STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055489	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta View Care Center	1795 Walnut Street Red Bluff, CA 96080

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and record review the facility failed to ensure a reasonable accommodation(s) of resident needs and preferences for three of 33 residents (Resident 45, 38 and 35) in room [ROOM NUMBER] with less than 80 square feet per resident. This resulted in Resident 35 not being able to achieve independent functioning, dignity, and put all residents in room [ROOM NUMBER] at risk for accidents and hazards. Refer to F 912. Findings: A review of a facility policy titled Accommodation of Needs revised March 2021, indicated our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. Moving furniture or large items in rooms and common areas that may obstruct the path of a resident using a walker, arranging furniture as the resident requests, providing the arrangement is safe, his or her roommate agrees, and space allows. In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes. Arranging toiletries and personal items so that they are in easy reach of the resident. During a concurrent observation and interview on 8/07/24 at 3:35 pm, Resident 35 stated he does not have enough room to get to his stuff. room [ROOM NUMBER] has three beds and three residents. Resident 35 stated the fan in front of the bathroom near his bed (middle Bed 2) blows on him and does not like it. The fan was plugged into the bathroom outlet and the cord was not secured. Resident 35 was observed trying to get his personal belongings out of his bedside cabinet and there were incontinent pads on the floor blocking the drawer. Resident 35 almost fell out of his wheelchair trying to get to his bedside table. Resident 35 stated he cannot use the bathroom to clean and put in his dentures due to his wheelchair not fitting in the bathroom. Resident 35 stated he cannot move around his room and use his bedside table when cleaning his dentures (not enough space between the beds). room [ROOM NUMBER] had a portable air conditioner on the floor in the far corner of Bed 3 near the window and the exhaust tubing was vented out the window. There was another fan in the far corner by Bed 1. Resident 45 who was in Bed 1 had a wheelchair. A review of Resident 35 admission record indicated he was admitted to facility on 4/29/24, with diagnoses which included heart failure, right and left below knee amputation, and weakness. Resident 35 was able to make his own health care decisions. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 35's Minimum Data Set (MDS, resident assessment) dated 5/5/24, indicated he had a wheelchair and had impairment on both sides of his lower extremities. Resident 35 required partial moderate assistance with oral hygiene. A review of Resident 45 admission record indicated he was admitted to facility on 4/30/24, with diagnoses which included weakness and difficulty in walking. Resident 45 was able to make health care decisions for himself. A review of Resident 45's MDS dated [DATE], indicated he had a wheelchair and walker mobility devices. Resident 45 required set up assistance for toileting, resident completes activity with help before and after. Resident 45 able to walk with assistance 10-150 feet. A review of Resident 38 admission record indicated he was admitted to facility on 12/13/23 with diagnoses which included dependence on wheelchair, muscle weakness and history of falling. A review of Resident 38's MDS dated [DATE], indicated he had a wheelchair for mobility. Resident 38 required set up assistance for toileting, resident completes activity with help before and after. During a concurrent observation and interview on 8/08/24 at 8:58 am, Licensed Vocational Nurse (LVN C) stated that the room was even more crowded before when Bed C resident also had a wheelchair, then, you could not get around at all. During a concurrent observation and interview on 8/8/24 at 9:15 am, Certified Nursing Assistant (CNA K) confirmed that fan was in the way and Resident 45 does use the restroom. CNA K stated the fan was blocking the isle right outside the bathroom and the cord was not secured anywhere. CNA K stated there were multiple trip hazards for all three residents in the room. CNA K stated both Resident 38 and 45 can use the bathroom. During a concurrent observation and interview on 8/13/24 at 1:30 PM, Director of Nursing (DON) confirmed two fans one in front of bathroom and one in far corner near Bed 1. DON stated the residents in this room are capable of moving their items around and getting to the bathroom, with cords unsecured, two guitars on Bed 2, three bedside tables, three night cabinets, and a portable air conditioner on the floor with a long tube exiting the window. DON stated room [ROOM NUMBER] cannot have an air condition in the window, due to electric needs in the building. DON stated they offered to remove the fans, but the residents refused and did not offer any other solutions to ensure the safety of residents.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to ensure two Quarterly Minimum Data Set Set (MDS, a standardized assessment of an adult's functional, medical, psychosocial, and cognitive status) assessments were accurate for one of seven (Resident 15) residents sampled for falls, when the fall section of the MDS did not identify Resident 15's two falls. This failure resulted in Resident 15 having multiple falls due to having an inaccurate reflection of what care was needed to prevent falls. Findings: A review of the facility's policy titled, MDS 3.0 Completion (undated), indicated Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. According to federal regulations the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI (Resident Assessment Instrument) specified by the State. A record review of Resident 15's Admission Record dated 11/10/23, indicated Resident 15 was admitted on [DATE] with the diagnoses that included Alzheimer's disease (a disease of the brain that destroys memory and other important mental functions), diabetes (high sugar in the blood), heart disease, and cancer. A review of Resident 15's Nursing Progress notes dated 1/1/24 at 11:12 am, Director of Staff Development (DSD) documented Patient has witnessed fall. was [Was] sitting in walker in main lobby, started scooting forward and his bottom slid out of the walker, and he slid onto the floor, stated his butt hurts. A review of Resident 15's Quarterly MDS (an assessment that reviewed resident activity over the last three months), section J- Health Conditions dated 2/16/24, indicated Resident 15 had not had a fall in the past three months. A review of Resident 15's Fall Interdisciplinary Team (IDT, a group of healthcare professional from different disciplines who work together to treat a patient's condition or diagnoses) Post Event Note, dated 4/1/24 at 8:45 am, by Infection Preventionist (IP), indicated that at 4:20 am, on 4/1/24 Resident 15 had an unwitnessed fall. The IP documented Resident observed by CNA (Certified Nursing Assistant) sitting on buttocks at foot of bed. Resident assisted off floor with two persons assist. A review of Resident 15's Quarterly MDS section J- Health Conditions dated 5/16/24, indicated Resident 15 had not had a fall in the past three months. During an interview and record review, on 8/9/24 at 10:19 am, with the Minimum Data Set Licensed Vocational Nurse (MDSLVN), Resident 15's MDS was reviewed. The MDSLVN confirmed that the falls on 1/1/24 and 4/1/24 had not been identified on the 2/16/24 and the 5/16/24's Quarterly MDS assessments and they should have been.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to complete baseline care plans (initial goals with interventions based on admission orders and assessments, which provide instructions for immediate care of the resident) for two of seven residents (Resident 15 and 303) when Resident 15 and Resident 303 did not have a baseline care plan developed for being at risk for falls in the first 48 hours of admission to the facility. This failure resulted in Resident 15 and Resident 303 not having appropriate care needed to prevent falls. Findings: A review of the facility's policy titled, Baseline Care Plan (undated), the policy indicated The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. 2. The admitting nurse, or supervision nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall or pressure injury risk. ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. 1. A review of Resident 15's Admission Record dated 11/10/23, indicated Resident 15 was admitted on [DATE] with the diagnoses that included Alzheimer's disease (a disease of the brain that destroys memory and other important mental functions), diabetes (high sugar in the blood), heart disease, and cancer. A review of Resident 15's Admission Minimum Data Set (MDS a standardized assessment of an adult's functional, medical, psychosocial, and cognitive status), dated 11/16/23, indicated Resident 15 required supervision or touching assistance with standing, transfers, and walking. Resident 15's Brief Interview for Mental Status (BIMS, evaluates a person's cognition, [ability to think, learn, remember, use judgement, and make decisions] with scores from 00 to15) score was 00, indicating Resident 15's cognition was severely impaired. A review of Resident 15's Fall Risk Evaluation of the admission physcial assment dated 11/11/23, indicated Resident scored a 7 (indicating he was at moderate risk for falls). A review of Resident 15's baseline care plan revealed there was no Fall Care Plan developed and no interventions initiated for his identified at moderate risk for falls. During an interview and record review on 8/9/24 at 10:19 am, with the Minimum Data Set Licensed Vocational Nurse (MDSLVN), Resident 15's care plans were reviewed. The MDSLVN confirmed that Resident 15 did not have a baseline care plan for falls on admission and he should have had. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A record review of Resident 303's Admission Record (undated), indicated Resident 303 was originally admitted on [DATE] and then readmitted on [DATE] after a brief hospital stay. Resident 303's diagnoses included fracture (broken bone) of right leg, lung disease, muscle weakness, anxiety disorder, dependence on oxygen, and depression. A review of Resident 303's's Admission MDS dated [DATE], indicated Resident 303 required partial or moderate assistance with going from a sitting position to a lying position and supervision or touching assistance with standing and transfers. Resident 303 used a wheelchair and was identified on the MDS as not walking on admission. Resident 303's BIMS score was 15, indicating Resident 15's cognition was intact. A review of Resident 303's Physician Orders dated 6/22/24, indicated she was taking Lasix (a diuretic that excretes the water from the body through urine and can cause low blood pressure which will increase the risk for falls) 20 mg (milligram, a form of measurment) tablet take once daily, Metoprolol (an antihypertensive medication that lowers the blood pressure which will increase the risk for falls) 50 mg tablet take twice daily, and Prazosin (also an antihypertensive medication that lowers the blood pressure which will increase the risk for falls) 2 mg tablet take 2 tablets daily. A review of Resident 303's baseline care plan revealed there was no Fall Care Plan developed. During an interview with the Director of Nursing (DON) and record review on 8/13/24 at 11:02 am, Resident 303's admitting diagnoses, Physician Orders and care plans were reviewed. DON confirmed that Resident 303 was at risk for falls on admission and should have had a baseline care plan with interventions to prevent falls and there was not one.

