed on the steam table. [NAME] 1 was asked which mechanically altered diet the chopped chicken was for. [NAME] 1 responded, Mechanical Soft ground diets. The CDM was asked which mechanically altered diets were served at the facility. The CDM did not respond to the question. The [NAME] stated there were only five residents who were on a Mechanical Soft ground diet the rest of the residents were on a Soft Bite sized diet. [NAME] 1 was asked again where the ground meat for the Mechanical soft diets was on the steam table. [NAME] 1 again stated the chopped chicken 1/2 inch in size was for the Mechanical Soft ground diets. [NAME] 1 then asked, Do you want me to grind the meat? [NAME] 1 then removed five portions from the 1/2 inch bite sized chicken and ran it through the Robot Coupe, a device used to grind and puree foods to produce ground chicken needed for the Mechanical Soft ground meat diets. On 11/1/24 at 1120 hours, an interview was conducted with the Registered Dietitian (RD). The RD confirmed the Therapeutic Spreadsheets should be followed for all diets.

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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. 50967 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure food safety and sanitation guidelines were followed when: 1. The cool down process for time, temperature control for safety (TCS) food, food that need to be kept at specific temperatures to prevent bacteria growth and foodborne illnesses, was not monitored. 2. Food preparation surfaces were not sanitized. 3. Fresh lettuce was not washed prior to use. 4. A sanitizing solution was not available for manual dishwashing in emergency situations. 5. Gloves were not used appropriately. 6. Facial hair was not covered. 7. Two of 14 kitchen employees had drinking cups or personal drinking containers in the kitchen. 8. One of 14 kitchen employees wore artificial nails and jewelry during food preparation. 9. Food preparation equipment and utensils were not clean or in good working condition. 10. Meal preparation equipment was not air dried. 11. The kitchen environment was not clean or in good working order. 12. Cleaning equipment was not stored in a sanitary manner. 13. A food preparation sink did not have backflow prevention. These failures posed the risk for food borne illnesses in highly susceptible resident population of 84 facility residents who received food prepared in the kitchen. Findings: Review of the facility matrix showed 84 of 88 residents who resided in the facility consumed food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 3-501.14 (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 135 F to 70 F and (2) Within a total of 6 hours from 35 F to 41 F or less. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the USDA Food Code 2022, Section 3-501.14 Cooling. (B) Time/Temperature Control for Safety Food shall be cooled within 4 (four) hours to 41 degrees Fahrenheit (F) or less if prepared from ingredients at ambient temperature, such as reconstituted foods and canned tuna. On 10/30/24 at 0850 hours, an interview was conducted with [NAME] 1. [NAME] 1 was asked when he would prepare the pureed meal items for lunch. [NAME] 1 stated he had already prepared the pureed meal items for the lunch meal. [NAME] 1 added he cooked the pork the previous day. When asked if he had monitored the temperature or time of the pork, [NAME] 1 stated he cooked the pork then cooled it with ice water. [NAME] 1 confirmed he did not monitor the pork for time or temperatures. [NAME] 1 stated the kitchen did not keep a cooling log to monitor the cool down process for TCS foods. On 10/30/24 at 0908 hours, an interview was conducted the Administrator and CDM. The CDM confirmed [NAME] 1 cooked the pork the previous day. The CDM also verified the kitchen did not use a cool down log to monitor the cool down process for TCS foods. On 10/30/24 at 0936 hours, an interview was conducted with the Administrator and CDM. The Administrator confirmed the pork cooked the previous day would be discarded. The lunch menu would be substituted with the dinner menu and tuna salad would be served for the dinner meal. When asked about the tuna salad cool down process, the Administrator stated, The CDM will give an in-service right away about the cool down process and cool down log. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD confirmed the facility did not have a cool down log in place. 2. According to the USDA Food Code 2022, Section 3-304.14 Wiping Cloths, Use Limitation. (B) Cloths in-use for wiping counters and other surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114. Review of the facility's P&P titled Sanitation revised 11/2022 showed all equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. Review of the surface sanitizer used by the facility to sanitize food preparation surfaces showed disinfection directions to disinfect hard, nonporous surfaces as follows: - Visible soil must be removed prior to disinfecting; - Spray, pour, or apply this product with a cloth, mop, or sprayer device until surface is thoroughly wet; - For spray applications, spray six to eight inches from surface; - Treated surfaces must remain visibly wet for contact time listed below on this label; - To kill mold and mildew (A. niger) and Mycobacterium bovis (tuberculosis) surfaces must remain visibly wet for five or two and a half minutes; and - Wipe or all to air dry. No rinse required even on food-contact surfaces. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/31/24 at 0836 hours, an observation was conducted in the kitchen with [NAME] 1. [NAME] 1 was observed to prepare boiled chicken for the puree lunch menu. At 0917 hours, [NAME] 1 was observed wiping the food preparation table with a dry soiled cleaning cloth. On 10/31/24 at 0938 hours, an observation was conducted with DA 1. DA 1 was observed preparing lettuce for salads. After her preparation, DA 1 did not sanitize the preparation table using the sanitizing spray. On 10/31/24 between the hours of 0838 and 1039 hours, an observations of [NAME] 1 was conducted. The following were observed: -After the lunch meal items were pureed, [NAME] 1 wiped the food preparation table with a dry soiled cleaning cloth. [NAME] 1 then proceeded to prepare cake for the lunch meal on the same food preparation table without sanitizing the table. -A wet soiled cleaning cloth was observed on the tray line not held in a sanitizing solution; -A soiled cleaning cloth was used to wipe the food preparation counter and the soiled cleaning cloth was left on the counter a total of three incidences. -A pitcher with water and soiled cleaning cloth was used to wipe off a preparation sink where raw chicken was thawed. The soiled cleaning cloth was rinsed in water. He used the same soiled cleaning cloth to wipe the food preparation table. On 10/31/24 at 1053 hours, an observation of [NAME] 1 was conducted. [NAME] 1 cleaned a food preparation sink where raw chicken had been thawed with soap and