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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** 43755 Based on interview and record review, the facility failed to develop comprehensive care plans for two of seven sampled Residents when: 1. Resident 15 was at risk for falls and there was no comprehensive Fall Care Plan developed with interventions to prevent Resident 15 from falls. This failure resulted in three falls for Resident 15. 2.a. Resident 303 was at risk for falls and there was no comprehensive Fall Care Plan developed to prevent 303 from falls. b. Resident 303 was planning on going home but there was no Discharge Care Plan developed. These failures put Resident 303 at risk for falls and the feeling of being uniformed of her discharge plans. Refer to F689 Findings: A review of the facility's policy titled, Comprehensive Care Plans revised date of October 2022, indicated It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following . a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate. 1. A review of Resident 15's Admission Record dated 11/10/23, indicated Resident 15 was admitted on [DATE] with the diagnoses that included Alzheimer's disease (a disease of the brain that destroys memory and other important mental functions), diabetes (high sugar in the blood), heart disease, and cancer. A review of Resident 15's admission Minimum Data Set (MDS, a clinical assessment), dated 11/16/23, indicated Resident 15 required supervision or touching assistance with standing, transfers, and walking. Resident 15's Brief Interview for Mental Status (BIMS, evaluates a person's cognition, [ability to think, learn, remember, use judgement, and make decisions] with scores from 00 to15) score was 00, indicating Resident 15's cognition was severely impaired. A review of Resident 15's admission Fall Risk Evaluation dated 11/11/23, indicated Resident scored a 7 (indicating he was at moderate risk for falls). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 15's comprehensive care plan revealed there was a Fall Care Plan developed on 7/2/2024 (8 months after admission). There was no Fall Care Plan developed and no interventions initiated for his identified at moderate risk for falls in November 2023. A review of Resident 15's Nursing Notes indicated that Resident 15 had a fall on 1/1/24, 4/1/24 and 7/2/24. During an interview and record review on 8/9/24 at 10:19 am, with the Minimum Data Set Licensed Vocational Nurse (MDSLVN), Resident 15's care plans and falls were reviewed. The MDSLVN confirmed that Resident 15 did not have a comprehensive care plan to prevent falls on admission and he should have had. The MDSLVN confirmed that Resident 15 had had three falls since admission and one of the falls Resident 15 had incurred injuries. 2. a. A record review of Resident 303's Admission Record (undated), indicated Resident 303 was originally admitted on [DATE] and then readmitted on [DATE] after a brief hospital stay. Resident 303's diagnoses included fracture (broken bone) of right leg, lung disease, muscle weakness, anxiety disorder, dependence on oxygen, and depression. A review of Resident 303's's admission MDS dated [DATE], indicated Resident 303 required partial or moderate assistance with going from a sitting position to a lying position and supervision or touching assistance with standing and transfers. Resident 303 used a wheelchair and was identified on the MDS as not walking on admission. Resident 303's BIMS score was 15, indicating Resident 15's cognition was intact. A review of Resident 303's Physician Orders dated 8/9/24, indicated Resident 303 could understand rights, responsibilities, and informed consent. A review of Resident 303's Physician Orders dated 6/22/24 indicated she was taking Lasix (a diuretic that excretes the water from the body through urine and can cause low blood pressure which will increase the risk for falls) 20 mg tablet take once daily, Metoprolol (an antihypertensive medication that lowers the blood pressure which will increase the risk for falls) 50 mg tablet take twice daily, and Prazosin (also an antihypertensive medication that lowers the blood pressure which will increase the risk for falls) 2 mg tablet take 2 tablets daily. A review of Resident 303's comprehensive care plan revealed there was no Fall Care Plan developed. During an interview with the Director of Nursing (DON) and record review on 8/13/24 at 11:02 am, Resident 303's admitting diagnoses, physician orders and care plans were reviewed. DON confirmed that Resident 303 was at risk for falls on admission and should have had a comprehensive care plan with interventions to prevent falls and there was not one. b. During an interview on 8/6/24 at 3:42 am, Resident 303 indicated she had not talked with anyone about a care plan or what her discharge plans were, and she wanted to. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review, on 8/9/24 at 3:40 pm, with the Social Services Coordinator (SSC), Resident 303's care plan was reviewed. SSC indicated there was no Discharge Care Plan developed for resident 303 and there should have been. The SSC stated I would expect to have this done within the first 72 hours of admission and discussed with her (Resident 303). It (Discharge Care Plan) should have absolutely been in (developed) and it was not. I could be more organized. The SSC indicated the Discharge Care Plan informed everyone what the discharge plan was for Resident 303 to help her achieve her goal.

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F 0657 Level of Harm - Minimal harm or potential for actual 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** 43755 Based on interview and record review, the facility failed to ensure that the Interdisciplinary Team (IDT, the facility managers who meet to discuss the care needs of the residents) reviewed and revised the care plan for three of seven (Resident 8, 15, and 52)) sampled residents when: 1. Resident 15 had two falls without injury and the care plan was not revised or reviewed which resulted in Resident 15 having another fall with injury. Refer to F689. 2. Resident 8 had two Hoyer lift (a mechanical device use to lift an individual from a bed or wheelchair) incidents and the care plan was not revised or reviewed timely. 3. Resident 52 who had multiple fall history, the care plan was not revised or reviewed timely. These failures had the potential for staff to not be fully informed of the residents' health status to determine the need for further assessment and intervention. Findings: A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered dated March 2022, indicated 11. Assessments of resident are ongoing and care plans are revised as information about the residents and the residents' condition change. 12. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition. A review of the facility's policy titled, Fall Prevention Program (undated), indicated 9. When any resident experiences a fall the facility will: .e. Review the resident's care plan and update as indicated. 1. Resident 15 A record review of Resident 15's Admission Record, dated 11/10/23, indicated Resident 15 was admitted on [DATE] with the diagnoses that included Alzheimer's disease (a disease of the brain that destroys memory and other important mental functions), diabetes (high sugar in the blood), heart disease, and cancer. A review of Resident 15's nursing progress notes, dated 1/1/24 at 11:12 am, Director of Staff Development (DSD) documented Patient has witnessed fall. was [Was] sitting in walker in main lobby, started scooting forward and his bottom slid out of the walker, and he slid onto the floor, stated his butt hurts. will continue to monitor. A review of Resident 15's care plans showed no care plan for being at risk for falls had been developed or reviewed after the 1/1/24 fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 15's Fall Interdisciplinary Team (IDT, the facility managers who meet to discuss the care needs of the residents) Post Event Note, dated 4/1/24 at 8:45 am, by Infection Preventionist (IP), indicated that on 4/1/24 at 4:20 am, Resident 15 had an unwitnessed fall. The IP documented Resident observed by CNA (Certified Nursing Assistant) sitting on buttocks at foot of bed. Resident assisted off floor with two persons assist. Medical factors relating to the fall were identified as incontinence (lack of control of urine), unstable gait (the way one walks), weakness, poor lighting, walker, confused, forgetful, short term memory problem, non-compliant, poor safety awareness, improper use, or failure to use assistive device. Interventions recommended were Medication Review, Rehab Referral and Care Plan Revision. A review of Resident15's care plans showed no care plan for being at risk for falls or actual falls had been developed or reviewed after the 4/1/24 fall. A review of Resident 15's IDT notes dated 7/2/24, indicated Resident 15 had a fall on 7/1/24 at 8:50 am. The Director of Nursing (DON) documented LN (Licensed Nurse) went to residents' room and found resident sitting on his bottom. Resident face, hands, floor, and clothing saturated in blood. Resident repeating ow to staff. Resident seemed to have been attempting self-transfer. Resident has laceration (cut) to R (right) eyebrow, nose swollen, and discolored, bottom lip bitten. Recommendations were to send to acute for possible head injury and possible stitches to right eyebrow laceration. During an interview and record review on 8/9/24 at 10:19 am, with the Minimum Data Set Licensed Vocational Nurse (MDSLVN), Resident 15's care plans were reviewed. The MDSLVN confirmed that Resident 15 had a fall on 1/1/24, 4/1/24 and 7/2/24 and that there were no Fall Care Plans with interventions developed or revised for his falls on 1/1/24 and 4/1/24. MDSLVN indicated that everyone should have a Fall Care Plan on admission, and it should be reviewed with each new fall. 43739 2. Resident 8 During a review of Resident 8's clinical record, indicated that Resident 8 was admitted to the facility on [DATE] with diagnoses which included quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), diabetes (high blood sugar), and chronic obstructive pulmonary disease (a common, progressive lung disease that damages the airways or other parts of the lungs, making it difficult to breathe). Resident 8 was her own health care decision maker. During a review of Resident 8's Minimum Data Set (MDS - an assessment and care screening tool) at section C - Cognitive Pattern, dated 5/13/2024, Resident 8 had a brief interview for mental status (BIMS) score of 14, indicated that Resident 8 was cognitively intact. During a review of Resident 8's MDS at section GG - Functional Abilities and Goals, dated, 11/2/2023, indicated that Resident 8's both upper and lower extremities were impaired, and was completed dependent on self-care and mobility. During a review of Resident 8's progress note, dated 11/11/2023, at 7:15 pm, indicated that Resident 8 was transferred from Hoyer lift to the wheelchair, a Certified Nursing Assistant (CNA) pulled Resident 8 up by pulling the sling, causing the Hoyer lift to come forward and over Resident 8's body. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's progress note, dated 6/5/2024, at 9:30 am, indicated that Resident 8 was injured and had redness under her left eye due to a CNA incorrectly operated the Hoyer lift. During a concurrent interview and record review on 8/13/2024, at 11:22 am, with the DON, Resident 8's progress notes and care plan were reviewed. The DON confirmed that Resident 8 did have these two Hoyer lift incidents and she could not locate the revised care plan for these incidents. The DON stated, the shift nurse should have initiated the short-term Hoyer lift care plan right after the incidents had happened. 3. Resident 52 During a review of Resident 52's clinical record, indicated that Resident 52 was admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (Dementia is a mental disorder that can cause people to lose their ability to think, learn, remember, make decisions, and solve problems. Dementia without behavioral disturbance is a dementia diagnosis that doesn't include behavioral symptoms), adult failure to thrive, and depression. Resident 52 was not her healthcare decision maker. During a review of Resident 52's MDS at section C - Cognitive Pattern, dated 4/8/2024, Resident 52 had a BIMS score of 4, indicated that Resident 52's cognition was severely impaired. During a review of Resident 52's Fall Risk Evaluation, dated 4/27/2024, Resident 52 scored 12, indicated that she was at high fall risk. During a review of Resident 52's progress note, dated 4/27/2024 at 9:44 pm, indicated that Resident 52 had an unwitnessed fall at around 9:40 pm. Resident 52 sustained a large hematoma on the left side of her forehead above the left eye. There's no revised care plan to be found related to this incident. During a review of Resident 52's progress note, dated 5/15/2024 at 11:40 pm, indicated that Resident 52 had a witnessed fall and was sent to the acute hospital. Resident 52 was later diagnosed with mechanical fall with right hip fracture. There's no revised care plan to be found related to this incident. During a concurrent interview and record review on 8/13/2024, at 11:19 am, with the DON, Resident 52's care plan and progress note were reviewed. The DON confirmed that there's no care plan created for these two incidents. The DON stated that the shift nurse should have initiated the short-term fall care plan for these incidents on the date that Resident 52 had the fall.