water then rinsed the sink with water. After cleaning and rinsing the food preparation sink, [NAME] 1 wiped the sink with a soiled cleaning cloth. At 1056 hours, [NAME] 1 sprayed the food preparation sink with the sanitizing spray then one minute later at 1057 hours, [NAME] 1 wiped the food preparation sink with a clean cloth. [NAME] 1 was asked if he had been trained in the proper use of the sanitizing spray, [NAME] 1 responded he had not been trained in the proper use of the sanitizing spray. On 10/31/24 at 1430 hours, an interview was conducted with the IP. The IP stated she did a monthly in-depth audit of the kitchen. The IP added she had been in the facility for one year and was not aware how surfaces were sanitized. Furthermore, she stated she was not aware the facility was using a new product. The IP stated not sanitizing food prep surfaces is an infection control issue. On 10/31/24 1443 hours, an interview was conducted with the CDM. The CDM was asked when the sanitizing spray was implemented. The CDM stated the facility used a sanitizing solution however, after the last survey in 2023, the facility decided to change to a spray sanitizer because the sanitizing solution was not being changed. The CDM added he was not sure who made that decision. The process to sanitize was to spray the sanitizing solution then wipe with a clean cloth then discard cloth. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was asked regarding the use of the sanitizing spray. The RD stated, I know during Covid, the sanitation solution spray was food safe, and we found it was better to use the spray than a sanitizing solution. We have been using the sanitizing spray for two years. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the facility's P&P titled, HPSI Guidelines for the Food and Nutrition Services Department Section F. Vegetable Preparation revised on 2/4/20 showed the following: -Fresh vegetables should be thoroughly washed in water to remove soil and other contaminants before being cut, peeled, or scraped. On 10/31/24 at 0938 hours, an observation and concurrent interview was conducted with DA 1. DA 1 obtained a fresh head of lettuce from the refrigerator and started to slice it. When asked if she had washed the lettuce, DA 1 stated she had not washed the lettuce, but she usually did wash it. DA 1 proceeded to make salads using the unwashed lettuce. On 10/31/24 at 0943 hours, an interview was conducted with the CDM. The CDM was asked if the lettuce was pre-washed, and he stated was not sure, but he would contact the food supplier. On 10/31/24 at 1112 hours, an interview was conducted with the CDM. The CDM stated the lettuce was not pre-washed from the supplier. The CDM was asked if he was going to serve the salads made with the unwashed lettuce. The CDM stated it was too close to tray line to make more. There were 14 salads prepared using the unwashed lettuce. On 10/31/24 at 1122 hours, the CDM stated he would make the salads again using washed lettuce. The CDM was observed preparing new salads. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was informed and acknowledged the above findings. 4. Review of facility's P&P titled HPSI Guidelines for the Food and Nutrition Services Department under Manual Washing for the two compartments sink method revised on 2/4/20 showed the following: -Drain sink two, refill with appropriate amounts of sanitizing solution and water; -Use the provided test strips to test the concentration of the sanitizing solution and record on the sanitizing sink log. If solution is incorrect, notify the supervisor and do not use until the correct concentration is available and verified; and -Submerse the clean dishes in the sanitizing solution according to chemical vendor's time requirements. On 10/30/24 at 1358 hours, an interview was conducted with DA 2. The manual dish washing sink was observed to be a two-compartment sink. DA 2 was asked to explain the manual dish washing process in the event of an emergency. DA 2 stated he was not trained at this facility; however, he was able to explain the process of manual dish washing for the two-compartment sink. DA 2 added there was no sanitizing solution or test strips available in the kitchen needed to sanitize dishes. On 10/30/24 at 1410 hours, the CDM was asked what would happen if the dish machine was broken and he stated, I would talk to the RD and figure out a plan since we don't have any sanitizer. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD stated if the dish machine was not working, the kitchen would use Styrofoam plates and utensils and inform maintenance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Review of the facility's P&P titled, Preventing Foodborne Illness: Employee Hygiene and Sanitary practices revised on 11/2022 showed the employees must wash their hands: - after personal body functions like toileting, blowing/wiping noise, cough, sneezing, etc.; - after using tobacco, eating, or drinking; - before coming in contact with any food surfaces; - after handling raw meat, poultry, or fish and when switching between working with raw food and working with ready-to-eat food; - after handling soiled equipment or utensils; - after engaging in other activities that contaminate the hands; and - contact between food and bare (ungloved) hands is prohibited. Gloves are considered single use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed, and gloves are replaced: - between handling raw meats and ready-to-eat foods; - between handling soiled and clean dishes; and - the use of disposable gloves does not substitute for proper handwashing. On 10/31/24 between 0917 and 1053 hours, an observations of [NAME] 1 was conducted. The following was observed: - [NAME] 1 wiped a food preparation table with a dry soiled rag then did not change his gloves or wash his hand before the next task, - [NAME] 1 placed his gloved hands in his pocket to get a thermometer then proceeded to prepare green beans for lunch without washing his hands or changing gloves, - [NAME] 1 opened a kitchen drawer to get a lighter out, touched his eyeglasses and picked up a cutting board and knife allowing the cutting board to touch his clothing without changing gloves and washing his hands before proceeding to prepare food; - [NAME] 1 used gloved hands to separate thawing raw chicken in a metal bowl and then changed his gloves without his hand washing; - [NAME] 1 took a cup of water to drink with the same gloved hands after touching raw chicken; - [NAME] 1 removed his gloves, did not wash his hands, and wiped the stove with a white rag from the tray line before donning new gloves; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- [NAME] 1 touched his eyeglasses with bare hands then donned new gloves without hand washing; - [NAME] 1 poured water from thawing chicken into the sink and placed the chicken on the tray then poured the rest of the water into the sink. He removed his gloves without hand washing; - [NAME] 1 touched the refrigerator handle then put on new gloves without hand washing then used his gloved hands to sprinkle parsley flakes on the chicken; - [NAME] 1 checked the temperature of chicken, touched his face, and eyeglasses with gloved hands. He did not perform hand washing or change his gloves then he picked up a clean utensil. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was asked about hand washing and changing of gloves by the kitchen staff. The RD stated the kitchen employees must wash their hands and change their gloves every time they touch their face or handling soiled utensils or equipment. 6. Review of the facility's P&P titled Preventing Foodborne Illness: Employee Hygiene and Sanitary practices revised on 11/2022 showed the following: - Hair nets or caps and/or beard restraints are worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens. On 10/30/24 at 0841 hours, an observation was conducted with DA 2. DA 2 was observed with uncovered facial hair while he worked in the dish machine area. On 10/30/24 at 1406 hours, an interview was conducted with the CDM. The CDM was asked about the facility's policy regarding hair restraints. The CDM stated facial hair should be covered if long. The CDM was informed of DA 2's uncovered facial hair and confirmed all facial hair should be covered with a hair restraint. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD stated if any kitchen staff had facial hair or beard, it should be covered with beard restraint. 7. Review of the facility's P&P titled, Preventing Foodborne Illness: Employee Hygiene and Sanitary practices revised on 11/2022 showed personnel may not smoke or use other tobacco products, eat, or drink in the food preparation area. On 10/31/24 at 0916 hours, an observation and concurrent interview was conducted with DA 1. The purple water bottle was observed on the food preparation table. DA 1 was asked if that was her water bottle and she stated, Yes and we can put our belongings in the CDM's office. However, she kept her water on the food preparation table and did not store in the CDM's office. On 10/31/24 at 0942 hours, an interview was conducted with the CDM. The CDM was informed of DA 1's water bottle on the food preparation table. The CDM stated, It's hot in the kitchen. I allow them to drink but it should be in the storeroom. On 10/31/24 at 0953 hours, [NAME] 1 was observed drinking from a white cup and placed the cup on the shelf above the preparation sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was informed of kitchen staff drinking in the food preparation area. The RD stated there should be no drinking in the food preparation area. 8. Review of the facility's P&P titled Preventing Foodborne Illness: Employee Hygiene and Sanitary practices revised on 11/2022 showed the following: - Jewelry will be kept to a minimum, Hand jewelry (e.g. rings) and wrist jewelry are kept covered with gloves during food handling; and - Fingernails shall be kept clean and trimmed. Intact, disposable gloves in good condition are worn and changed appropriately to reduce the spread of infection. On 10/31/24 at 0930 hours, an observation was conducted with DA 1. DA 1 was preparing salads for the resident lunch meal. DA 1 wore gloves; however, both wrists had long dangling bracelets and she had long painted artificial nails. On 10/31/24 at 0942 hours, an interview was conducted with the CDM. The CDM was informed of DA 1's long painted artificial nails and bracelets. The CDM stated DA 1 should not have artificial nails or jewelry. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was informed and acknowledged the above findings. 9. Review of the facility's P&P titled Sanitization revised on 11/2022 showed the following: - All kitchens, kitchen areas, and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects; - All utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners are kept in good repair; - All equipment, food contact surfaces and utensils are cleaned and sanitized using eat or chemical sanitizing solutions. On 10/29/24 at 0759 hours, during the initial tour of the kitchen with the CDM , the following was observed and confirmed by the CDM: - one knife stored in the knife rack was not clean; - four drawers used to store clean food preparation utensils were not clean; - four large pans with thick black residue; - three pans not clean; - four pans with anti-stick covering not intact; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- dome rack not clean; - mixer with rusted parts; - four of six storage bins not clean; - two cutting boards were heavily marred; and - uncovered service ware was stored near the floor. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was informed and acknowledged the above findings. 10. Review of the facility's P&P titled Sanitization revised on 11/2022 showed the following: - Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. On 10/31/24 at 0838 hours, an observation and concurrent interview was conducted with [NAME] 1. A clean blender was observed stored wet with the lid on. [NAME] 1 confirmed the inside of the blender was not air-dried and he stated the dietary aide used it earlier and washed it. [NAME] 1 proceeded to use the blender and placed boiled chicken and broth. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was informed and acknowledged the above finding. 11. Review of the facility's P&P titled Sanitization revised on 11/2022 showed the following: -All kitchens, kitchen areas, and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. During the initial tour of the kitchen with the CDM on 10/29/24 at 0759, the following was observed and confirmed by the CDM: - The wall above the back door was cracked and chipped; - The ceiling above the back door was bulging with brown stains; - The ceiling vents above the dish machine had black residue; - The hood above the stove was not intact; and - The meal tray line bars were loose and fixed with tape. On 10/29/24 at 0855 hours, an interview was conducted with the CDM. The CDM stated the maintenance staff was responsible to clean the wall, ceiling, and vents in the kitchen. The CDM added the Maintenance Supervisor (MS)- fixed the tray line with tape. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/30/24 at 0830 hours, an observation and concurrent interview with the MS. The MS was informed of the above findings and acknowledged them. The MS stated, I do not clean the ceiling vents, the kitchen does. I am not aware of this water leak on the ceiling. It is concerning. All these issues were not brought up to my attention. On 10/31/24 at 1142 hours, an observations kitchen area was conducted. The following was observed: - A pipe along the ceiling above the kitchen food preparation area had heavy dust. On 11/1/24 at 0853 hours, an observation and concurrent interview with the MS. The MS confirmed the pipe along the ceiling above the kitchen food preparation area had heavy dust. The MS was asked if he did any routine cleaning in the kitchen. The MS stated the kitchen staff should be responsible, but he could clean it if they would have asked him. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was informed and acknowledged the above findings. 12. According to the USDA Food Code 2022 Section 6-501.113 Storing Maintenance Tools. Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be: (A) Stored so they do not contaminate food, equipment, utensils. On 10/31/24 at 1214 hours, an observation of the area outside the kitchen back door and concurrent interview was conducted with the CDM. The kitchen broom was on the grass and the dustpan, mop, and mop bucket were stored outside. The CDM confirmed the findings. The CDM stated the kitchen did not have a storage area for the cleaning equipment. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was informed and acknowledged the above findings. 13. According to the USDA Food Cod 2022 Section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. On 10/29/24 at 0759 hours, during the initial tour of the kitchen with the CDM the food preparation sink was observed without backflow prevention. On 10/30/24 at 0825 hours, an observation and concurrent interview was conducted with the MS. The MS confirmed the food preparation sink did not have backflow prevention. The MS stated the drain was connected to the sewer but there was an air vent connected to the drainpipe outside of the facility. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD was informed and acknowledged the above finding.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical records were complete and accurately documented for three of 20 final sampled residents (Resident 30, 33, and 60) and one closed record (Resident 90). * The facility failed to ensure Resident 33's blood pressure access site was accurately documented in the resident's medical record. * Resident 60's TAR had two blank treatment administrations. * Resident 90's POLST was incomplete. * The facility failed to ensure the scratched-out Depakote dosage on Resident 30's Facility Verification of Informed Consent form was signed and dated and failed to complete the informed consent when a change of indication for the use of Olanzapine was noted as per the physician's order for Resident 3. These failures had the potential for the residents' care needs not being met as their medical information was inaccurate. Findings: Review of the facility's P&P titled Hemodialysis Access Care revised ,d+[DATE], showed do not use the resident's access arm to take the blood pressure. 1.a. Medical record review for Resident 33 was initiated on [DATE]. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 33's Order Summary Report dated [DATE], showed an order dated [DATE], for no blood pressure check or blood draw on the left upper extremity. Review of Residents 33's MDS dated [DATE], showed a BIMS score of 15 (meaning cognitively intact). Review of Resident 33's Plan of Care showed a care plan problem dated [DATE], for with Focus Impaired Renal Function End Stage Renal Disease on hemodialysis. The care plan interventions included no blood pressure check or blood draw on the left upper extremity. Review of Resident 33's Weights and Vitals Summary from ,d+[DATE] to [DATE], showed documentation the BP readings were obtained from the left arm one to two times each day. For example: - On [DATE] at 1318 hours, a BP reading of ,d+[DATE] mmHg on the left arm - On [DATE] at 1318 hours, a BP reading of ,d+[DATE] mmHg on the left arm (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On [DATE] at 1019 hours, a BP reading of ,d+[DATE] mmHg on the left arm - On [DATE] at 1303 hours, a BP reading of ,d+[DATE] mmHg on the left arm On [DATE] at 1120 hours, an interview and concurrent medical record review for Resident 33 was conducted with RN 2. RN 2 verified the licensed nurses' documentation of BP showed Resident 33's blood pressure(s) were obtained from the resident's left upper extremity. On [DATE] at 1122 hours, an interview and concurrent medical record review for Resident 33 was conducted with the DON. The DON verified the findings and stated the blood pressure should not have been taken on the left upper arm for Resident 33. On [DATE] at 1436 hours, an interview was conducted with Resident 33. Resident 33 stated he never allowed the licensed nurses to take his blood pressure on the left upper arm. b. Review of the facility's P&P titled Charting Errors and/or Omissions revised ,d+[DATE] showed the following: - If it is necessary to change or add information in the resident's medical record, it shall be completed by means of an addendum and signed and dated by the person making such change or addition. - Late entries in the medical record shall be dated at the time of the entry and noted as a late entry. Review of Resident 33's H&P examination dated [DATE], showed Resident 33 did not have the capacity to understand and make decisions. Further review of Resident 33's medical record showed another H&P examination form dated [DATE], which showed Resident 33 had the capacity to understand and made decisions, and the section for did not have the capacity to understand and make decisions was crossed out with initials, and not dated. Both of the H&P examinations dated [DATE], contained identical information, with the exception of the resident's capacity and the physician's name. One H&P form showed blank for the physician's name, and the other H&P form showed Resident 33's physician's name written On [DATE] at 1247 hours, an interview and concurrent medical record review for Resident 33 was conducted with the DON. When the DON was asked regarding the facility's process of correcting information entered incorrectly in the resident's medical records, the DON stated the physician needed to reassess the resident's capacity and write an addendum on the resident's medical record and could also write a new progress notes regarding the changes made. On [DATE] at 1511 hours, an interview was conducted with Resident 33's physician regarding Resident 33's two H&P examinations dated [DATE], with two different assessment of Resident 33's mental capacity. Resident 33's physician stated he made a mistake in documenting the resident's capacity to make decision. When Resident 33's physician was asked regarding the process when an error was made in the resident's medical record, the physician stated he needed to write another progress note or write an addendum on Resident 33's medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39683 2. Review of the facility's P&P titled Administering Medications revised [DATE] showed the person administering the medication documents the medication administration after administration in the TAR. Closed medical record review for Resident 60 was initiated on [DATE]. Resident 60 was readmitted to the facility on [DATE]. Review of Resident 60's Order Summary Report dated [DATE], showed a physician's order for clotrimazole cream 1% (an antifungal), to apply to the bottom of the resident's feet twice a day for 14 days. Review of Resident 60's TAR for [DATE], showed clotrimazole cream 1% was not documented as administered on [DATE] at 1700 hours, and [DATE] at 0900 hours. On [DATE] at 1106 hours, a concurrent interview and medical record review was conducted with LVN 2. When asked if LVN 2 completed Resident 60's treatment that morning, LVN 2 stated they completed it around ,d+[DATE] hours. LVN 2 then reviewed the TAR for [DATE], and verified the TAR failed to show documentation the treatment was completed on [DATE] at 1900 hours, and [DATE] at 0900 hours. LVN 2 stated she must have forgotten to document the treatment, and verified the treatment should be documented in the TAR as soon as the treatment completed. 