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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** 43755 Based on observation, interview and record review, the facility failed to ensure that two of seven sampled residents (Resident 15 and 303) who were evaluated for their risk for falls, reevaluated after falls, or had care planned interventions to prevent falls and/or further falls when: 1. Resident 15 had inaccurate and absent Fall Risk Evaluations, (an assessment that checks a resident's risk of falling by assessing clinical conditions including mental status, history of falls, vision, walking and balance, blood pressure, and medications that would increase a risk of falling.) and did not have Fall Care Plans developed with interventions to prevent falls. 2. Resident 303 had an inaccurate Fall Risk Evaluation and did not have a Fall Care Plan developed with interventions. These failures resulted in continued falls for Resident 15 and put Resident 303 and all residents, who were at risk for falls, to be at risk for further falls and injuries. Findings: A review of the facility's policy titled, Fall Prevention Program (undated), indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The nurse will indicate on the (specify location) [care plan] the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. The facility utilizes a standardized risk assessment (Fall Risk Evaluation) for determining a resident's fall risk. The risk assessment categorizes residents according to low/moderate, or high risk. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions. A review of the facility's policy titled, Falls and Fall Risk, Managing revised March 2018, indicated, If falling recurs despite initial interventions, staff will implement additional or different intervention, or indicate why the current approach remains relevant. The staff will monitor and document each resident response to interventions intended to reduce falling or the risks of falling. 1. A record review of Resident 15's Admission Record dated 11/10/23, indicated Resident 15 was admitted on [DATE] with the diagnoses that included Alzheimer's disease (a disease of the brain that destroys memory and other important mental functions), diabetes (high sugar in the blood), heart disease, and cancer. A review of Resident 15's Admission Minimum Data Set (MDS, an assessment and care screening tool) dated 11/16/23, indicated Resident 15 required supervision or touching assistance with standing, transfers, and walking. Resident 15's Brief Interview for Mental Status (BIMS, evaluates a person's cognition, [ability to think, learn, remember, use judgement, and make decisions] with scores from 00 to 15) score was 00, indicating Resident 15's cognition was severely impaired. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/06/24 at 12:14 pm, in Resident 15's room with Resident 15's daughter. Resident 15 was sitting up had his feet hanging over the side of the bed. Resident 15's daughter came in the room and assisted Resident 15 back to bed. The daughter indicated that Resident 15 had a fall in the last month and had to go to the emergency room because he got a cut above his eye. A review of Resident 15's medical record reflected three falls for Resident 15 since admission: *On 1/1/24 at 11:12 am, Director of Staff Development (DSD) documented in the Nursing Progress notes, Patient has witnessed fall. was [Was] sitting in walker in main lobby, started scooting forward and his bottom slid out of the walker, and he slid onto the floor, stated his butt hurts. There was no Interdisciplinary Team (IDT, a group of health care disciplines that determine root cause for falls and develops new fall interventions) meeting for this fall. *On 4/1/24 at 8:45 am, an IDT Event Note indicated Resident observed by CNA (Certified Nursing Assistant) sitting on buttocks at foot of bed. Resident assisted off floor with two persons assist. Medical factors relating to the fall were identified as incontinence (lack of control of urine), unstable gait (the way one walks), weakness, poor lighting, walker, confused, forgetful, short term memory problem, non-compliant, poor safety awareness, improper use, or failure to use assistive device. Interventions recommended were Medication Review, Rehab Referral and Care Plan Revision. *On 7/2/24 at 8:50 am, The Director of Nursing (DON) documented LN (Licensed Nurse) went to residents' room and found resident sitting on his bottom. Resident face, hands, floor, and clothing saturated in blood. Resident repeating ow to staff. Resident seemed to have been attempting self-transfer. Resident has laceration (cut) to R (right) eyebrow, nose swollen, and discolored, bottom lip bitten. Recommendations were to send to acute for possible head injury and possible stitches to right eyebrow laceration. Resident 15's Fall Risk Evaluations were reviewed: *On admission, dated 11/11/23, the Fall Risk Evaluation indicated Resident scored a 7 (indicating he was at moderate risk for falls). *In January 2024 after the 1/1/24 fall there was no Fall Risk Evaluation done. *On 4/1/24 at 4:28 am, Resident 15's Fall Risk Evaluation incorrectly identified Resident 15 as having no falls in the past 3 months when this was his second fall recorded in his medical record in the past 3 months. Resident 15 scored a 6 (indicating he was at moderate risk for falls) *On 7/1/24 at 9:51 am, Resident 15's Fall Risk Evaluation indicated Resident scored a 15 (indicating he was at high risk for falls) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 15's Care Plans reflected no Fall Care Plan was developed and no interventions initiated on admission or after the falls on 1/1/24 and 4/1/24. A Fall Care Plan was developed on 7/2/24 which indicated [Resident 15] is at risk for falls r/t [related to] Confusion, Gait/balance problems, unaware of safety needs. Interventions included: anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all request for assistance. A short-term Fall Care Plan was developed on 7/2/24 with interventions including fall mat to left side of bed, assist to bathroom after meals, Physical Therapy to evaluate and treat, and pharmacy to review medications. During an interview and record review on 8/9/24 at 10:19 am, with the Minimum Data Set Licensed Vocational Nurse (MDSLVN), Resident 15's MDSs and care plans were reviewed. The MDSLVN confirmed that Resident 15 had a fall on 1/1/24, 4/1/24 and 7/2/24 and that there were no Fall Care Plans with interventions developed on admission and for his falls on 1/1/24 and 4/1/24. She indicated that everyone should have a Fall Care Plan on admission, and it should be reviewed with each new fall. The MDSLVN confirmed that the falls on 1/1/24 and 4/1/24 had not been identified on the 2/16/24 and the 5/16/24's Quarterly MDS assessments and they should have been. MDSLVN indicated she did not know why they were missed. During an interview with the Infection Preventionist (IP) on 8/9/24 at 11:56 am, the IP indicated during these falls the facility did not have a Director of Nursing (DON) to follow up on falls, so she filled in for the DON. The IP indicated there should have been Fall Care Plans developed for Resident 15. The IP stated, at that time . I was doing all the follow-ups and because I was doing a lot of things it got missed. During an interview and review of Resident 15's medical records on 8/13/24 at 11:08 am, the DON confirmed Resident 15 had a fall on 1/1/24 and there was no IDT meeting, no Fall Risk Evaluation or Care Plan done and there should have been. The DON confirmed Resident 15 had a fall on 4/1/24 and an IDT meeting was done but no Fall Care Plan with interventions was developed, and the Fall Risk Evaluation was incorrect when it reflected that Resident 15 had no falls in the past three months. The DON indicated Care Plans should be done so everyone (facility staff) would understand the resident's needs and be able to initiate interventions to prevent falls and injuries. During an interview and record review on 8/13/24 at 11:58 am, Resident 15's therapy notes were reviewed. The Director of Therapy (DOR) indicated Resident 15 had orders for Physical and Occupational Therapy on admission (11/10/24) but was not evaluated by the therapists until 7/5/24 (8 months after admission). The DOR indicated she started at the end of April and did not know why Resident 15 was not evaluated earlier. The DOR confirmed that the IDT note for the 4/1/24 fall recommended Resident 15 to have a physical therapy evaluation, but she was not sure if that happened. During an interview and record review on 8/13/24 at 1:36 pm, Resident 15's therapy notes were reviewed. The Physical Therapist (PT) indicated he was working during the time Resident 15 was admitted and when Resident 15 fell on [DATE] and 4/1/24. He confirmed there were no therapy evaluations done with Resident 15 until 7/5/24. PT indicated he did not know why it was not done but that it was a missed opportunity, and it should have been done. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A record review of Resident 303's Admission Record (undated), indicated Resident 303 was originally admitted on [DATE] and then readmitted on [DATE] after a brief hospital stay. Resident 303's diagnoses included fracture (broken bone) of right leg, lung disease, muscle weakness, anxiety disorder, dependence on oxygen, and depression. A review of Resident 303's Admission MDS dated [DATE], indicated Resident 303 required partial or moderate assistance with going from a sitting position to a lying position and supervision or touching assistance with standing and transfers. Resident 303 used a wheelchair and was identified on the MDS as not walking on admission. Resident 303's BIMS score was 15, indicating Resident 15's cognition was intact. A review of Resident 303's Physician Orders dated 6/22/24 indicated she was taking Lasix (a diuretic that excretes the water from the body through urine and can cause low blood pressure which will increase the risk for falls) 20 milligrams (mg, a unit of measure) tablet take once daily, Metoprolol (an antihypertensive medication that lowers the blood pressure which will increase the risk for falls) 50 mg tablet take twice daily, and Prazosin (also an antihypertensive medication that lowers the blood pressure which will increase the risk for falls) 2 mg tablet take 2 tablets daily. A review of Resident 303's admission Fall Risk Evaluation dated 6/22/24, incorrectly indicated that Resident 303 had no predisposing diseases such as a fracture and was not taking medications that increased her risk for falls such as diuretics and antihypertensives. Resident 303 scored a 4 on her Fall Risk Assessment (indicating she was at low risk for falls). A review of Resident 303's Baseline Care Plan and Admission Comprehensive Care Plan revealed there was no Fall Care Plan developed. During an interview with the DON and record review on 8/13/24 at 11:02 am, Resident 303's Fall Risk Evaluation, Admitting Diagnoses, Physician Orders and Care Plans were reviewed. The DON confirmed that Resident 303 had a fracture and was on a diuretic and antihypertensive medications and they were not included on her Fall Risk Evaluation assessment. The DON confirmed that Resident 303's score of 4 (low risk for falls) would have been higher if the Fall Risk Evaluation had been completed correctly. DON confirmed that Resident 303 should have had a Care Plan developed upon admission that included interventions to prevent falls and there was not one.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50363 Based on interview and record review, the facility's nursing staff failed to assess and reevaluate the continued need for a suprapubic urinary catheter (a hollow flexible tube inserted through a cut in the abdomen that is used to drain urine from the bladder into a bag) for one of four sampled residents (Resident 12). The delay in identifying a change in condition resulted in emergent hospitalization , pain, and urinary tract infection (UTI - bacterial infection in urinary system). Findings: A review of a policy titled Change in a Resident's Condition or Status, revised February 2021, the nurse will notify the resident's attending physician if a significant change in the resident's physical/emotional/mental condition; a significant change of condition is a major decline that will not normally resolve itself without intervention and requires interdisciplinary review and/or revision of care plan. Review of document Pain - Clinical Protocol 2001 MED-PASS, Inc. indicated The nursing staff will assess each individual for pain .whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. The staff and physician will evaluate how pain is affecting .quality of life. The physician will perform, or order appropriate tests as needed to help clarify sources of pain. Review of admission record indicated Resident 12 was admitted on [DATE] with diagnoses that included type 2 diabetes, epilepsy (seizures), neuromuscular dysfunction of bladder (nerves and muscles of urinary systems do not work together due to damage to the nervous system), and suprapubic catheter. Review of document Orders 12/14/2023 indicated an active order for Resident 12 to receive a urology evaluation and treatment with follow up as indicated for history of suprapubic catheter. No further documentation noted to show a consult occurred. Review of document Care Plan 1/1/2024 for Resident 12 indicated urology eval and treatment with follow up appointments as indicated. There was no indication of a urology referral or consult for Resident 12. Record review of Progress Notes 7/14/2024 indicated Resident 12 was treated for a urinary tract infection (UTI - bacteria in urinary tract). MD prescribed Resident 12 Doxycycline Hyclate Oral Tablet 100 MG (antibiotic), 1 tablet by mouth two times a day for 7 days. During a concurrent interview on 8/6/2024 at 9:45 am, Resident 12 stated she had right kidney pain, and that she had notified staff. During a concurrent observation, white sediment was floating in the catheter tubing, and urine was cloudy. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of MAR July 2024 indicated Resident 12 was administered Hydrocodone-Acetaminophen 10-325 mg by mouth as needed for moderate pain 4-6 22 times. Resident 12 complained of documented head and generalized pain during this month. Record review of MAR August 2024 indicated Resident 12 was administered Hydrocodone-Acetaminophen 10-325 mg by mouth as needed for moderate pain 4-6/10 for documented back pain from 8/4/2024-8/7/2024. During a concurrent interview with Director of Nursing (DON) on 8/6/2024 at 10:01 am, DON stated she would follow-up with Resident 12. Review of document Change in Condition 8/6/2024 10:15 am indicated that a urine assessment was not clinically applicable to the change in condition being reported. The document indicated Resident 12 was having 6/10 pain (moderate pain) in her urethra (duct in body where urine exits body), physician recommendation to monitor due to pain in her urethra, cloudy urine. No body temperature was obtained. Review of document Change in Condition 8/7/2024 9:57 am indicated that a urine assessment was relevant to the change being reported due to light bleeding coming from vagina with bright red spot on her brief about the size of a dime, physician recommendation to monitor for changes. During a concurrent interview with DON on 8/7/2024 at 2:30 pm, she stated that Resident 12's catheter looked better than it has in a while, but we got a UA on her yesterday. Record review of laboratory results Urinalysis (UA) Results 8/6/2024 collected on 8/6/2024, reported on 8/8/2024 showed bacteria and blood in urine indicating an infection. Lab results were not signed by MD. Record review of physician notes did not show any physician review of UA results. Review of document Change in Condition 8/8/2024 10:33 am indicated Resident 12 had increased back pain and vaginal bleeding. Author of Change in Condition report was Director of Nursing (DON) who reported UA was neg for UTI, and there was no blood in urine. MD gave order to send to acute for evaluation and treatment if Resident 12 wanted to go. Resident 12 requested to be transported to hospital. Record review of Progress Notes 8/8/24 11:13 indicated Resident 12 transported to hospital. Record review of Emergency Documentation - MD 8/8/2024 15:09 indicated Resident 12 complained of bilateral flank (kidney) pain radiating to her pubic (vaginal) area with accompanying nausea for one week. Hospital UA confirmed presence of bacteria and blood in urine. Resident 12 was prescribed dose of Rocephin (antibiotic) with an outpatient prescription of Cefdinir (antibiotic) to be administered at facility upon discharge. Record review of Progress Notes 8/8/24 3:45 pm indicated Resident 12 returned from acute hospital. Provider at acute hospital prescribed antibiotics to treat UTI. MD was notified. Suprapubic catheter was changed while at acute hospital. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 8/8/2024 at 8:53 am, Certified Nurse Aide (CNA A) stated Resident 12 told her she was not feeling well this morning and she informed her licensed nurse. Observed Resident 12 sleeping in bed, lights out, curtains drawn around bed. CNA A stated Resident 12 will let staff know when she thinks she has a UTI. CNA A stated Resident 12 typically requested pain medication for headaches. CNA A stated Resident 12 could communicate needs and preferences adequately. During a concurrent interview and record review with DON on 8/9/2024 at 10:09 am, DON stated UA results not signed by MD. During a concurrent interview and record review with MD on 8/9/2024 at 11:25 am, MD stated it was the first time he saw Resident 12's UA results from 8/6/2024. MD confirmed UA results showed an infection. MD stated he would not treat the UTI infection with antibiotics solely based on the UA results unless there were accompanying symptoms and pain. MD stated he was not told by facility staff that Resident 12 had accompanying symptoms and pain. MD stated he did not know why DON would tell you guys the UA was negative. MD confirmed the results were not signed by him. MD stated he told facility to send Resident 12 to hospital for evaluation and treatment of possible UTI. During a concurrent interview and record review on 8/13/2024 at 8:41 am with DON, she stated facility received UA results on 8/7/2024 and faxed to MD. DON stated facility process for lab results are uploaded to the resident's chart when signed by MD. DON stated MD saw UA results and told her it was negative. DON stated she read Resident 12's UA results to MD and faxed results to him. DON stated she was surprised MD denied seeing results. DON stated she did not know that results were not signed by MD. During a concurrent interview with Social Services Director (SSD) on 8/13/2024 at 10:00 am, SSD stated she was unaware Resident 12 had a referral to urology upon admission. SSD stated care conferences are held quarterly and as needed. SSD stated residents have told her care conferences were inconsistent prior to her arrival.