3. Closed medical record review for Resident 90 was initiated on [DATE]. Resident 90 was admitted to the facility on [DATE], and had expired at the facility on [DATE]. Review of Resident 90's POLST initiated [DATE] and signed by the physician on [DATE], was incomplete to show if the resident had or had not formulated an advanced directive. Review of Resident 90's Advanced Healthcare Directive Acknowledgement Form dated [DATE], showed the resident did not have an advance directive. On [DATE] at 1206 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 reviewed Resident 90's POLST and verified the form was incomplete and failed to show if the resident had or did not have an advanced directive. RN 2 then reviewed Resident 90's Advanced Healthcare Directive Acknowledgement Form dated [DATE], which showed the resident did not have an advanced directive. RN 2 verified the resident's POLST was signed by the physician on [DATE], and the facility staff had time to update the resident's POLST to show the resident did not have an advanced directive, before the physician signed the POLST. 49644 4. Review of the facility's P&P titled Charting and Documentation revised ,d+[DATE] showed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Review of the facility's P&P titled Charting Errors and/or Omissions revised ,d+[DATE], showed the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Accurate medical records shall be maintained by this facility. - If an error is made while recording the data in the medical record, line through the error with a single line and correct the error. - All corrections, changes, or addenda must be signed and dated by the person making such entries. Medical record review for Resident 30 was initiated on [DATE]. Resident 30 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 30's SOAP Note dated [DATE], showed the resident was confused but able to make needs known. Review of Resident 30's Psychiatric Evaluation Note dated [DATE], showed the diagnosis of Bipolar Disorder. a. Review of Resident 30's Order Summary Report for [DATE], showed a physician's order dated [DATE], to administer Depakote (a medication for seizures and bipolar disorder) Sprinkles oral capsule delayed release sprinkle 125 mg (divalproex sodium) two capsules by mouth three times a day for Bipolar Disorder manifested by sudden change of mood from pleasant to angry; may open capsule and mix contents with applesauce; and do not crush. Review of Resident 30's Facility Verification of Informed Consent dated [DATE], showed for the use of Depakote Sprinkle capsule 250 mg three times a day. Mood manifested by change of mood from pleasant to angry. Resident 30's Facility Verification of Informed Consent form also showed the Depakote's dosage was scratched-out. On [DATE] at 1200 hours, an interview and concurrent medical record review for Resident 30 was conducted with LVN 3. LVN 3 verified Resident 30's Facility Verification of Informed Consent form showed the dosage was scratched-out with pen. LVN 3 stated the dosage mistake should have been corrected with just one line and initialed by the licensed nurse. LVN 3 stated the licensed nurse should have initialed the dosage mistake with the first letter of the licensed nurse's first and last names. b. Review of Resident 30's Order Summary Report for [DATE], showed a physician's order dated [DATE], to administer olanzapine (a medication to treat mental disorders including schizophrenia and bipolar disorder) oral tablet 5 mg one tablet by mouth at bedtime for Bipolar Disorder manifested by striking out at staff. Review of Resident 30's Facility Verification of Informed Consent dated [DATE], showed for the use of olanzapine 5 mg daily at bedtime for psychosis (a mental disorder characterized by a disconnection from reality) manifested by striking out at staff. On [DATE] at 1200 hours, an interview and concurrent medical record review for Resident 30 was conducted with LVN 3. LVN 3 acknowledged Resident 30's most recent physician's order to give olanzapine was indicated for Bipolar Disorder. LVN 3 verified Resident 30's Facility Verification of Informed Consent form showed psychosis manifested by striking out at staff instead of Bipolar Disorder manifested by striking out at staff. LVN 3 stated the RN supervisor or the admission nurse obtained the residents' informed consent. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1606 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 30's Facility Verification of Informed Consent for Olanzapine 5 mg was not updated to the new Bipolar Disorder indication for the use of Olanzapine as ordered by the physician. RN 2 stated they only changed the informed consent when there was a change of dose. RN 2 stated they clarified Resident 30's psychiatric notes and the physician's order was updated as recommended by the pharmacist. On [DATE] at 1532 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vista Care Center	1440 S Euclid Avenue Anaheim, CA 92802

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the infection control practices were followed for two of 20 final sampled residents (Resident 33 and 75) and three nonsampled residents (Residents 41, 61 and 791); in the laundry area; devices surfaces cleaning; hand washing; and preventing Legionella. In addition, the facility failed to ensure the infection control ;surveillance log was accurate. * Resident 41's bedside commode was not clean. * Resident 61's flush syringe touched the resident's blanket and the RN fanned the resident's uncapped iv port with her hand . * The facility's infection control surveillance logs were inaccurate. * The facility's laundry area had multiple infection control concerns. * The facility's decorative fountain was not monitored to prevent Legionella. * The facility's sit to stand device did not have a cleanable surface. * The facility failed to ensure the staff wore gloves and gown for a resident on enhanced barrier precautions (Resident 33). * The facility failed to ensure Resident 75's indwelling urinary catheter bag was not touching the floor. * The facility failed to hand washing was performed before and after medication administration. * CNA 1 failed to perform hand hygiene after removing gloves. * Resident 791's water pitcher had dark yellow build up and was unlabeled. These failures posed the risk of contamination and transmission of communicable diseases to other residents in the facility. Findings: 1. On 10/29/24 at 1418 hours, a strong constant urine odor was in the hallway outside the facility's conference room. On 10/29/24 at 1545 hours, a concurrent observation and interview was conducted with the IP. The IP identified the urine odor coming from Resident 41's bedside commode. The IP verified the bedside commode needed to be emptied. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/24 0904 hours, a concurrent observation and interview was conducted with the IP. The IP verified the odor of urine coming out into hallway was from Resident 41's bedside commode. The IP verified Resident 41's bedside commode had a plastic bag inside half filled with urine. The IP also verified a towel on the floor between Resident 41's bed and bedside commode was observed with yellow stains on it. When asked about Resident 41's bedside commode, the IP verbalized the staff were expected to empty the bedside commode every two hours or as notified by Resident 41. On 10/31/24 at 1152 hours, an interview was conducted with CNA 1. When asked about Resident 41's bedside commode, CNA 1 stated she checked Resident 41's bedside commode every two hours or when notified by Resident 41. When asked why Resident 41 had a towel on the floor, CNA 1 stated Resident 41 used the towel because sometimes she would not be able to self transfer to the bedside commode and the towel would be used to catch Resident 41's urine or bowel movement while she transferred herself onto the bedside commode. Per CNA 1 she used disinfectant wipes to clean Resident 41's bedside commode. When asked when she replaced or washed Resident 41's bedside commode, CNA 1 stated she would change or wash the bedside commode when soiled or ever one to two days with soap and water. When asked about the urine or bowel movement odors, CNA 1 acknowledged would be coming from Resident 41's bedside commode. When asked about following up when the odor of urine was coming out of Resident 41's bedside commode, CNA 1 was unable to explain. Medical record review for Resident 41 was initiated on 10/29/24. Resident 41 was readmitted to the facility on [DATE]. Review of Resident 41's ADL for bladder and bowel continence for October 2024, showed Resident 41 was sometimes continent and sometimes incontinent of both bladder and bowel. On 11/01/24 at 1415 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 verified there was no care plan problem to address Resident 41's use of a bedside commode. 2. On 10/29/24 at 1101 hours, a concurrent observation and interview was conducted with Resident 66. Resident 66 was observed in bed with his IV catheter site. Resident 66 stated he was receiving an antitiobtic medication via his IV catheter. Medical record review for Resident 66 was initiated on 10/29/24. Resident 66 was admitted to the facility on [DATE], with diagnoses including urinary tract infection (UTI, bacterial infection in the bladder, kidneys or urethra). On 10/31/24 at 1044 hours, a concurrent interview and observation was conducted with RN 1. RN 1 was asked to check Resident 66's IV port for appropriate flow. RN 1 was observed using her right hand, to fan Resident 66's uncapped IV port after wiping the port with an alcohol wipe. RN 1 was observed with an uncapped syringe containing normal saline solution in her other hand. While RN 1 was fanning Resident 66's uncapped IV port with her hand, the uncapped syringe tip kept touching Resident 66's blanket. RN 1 verified she fanned Resident 66's IV port with her hand. RN acknowledged Resident 66's syringe touching Resident 66's blanket would go against infection control practices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/24 at 1125 hours, a concurrent observation and interview was conducted with the Maintenance Director. The Maintenance Director verified the above findings. Also, at this time one of the gray dirty laundry bins had a dry yellow colored leaf on top of the dirty uncovered laundry. The Maintenance Director stated the wheelchairs were not supposed to be stored in the patio. During the laundry room inspection, the Maintenance Director verified personal tumblers were stored alongside clean table cloths used for residents. The Maintenance Director staff were supposed to use the designated vacuum to remove lint from the dryers. 5. According to CDC.gov, in manmade water systems, Legionella can grow and spread to susceptible hosts, such as persons who are at least [AGE] years old, smokers, and those with underlying medical conditions such as chronic lung disease or immunosuppression. Legionella can grow in parts of building water systems that are continually wet, and certain devices can spread contaminated water droplets via aerosolization. Examples of these system components and devices include decorative water fountains. On 10/30/24 at 1125 hours, a concurrent observation and interview was conducted with the Maintenance Director. When asked about a decorative fountain and monitoring for Legionella not entering this area, the Maintenance Director stated he was not checking this fountain because it recycled water and did not have standing water. The Maintenance Director stated Legionella was found in standing water. The fountain was observed with an asymmetrical crack on one of its tiers and a green colored substance at the bottom tier with leaves in the water. On 10/31/24 at 1100 hours, a concurrent interview and facility document review was conducted with the Administrator. The Administrator verified the decorative water fountain was not included in the facility's Water Management Program P&P, to monitor for water tempertures. Also, there was no cleaning log to show when the fountain was cleaned. 6. On 10/30/24 at 1300 hours, a concurrent observation and interview was conducted with RNA 1 and the IP. RNA 1 verified there was black duct tape on a device used to help the residents from a sitting to standing position. When asked about cleaning the area with the duct tape, RNA 1 stated she was just told to clean the device. The IP was also asked about the duct tape and verified the area underneath the duct tape was ripped, exposing the foam, and this area was not a cleanable surface. 50953 7. Review of the facility's P&P titled Administering Medication dated 4/2018, showed staff follows establish facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions etc) for the administration of medication as applicable. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 8/2019 showed this facility considers hand hygiene the primary means to prevent the spread of infection. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively , soap (antimicrobial on non-antimicrobial) and water for the following situation: before and after direct contacts with resident; before preparing or handling medication; after contact with resident's intact skin; after removing gloves .Hand hygiene is the final step after removing and disposing of personal protective equipment. Medical Record Review for Resident 33 was initiated on 10/29/24. Resident 33 was admitted to the facility on [DATE], and readmitted on ,d+[DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 33's Order Summary Report 10/31/24 showed an order dated 1/3/24, to monitor bruit and thrill of dialysis shunt (left upper arm) every shift, and to document the findings outside of baseline and call MD. Review Residents 33's MDS dated [DATE], showed a BIMS score of 15 (meaning cognitively intact). On 11/1/24 at 0919 hours, an observation was conducted of Resident 33 and LVN 5 in Resident Room B. The room had signage for enhanced barrier precautions for Resident 33, and for everyone entering to wear gloves and gown for the following high-contact resident care activities. Device care or use: central line. LVN 5 was observed checking for bruit and thrill for Resident 33 but did not wear gloves or a gown. On 11/1/24 at 1009 hours, interview was conducted with LVN 5. LVN 5 verified she did not use gloves and gown when she provided care for Resident 33. 8. Medical record review for Resident 75 was initiated on 10/29/24. Resident 75 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 75's H&P examination dated 7/18/24 showed the resident was able to understand and make treatment decisions. Review of Residents 75's MDS dated [DATE], showed a BIMS score of 15 (meaning cognitively intact). Review of Resident 75's Physician Order Summary dated 10/30/24 showed an order dated 7/16/24, for Foley catheter 16 Fr/10 cc to bedside drainage diagnosis of obstructive uropathy (blockage on the urinary tract). On 10/31/24 at 1234 hours, a concurrent observation of Resident 75 and interview was conducted with CNA 2. Resident 75 was observed sitting on his wheelchair. The indwelling urinary catheter drainage bag was observed touching the floor. CNA 2 verified the indwelling urinary catheter drainage bag was the touching the floor. 9.a. On 10/30/24 at 0841 hours, a medication administration observation for Resident 75 was conducted with LVN 3. LVN 3 did not perform hand washing before and after administering Resident 75's medications. On 10/30/24 at 0909 hours, an interview was conducted with LVN 3. LVN 3 verified the findings and stated she needed to wash her hands before and after medication administration. b. On 10/30/24 at 0928 hours, a medication administration observation for Resident 444 was conducted with LVN 1. LVN 1 did not perform hand washing before and after administering Resident 444's medications. On 10/30/24 at 0955 hours, an interview was conducted with LVN 3. LVN 3 verified the findings and stated she needed to wash her hands before and after medication administration. On 11/1/24 at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	39683 10. On 11/1/24 at 0847 hours, a concurrent observation and interview was conducted with CNA 1. CNA 1 was observed leaving Room A with gloves on. CNA 1 went to the medication cart across the hallway and removed and disposed the gloves in the medication cart's trash receptacle. CNA 1 then went to the clean linen cart in the hallway, lifted the clean linen cart mesh flap, and retrieved a bathe blanket without performing hand hygiene. CNA 1 verified they should have performed hand hygiene after removing their gloves and before retrieving the bath blanket from the clean linen cart. CNA 1 was still holding the clean bath blanket and proceeded into Room A. 50787 11. Review of the facility's P&P titled Sanitization revised 11/2022, showed a general description of how all equipment areas, counters, shelves, and equipment are kept clean, maintained in good repair. Manual washing and sanitizing are a three-step process for washing, rinsing, and sanitizing - scrape food particles and wash using hot water and detergent, rinse with hot water to remove soap residue, and sanitize with hot water or chemical sanitizing solution according to manufacturer's instructions. On 10/29/24 at 0858 hours, during the initial tour of the facility, the blue water pitcher on Resident 791's bedside table was observed to have dark yellow build up inside the water pitcher, on the mid to upper rim of the pitcher with thickened water, half full, and unlabeled. RN 1 verified the findings who also removed Resident 791's water pitcher from the bedside. Medical record review for Resident 791 was initiated on 10/30/24. Resident 791 was admitted to the facility on [DATE]. Review of Resident 791's H&P examination dated 10/17/24, showed the resident had no capacity to understand and make decisions. Review of Resident 791's Order Summary Report dated 10/30/24, showed a physician's order dated 10/19/24, for Fortified, High Protein, RCS (reduced concentrated sweets - limits the amount of dessert and sugar substitutes, often prescribed to diabetics) Puree, Nectar Mild Thick consistency. On 10/30/24 at 0805 hours, an interview was conducted with RN 2 regarding the process of providing water pitchers to the residents. RN 2 stated the water pitchers with regular water were changed everyday during the night shift and the pitchers with thickened water were changed during the day shift. Fresh water pitchers were delivered daily by the dietary staff and placed in the nurse's station where the exchange took place. Dietary staff then washed and sanitized the water pitchers. RN 2 further stated the thickened water pitchers were then labeled with the resident's name, room number, and the date on top of the water pitcher. Review of the facility's form titled Daily Cleaning Schedule log received from the facility's CDM showed the October 2024 log was completed on the dates from 09/29/24 to 10/26/24. The log failed to show documentation cleaning was done thereafter. On 11/1/24 at 1525 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the essential equipment in the safe operating conditions when: * The ice machine was not clean. * The ice machine was not cleaned and sanitized as per the manufacturer's instructions. * The ice storage bin did not have an air gap to prevent backflow. These failures had the potential for the essential equipment not functioning in the way they were intended and in turn cause contamination of food, leading to illnesses for the residents. Findings: Review of the facility's matrix showed 84 residents consumed food prepared in the kitchen. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. 1. On 10/29/24 at 1048 hours, an observation and concurrent interview was conducted with the MS. When the MS was asked about the cleaning of the ice machine, the MS stated he cleaned the ice machine once a month. Upon inspection of the ice machine internal components, the harvester (where ice was produced), the deflector (a plastic panel that directs ice from the harvester into the ice storage bin), had black residue that was removed when wiped with a white paper towel. The MS confirmed the findings. 