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50363 Based on observation, interview and record review, the facility failed to maintain acceptable parameters of nutritional status when staff did not identify insidious weight loss (gradual, unintended, progressive weight loss over time), implement, or modify a plan of care that was individualized and consistent with the resident's needs or preferences for one of two sampled residents (Resident 22). These failures resulted in severe weight loss and put Resident 22 at risk for further health decline. Refer to F 801. Findings: Record review of facility policy Weight Monitoring 2023 indicated: -Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. -Interventions will be identified, implemented, monitored and modified, consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. -Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following . o Identified causes of impaired nutritional status. o Reflect the resident's personal goals and preferences. o Identify resident-specific interventions. o Timeframe and parameters for monitoring. o Updated as needed such as when the resident's condition changes, goals are met, interventions are determined to be ineffective or new causes of nutrition-related problems are identified. o If nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate. o The resident and/or resident representative will be involved in the development of the care plan to ensure it is individualized and meets personal goals and preferences. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- A weight monitoring schedule will be developed upon admission for all residents. Residents with weight loss - monitor weight weekly. A significant change in weight is defined as 5% change in weight in 1 month (30 days). - The physician should be informed of a significant change in weight and may order nutritional interventions . if the interdisciplinary care team (IDT, a group of healthcare professionals who work together to treat a patient's condition or diagnosis) desires to explore specific meal consumption information for a resident, the Registered Dietician, Dietary Manager, or the nursing department may initiate this process .the registered Dietician or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress note. Record review of document Admission Record indicated that Resident 22 was initially admitted on [DATE] from a local assisted-living facility (a housing and care facility for people who need some assistance with daily activities but don't require nursing home care). Resident 22 had medical diagnoses that included: Cerebral infarction (stroke) affecting right dominant side with resulting weakness on one side of her body, mild cognitive (mental) impairment of uncertain or unknown etiology (origin), other seizures, anxiety disorder, encephalopathy unspecified (term used to widely define brain illness), and difficulty swallowing. Record review of document Nursing - Clinical Admission Evaluation 10/19/2023 indicated Resident 22 was cognitively intact (able to make needs known, able to follow simple commands, able to understand others) and had a good oral intake. Resident 22 was able to self-report her pain level. Resident 22 stated that she occasionally has pain in her right arm at level 3 (a pain rating scale from 0 to 10, where 0 is no pain, and 10 is the worst pain) and tingling at times. Resident 22 was able to feed herself, and her weight status listed as stable during past 3 months. Resident 22 ate 50-75% of most meals, with a fluid intake of 1000-2000 mL (milliliters, a unit of measure) daily, and consumed all snacks/supplements offered. Record review of Physician Diet Orders 10/19/2023 Resident 22 was on a regular texture, regular diet with no added salt, discontinued on 3/19/2024. Record review of document Weight Summary indicated Resident 22 weighed 153.4 pounds upon admission on 10/19/2023. Record review of document Care Plan 10/20/2023 indicated weekly weights until stable, then weigh monthly. Weight management team would follow Resident 22 as needed. One documented IDT Weight meeting occurred on 8/12/2024. Record review of document Minimum Data Set (MDS, resident assessment) MDS - Section C 10/31/2023 indicated that Resident 22's brief interview for mental status (BIMS) score was 6 (severely cognitively impaired) on a scale of 0 to 15, where 0 is completely impaired and 15 is unimpaired. MDS - Section B 10/31/2023 indicated that Resident 22 had clear speech and was able to communicate her needs to others. Review of document Weight Summary indicated Resident 22 weighed 152.0 pounds on 10/23/2023 and 152. 8 pounds on 10/30/2023. (continued on next page)

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Shasta View Care Center	1795 Walnut Street Red Bluff, CA 96080

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Record review of document Food Nutrition Services Evaluation - 10/27/2023 3:17 pm indicated that Resident 22's intake upon admission was near high end of 0-25% and low end of 26-50% ranges for meals with less than adequate intake. Registered Dietician (RD 1) recommended dietary manager visit Resident 22 to obtain her preferences and add 4 ounces of nutritional shake to add calories to Resident 22's intake twice daily. A review of Resident 12's physician orders and care plans indicated no orders placed to add 4 ounces of house supplement (nutritional shake that adds calories to person's intake) from 10/19/2023 to 8/9/2024. Record review of document IDT - Care Conference Summary 10/27/2023 indicated Resident 22's weight was 152.0 pounds, fair oral intake, weight stable. Resident 22 was not on special assistance with dining. Resident 22 was happy to be at facility and had no further concerns. Record review of document Progress Note 11/2/2023 11:30 am Entered by licensed nurse on 8/16/2024 at 3:02 pm, indicated a new order for 4 ounces of house supplement order twice a day was received. Record review of orders showed no order for house supplement shakes entered. RP (responsible party) was made aware. Record review of document Weights Summary indicated on 11/6/2023, Resident 22 weighed 151.0 pounds, a loss of 1 pound from 10/23/2023. Record review of document Weight Summary indicated Resident 22 was not weighed in December 2023. Record review of document Weight Summary indicated on 1/4/2024, Resident 22 weighed 141.0 pounds, which is a -6.62 % loss, a 10-pound loss (significant weight loss). Record review of document Weight Summary indicated Resident 22 weighed 140.0 pounds on 2/9/2024, down one pound. On 3/5/2024, Resident 22 weighed 139.0 pounds, down one pound. Record review of Food and Nutritional Services 2/23/2024 indicated by Unqualified Dietary Manager (UDM) a 7.5% weight loss, no physician notification, and no new interventions. Record review of document Progress Notes and type Social Service Evaluation 3/27/2024 indicated Resident's ability to communicate is impaired. Communication: Verbal, picture book. Resident is unable to communicate needs. Resident is not on hospice services (care for the terminally ill). Record review of Physician Readmission Diet Orders 3/28/2024 indicated small portions, pureed texture, nectar-thick liquids (fluids thickened to a nectar consistency), discontinued 4/19/2024. Record review of document Care Plan 3/28/2024 indicated Resident 22 had a communication problem related to dentition problems (missing or broken teeth) and neurological (cognitive) symptoms. Resident 22 would be able to make basic needs known by answering yes or no questions and using picture communication on a daily basis. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Record review of document Progress Note 4/11/2024 13:53 RD indicated Resident 22 had a gradual weight loss since October 2023. RD documented Resident 22's intake was 75% of meals with small portions. RD recommended discontinuing small portions to promote weight stabilization and ordered weekly weights for 4 weeks to monitor weight. Record review of document Weight Summary indicated Resident 22 weighed 135.0 pounds on 4/2/2024, 134. 7 pounds on 4/8/2024, 129.0 pounds on 4/22/2024, and 132.0 pounds on 5/1/2024. Review of document Physician Diet Orders 4/19/2024 indicated Resident 22's current diet order was a regular diet, puree texture, honey-thick (fluids thickened to a honey consistency) liquids consistency, and fortified (additional calories added) for trouble swallowing. No further physician diet orders found past this date. Record review of document Progress Note - Dietary Note 4/30/2024 by Assistant Director of Nursing (ADON) indicated RD was consulted and a new order for fortified meals due to poor oral intake. Record review of document Documentation Survey - Amount Eaten April 2024 indicated 18 meals out of 90 meals were not documented. A review of a policy titled Change in a Resident's Condition or Status, revised February 2021, indicated the nurse will notify the resident's attending physician if a significant change in the resident's physical/emotional/mental condition; a significant change of condition is a major decline that will not normally resolve itself without intervention and requires interdisciplinary review and/or revision of care plan. Record review of document IDT - Care Conference Summary 5/2/2024 indicated Resident 22's weight was 132.0 pounds. A weight loss of 10% over 180 days was identified. Resident 22 was eating 76-100% of her meals. Resident was working on trials to upgrade diet with additional assistance. Diet orders were listed as regular, puree, honey-thick liquids, no fortified meals, or health shakes. Present at care conference were Resident 22, the responsible party, Social Services Director, and UDM. No change in dietary orders. This was the last documented IDT Care Conference. There was no indication physician was notified, plan of care remained the same. Record review of document Speech Therapy Evaluation and Plan of Treatment 5/2/2024-6/26/2024 indicated that Resident 22 rarely could express ideas and wants. No interventions or treatments were indicated. Record review of document Weight Summary indicated Resident 22 weighed 133.0 pounds on 6/3/2024 and 6/12/2024. Record review of document Weight Summary indicated on 7/2/2024, Resident 22 weighed 130.0 lbs, a 3-pound loss. Record review of document Progress Notes and type Social Service Evaluation 7/9/2024 indicated Resident 22 was nonverbal and required a picture book to communicate. Resident 22 was unable to communicate her needs. Resident 22 was not on hospice services. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Record review of document Progress Note 7/27/2024 11:33 pm indicated Resident is on comfort measures (medical treatments that allow a dying person to naturally pass away while still being as comfortable as possible) and is not eating and not drinking much fluids, resident was agitated this evening shift and was medicated per MD order with good results noted. Record review of document Progress Note 7/28/2024 1:17 am indicated Resident 22 recently returned from the hospital. Record stated Resident 22 on comfort care and is declining. Resident is taking some fluids but not eating any food. Record review of document Progress Notes and type Social Service Evaluation 8/1/2024 indicated Resident's ability to communicate is impaired. Communication: Verbal, picture book. Resident is unable to communicate needs. Resident is not on hospice services. Record review of document Weight Summary indicated on 8/9/2024, Resident 22 weighed 119.0 pounds, which is a -8.46 % loss from 7/2/2024 to 8/9/2024. During an interview with Durable Power of Attorney (DPOA - care only) on 8/7/2024 at 12:35 pm, she stated she was not sure how aware resident was of her preferences. DPOA stated Resident 22 does not eat too much, and has lots of UTIs, which cause seizures, which leads to her eating less. DPOA stated she thought Resident 22 received more liquid type food when she ate. DPOA stated Resident 22 preferred nutritional shakes, but she is unsure if Resident 22 could communicate when she wanted one. DPOA stated Resident 22 needed a picture board to point to pictures to adequately communicate what she wanted. DPOA stated she was concerned with Resident 22's current weight status. DPOA stated she rarely spoke with facility or received updates. During an observation on 8/7/2024 at 3:00pm, unable to locate communication picture book in Resident 22's side table, on top of side table, or in room. No fall mat observed. Observed resident rubbing her head with left hand, mouth gaping. Resident 22 made eye contact when requested. Resident 22 was unable to communicate yes or no verbally or physically when asked to raise hand for yes keep hand down for no. During an interview with DPOA on 8/7/2024 at 3:39 pm, DPOA stated she did not speak to facility regarding transitioning to comfort-focused treatment. DPOA stated she could not define what comfort-focused treatment meant. DPOA stated I just want what's best for her, but I think she'd prefer to be alive . DPOA stated I know she has these seizures when she has a UTI, but then she gets antibiotics and gets better, and I know that's what she would want. A review of a job description for Dietician dated 2023, indicated the RD was responsible for planning, organizing, developing, and directing the nutritional care of the resident in accordance with current federal, state, and local standards, guidelines and regulations. Performs regular inspections of food service areas for sanitation, order, safety, and proper performance of assigned duties. Monitors residents for weight changes, nutrition support, and makes recommendations as needed. Participates in inspections surveys, ensuring compliance with nutritional and dietary policies. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review with Registered Dietician (RD) on 8/9/2024 at 3:40 pm, RD stated Resident 22 was on altered textures. Thickened liquids, and small portions were discontinued. RD stated she stabilized around April 2024, but had a history of going in and out of the hospital. RD stated he could not get weight committee meetings on time during time frame when Resident 22 was losing weight. RD stated weight meetings restarted when current Director of Nursing (DON) was hired at facility in April 2024. RD stated issue is when someone goes in and out of hospital, orders don't get restarted. RD stated he would not restart orders because I don't like to restart what they're currently on. I like to have a blank slate. RD stated accuracy of Activities of Daily Living (ADL) charting was hit or miss. RD stated Resident 22 was eating 75% or more. RD stated his process was to look at intakes in chart, and follow-up with staff to determine if residents were eating well. RD stated if resident was stable then he assumes they're eating. RD stated he was not a proponent of nutritional supplements. RD stated if he wanted to, he could make recommendation for nutritional supplements. RD stated even if a resident was on comfort care, they are not weighed weekly. RD stated he would expect a monthly weight for Resident 22. RD stated the expectation was for staff to document if any resident refused weight checks. RD stated at beginning of [AGE] year, we had a DON that didn't want to be involved in my work so a lot of it were my own findings. During an observation on 8/8/2024 at 12:30 pm, observed Resident 22 in dining room being fed by CNA A. Observed Resident 22 fidgeting with her hair with left hand, and brushing top of her head. CNA A stated Resident 22 was not eating like normal. CNA A stated Resident 22 usually grabbed the CNA's hand with spoon in it and guided the spoon to her own mouth. CNA A stated Resident 22 appeared extra fidgety. Observed Resident 22 unable to verbally communicate needs. Review of document IDT - Weight Meeting 8/12/2024 indicated Resident 22's weighed 119.0 pounds, 14 pounds in 2 months, 10.5% weight loss, supplement/nourishment house shake (nutritional supplement) TID (three times a day), and interventions house shakes, weekly weights. This was the only documented IDT Weight Meeting. During an interview with DON on 8/13/2024 at 9:25 am, DON stated she met with IDT weight committee every Thursday. DON stated she met with CNA B to identify who was at risk for weight loss when DON started employment at facility in April 2024. DON stated an IDT weight meeting was held on 8/12/2024 for Resident 22. DON stated that on comfort care, a resident is expected to lose weight and decline. DON stated she could not define facility standard for comfort care. DON stated she needed to read the facility comfort care policy before she could explain what it meant. DON stated Resident 22 was uncomfortable when she was fidgety. DON stated this was exhibited by Resident 22 pulling at her blanket and messing with her hair. DON stated the last care conference with DPOA was May 2024. DON stated care team would have another care conference with DPOA due to recently identified weight loss on 8/9/2024. DON stated Resident 22 on weekly weights for the next 4 weeks. DON stated meal intake slips were put in her box to ensure that the meal percentages were accurate in the documentation. DON stated Director of Staff Development (DSD) completed education with CNA new hires to make sure they are accurately charting meal percentages. During an interview on 8/13/2024 at 10:00 am, Social Services Director (SSD) stated Resident 22 does not communicate, is nonverbal and has been nonverbal since SSD began employment at facility in April 2024. SSD stated at last care conference on May 2, 2024, weight loss was identified. SSD stated there was a 10% weight change in 150 days with a plan to continue to monitor and no urology note. No new interventions or treatments documented. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a record request from facility on 8/14/2024 at 5:10 pm for Comfort Care policy, facility replied with Use hospice policy. Hospice Foundation of America (HFA) defined hospice as: Medical care for people with an anticipated life expectancy of 6 months or less, when cure isn't an option, and the focus shifts to symptom management and quality of life. An interdisciplinary team of professionals trained to address physical, psychosocial, and spiritual needs of the person; the team also supports family members and other intimate unpaid caregivers. HFA further stated that hospice is not A replacement for nursing home care or other residential care. https://hospicefoundation.org/Hospice-Care/Hospice-Services) National Cancer Institute defined comfort care as: The goal of comfort care is to control pain and other symptoms so the patient can be as comfortable as possible. (https://www.cancer.gov/search/results?swKeyword=comfort+care).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43739 Based on interview and record review, the facility failed to provide sufficient nursing staff for the first and second quarters of the year of 2024. This failure had the potential to result in the facility to not provide necessary care and services to meet the need of the resident, and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings: During a review of the facility mandatory submission of staffing information based on payroll data - the Payroll-Based Journal (PBJ- was created by The Centers for Medicare & Medicaid Services (CMS) as a method to collect auditable and verifiable staffing data from nursing facilities. PBJ reporting is a requirement of all long-term care facilities to promote accountability and consistency), indicated: 1. In the first quarter of 2024, dated 10/1/23 to 12/31/23, the facility failed to have Licensed Nursing Coverage 24 hours/Day on 10/28/23, 11/4/23, 11/5/23, 11/11/23, 11/16/23, 11/23/23, 11/25/23, 11/26/23, 12/9/23, and 12/25/23. 