2. Review of the facility's P&P titled Sanitization revised 11/2022 showed the ice machine and ice storage containers are drained, cleaned, and sanitized per manufacturer's instructions. Review of the ice machine manufacturer guidelines titled Cleaning and Sanitizing Procedure Instructions (undated) located on the interior cover of the ice machine showed the following: - Only use Manitowa approved ice machine cleaner and sanitizer for this application. - Step 1: Ice must not be on the evaporator during the clean/sanitize cycle. Press the manual harvest button in the service menu and allow the ice to harvest. Once all of the ice falls from the evaporator, turn the machine off by pushing the power button. - Step 2: Remove all ice from the bin/dispenser. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Step 3: Press the clean button, follow the prompts, and select Turn of when complete. The unit does not start dumping until you select Off or Ice mode. Water will flow through the dump valve and down the drain. When water trough has refilled (approximately 1 minute) and the display indicates: Add the proper amount of ice machine cleaner. - Step 4: Wait until the clean cycle is complete (approximately 24 minutes). - Step 5: Remove parts for cleaning. - Step 6: Mix a solution of the cleaner and warm water. Depending on the degree of mineral buildup. A large quantity of solution may be required. Use the table to mix enough solution to thoroughly clean all parks. Chart showed: use one gallon of water with 16 oz of cleaner solution. - Step 7: Use half of cleaner mixture to clean all components. Soak parts for five minutes, 20 minutes for heavily scaled parts. The cleaner solution will foam when it contacts lime scale and mineral deposits. Once the foaming stops, use a soft-bristle nylon brush, sponge or cloth to thoroughly clean the following ice machine areas: side walls, base (area above the trough), evaporator plastic parts (top, bottom, and sides), bin or dispenser. Rinse all the components with clean water - Step 8: While components are soaking, use half of the cleaner/water solution to clean all food zone surfaces of the ice machine and bin (or dispenser). Use nylon brush or cloth to thoroughly clean the following ice machine areas: side walls, base, evaporator plastic parts, bin, or dispenser. Rinse thoroughly with clean water. - Step 9: Mix a solution of sanitizer and lukewarm water. Three gallon (12 liters) of water and two ounces of sanitizer. - Step 10: Use half of the sanitizer/water solution to sanitize all removed components. Use a spray bottle to liberally apply the solution to all surfaces of the removed parts or soak the removed parts in the sanitizer/lukewarm solution. Do not rinse parts after sanitizing. - Step 11: Use half of the sanitizer/water solution to sanitize all food zone surfaces of the ice machine and bin. Use a spray bottle to liberally apply the solution: side walls, base, evaporator plastic parts, bin or dispenser. Rinse all areas thoroughly with clean water. - Step 12: Replace all removed components. - Step 13: Wait 20 minutes. - Step 14: Reapply power to the ice machine. Press the clean button and select make ice when complete. - Step 15: When ice trough was refilled, and the display indicates: add the proper amount of ice machine sanitizer to the water trough by pouring between the water curtain and evaporator. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 1041 hours, an observation of the ice machine and concurrent interview was conducted the MS. The MS was asked how he cleaned the ice machine. The MS stated he turned off the ice machine, removed all parts of the ice machine, and cleaned the parts with Nu Calgon Ice Machine Cleaner. The MS stated the internal portion of the ice machine was cleaned using the Manitowoc ice machine sanitizer. The ice machine instructions step 3 were reviewed with the MS. The MS stated he could not follow the manufacturer's instructions because he went by what he saw. Furthermore, the MS was asked about the amount of sanitizer he used to clean the ice machine. The MS stated there was no specific amount that he used. The MS was asked why a non-Manitowoc product called Nu Calgon [NAME] Cleaner was being used, the MS stated it was recommended for use by the equipment store. The MS verified the Nu Calgon [NAME] Cleaner was not to be used as per the manufacturer's guidelines. 3. On 10/19/24 at 1048 hours, an observation and concurrent interview was conducted with the MS. Upon inspection of the external parts of the ice machine, the ice storage bin had a drainage pipe which was connected directly to the sewer line. The MS verified an air gap was not present and stated an air gap was not necessary because the ice bin only had melted ice. On 11/1/24 at 1120 hours, an interview was conducted with the RD. The RD stated she checked the inside of the ice machine by wiping the ice deflector with a clean napkin. When asked if she inspected the internal components of the ice machine, the RD stated she was told by the MS not to look at the internal components of the ice machine. The RD added there should be an air gap for the ice storage bin.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 39856 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the kitchen was free from flies. This failure posed the risk for pests to contaminate the resident's food. Findings: Review of the facility's P&P titled Pest Control revised May 2008 showed the facility shall maintain an effective pest control program. Review of the facility's documents from a pest elimination company dated 8/20, 9/17, and 10/22/24, showed pests treated/inspected for were ants, roaches, mice, and rats. Review of the facility's document titled Maintenance Request Log completed by the CDM dated 7/6, 8/31, and 10/11/24, showed, Need screen door for dietary door, too hot in the kitchen and need screen door on delivery door to keep insects out. On 10/31/24 at 1136 hours, during the lunch meal tray line observation, an interview was conducted with the CDM. The back door to the kitchen which was adjacent to the trash in the parking lot was open. The back door did not have a screen. Two flies were observed in the kitchen near the lunch meal tray line. The CDM stated he allowed the back door to be open due to the heat in the kitchen. The CDM further stated he had requested for a screen for the back door multiple times. On 11/1/24 at 0854 hours, an interview was conducted with the DM. The DM stated he was aware the back door of the kitchen did not have a screen. The DM added the facility had investigated the problem but had not found a solution. The DM confirmed the back door had an air curtain (a device used to prevent flying insects from entering the kitchen) but it was not very effective. On 11/1/24 at 0859 hours, an interview was conducted with the Administrator. The Administrator confirmed she was aware of the problem that the back door of the kitchen needed a screen door but confirmed the facility had not found a solution to the problem.