2. In the second quarter of 2024, dated 1/1/24 to 3/31/24, the facility failed to have Licensed Nursing Coverage 24 hours/Day on 1/6/24, 1/7/24, 1/13/24 and 3/9/24. During a concurrent interview and record review with the administrator (ADMIN) on 8/6/2024 at 10:30 am, PBJ report for the first and second quarters of the year of 2024 was reviewed, the ADMIN stated, We reported it to CMS, I submitted the nursing staff data to them, I am not going to argue about it.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43739 Based on interview and record review, the facility failed to ensure an Registered Nurse (RN) was on duty at least eight consecutive hours a day, seven days a week for the first and second quarters of the year of 2024. This failure had the potential to result in the facility to not provide care and services to meet the residents' needs for nursing care in a manner and in an environment which promoted each resident's physical, mental, and psychosocial well-being, thus enhancing their quality of life. Findings: During a review of the facility mandatory submission of staffing information based on payroll data - the Payroll-Based Journal (PBJ- was created by The Centers for Medicare & Medicaid Services (CMS) as a method to collect auditable and verifiable staffing data from nursing facilities. PBJ reporting is a requirement of all long-term care facilities to promote accountability and consistency), indicated: 1. In the first quarter of 2024, dated 10/1/23 to 12/31/23, the facility failed to have RN hours on 10/21, 10/22, 10/28, 10/29; 11/04, 11/5, 11/11, 11/12, 11/15, 11/16, 11/17, 11/18, 11/19, 11/20, 11/21, 11/22, 11/23, 11/25, 11/26; 12/01, 12/02, 12/03, 12/04, 12/05, 12/08, 12/09, 12/10, 12/11, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18, 12/19, 12/23, 12/24, 12/25. 2. In the second quarter of 2024, dated 1/1/24 to 3/31/24, the facility failed to have RN hours on 1/13, 1/27, 1/28, 2/03, 2/04, 3/17. During a concurrent interview and record review with the administrator (ADMIN) on 8/6/24 at 10:30 am, PBJ report for the first and second quarters of the year of 2024 was reviewed, the ADMIN stated, we reported it to CMS, I submitted the nursing staff data to them, I am not going to argue about it.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview, and record review the facility failed to ensure social services met the needs for four of 12 sample residents (Resident 6, 8, 12, and 303) when: 1. Weekly telehealth psychic assessment and evaluation was ordered for Resident 6. This had the potential that mental health resources were overused and wasted, and unnecessary medical treatment was provided to Resident 6 who did not exhibit any behavior issue. 2. Quarterly care conference was not arranged for Residents 8. This failure resulted in Residents 8 missing the opportunities to discuss and express the concerns related to the care Resident 8 had received. 3. Discharge Care Planning was not developed for Resident 303. This had the potential for Resident 303 to not be emotionally prepared for discharge. 4. Urology consult was not arranged for Resident 12. This had potential for further infections and complications related suprapubic catheter (a hollow flexible tube that is used to drain urine from the bladder through a cut in the abdomen). Findings: During a review of the facility job description titled, Social Services Director (SSD), no revised date provided, indicated: - The SSD is responsible for overseeing the development, implementation, supervision, and ongoing evaluation of the Social Services Department designed to meet and assist residents in attaining or maintaining their highest practicable well-being. This includes identifying the need for medically related social services and ensuring that these services are provided in accordance with State and Federal regulations. - The SSD will contribute to and/or direct/delegate contribution of social services goals and approaches to the comprehensive care plan. These goals and interventions will be individualized to match the skills, abilities, and interests/preferences of each resident in compliance with Federal and State regulations, to include identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident. -The SSD will facilitate residents' safe transition back into the community through interdisciplinary discharge planning arrangement of community-based services and follow-up care. -The SSD participates in Resident and/or Family Council and needed or requested. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 6's clinical record, indicated that Resident 6 was admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (Dementia is a mental disorder that can cause people to lose their ability to think, learn, remember, make decisions, and solve problems. Dementia without behavioral disturbance is a dementia diagnosis that doesn't include behavioral symptoms), hypothyroidism (a condition where the thyroid doesn't create and release enough thyroid hormone into the bloodstream, makes the metabolism slow down), and shortness of breath. There were no diagnoses with behavioral issues noted. Resident 6 was not her own health care decision maker. During a review of Resident 6's Minimum Data Set (MDS - an assessment and care screening tool) at section C - Cognitive Pattern, and section E - Behavior, indicated: - On 12/3/2023, Resident 6 had a Brief Interview for Mental Status (BIMS) score of 2, suggesting that Resident 6's cognition was severe impaired. - On 5/8/2024, Resident 6 had a BIMS score coded as 99, indicated that Resident 6 was unable to complete the interview. - On 12/3/2023, Resident 6 had behavior assessment done, and indicated that Resident 6 did not exhibit any behavior symptoms. - On 5/13/2024, Resident 6 had behavior assessment done, and indicated that Resident 6 did not exhibit any behavior symptoms. During an interview on 8/8/2024 at 11:16 am with the Family 1, the Family 1 stated that Resident 6 had been in the facility since 11/2023, and the resident had advance dementia, the Family 1 said, They ordered psychiatric exam for her, she is [AGE] years old! I just wanted her to have peace and quiet day before she dies. I questioned it, but they still ordered it. I had never gotten an answer back. The only answer I got, was well, we do that for everybody there ., for no reason whatsoever. I got to talk to the psychologist, she told me, We interviewed her every week . I don't know how she could get her to talk, when I went to see her, most of the time, she just laid/or sat there, and did not say a word . During a concurrent interview and record review on 8/8/2024 at 1:10 pm with Licensed Vocational Nurse (LVN) B, Resident 6's physician order was reviewed. LVN B stated that she took care of Resident 6 very often, 5 days/a week, and she had not noticed that Resident 6 had any behavioral issues. LVN B confirmed that Resident 6 was not taking any psychotropic medication, and LN B was not aware that Resident 6 had been seen by a psychologist weekly. LVN B stated, I don't know why she would have the psychological interview. During a concurrent interview and record review on 8/9/2024 at 11: 07 am with the Medical Director (MD), Resident 6's medical diagnoses and physician order were reviewed. the MD stated that Resident 6 had diagnoses with dementia, but, no behavioral issue, and was not taking any medication related to behavioral issue, Resident 6 did not need psychological evaluation. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/9/2024 at 12:43 pm with the SSD, Resident 6's medical diagnoses, social services progress notes and psychological evaluation notes were reviewed. When asked the reason that psychological evaluation was arranged for Resident 6, the SSD stated, I thought Resident 6 had anxiety. After reviewing Resident 6's medical diagnoses, the SSD stated, I was mistakenly thinking that Resident 6 had anxiety. The SSD confirmed that Resident 6 did not have anxiety, and Resident 6 started had started seeing the psychologist weekly since 5/2024. The SSD was unable to identify the indication of Resident 6 periodically seeing a psychologist. 2. During a review of Resident 8's clinical record, indicated that Resident 8 was admitted to the facility on [DATE] with diagnoses which included quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), diabetes (high blood sugar), and chronic obstructive pulmonary disease (a common, progressive lung disease that damages the airways or other parts of the lungs, making it difficult to breathe). Resident 8 was her own health care decision maker. During a review of Resident 8's MDS at section C - Cognitive Pattern, dated 5/13/2024, Resident 8 had a BIMS score of 14, indicated that Resident 8 was cognitively intact. During an interview on 8/13/2024 at 12:10 pm, with Resident 8, Resident 8 stated she did not recall ever had care conference. During a concurrent interview and record review on 8/13/2024 at 12:37 pm with the SSD, - The SSD stated that a care conference would be held for each resident during the admission, and quarterly. - Resident 8's social service progress note, dated 5/17/2024 at 1:37 pm, was reviewed. The note indicated that Resident 8 refused to attend the care conference, and the SSD's note indicated that she will attempt to schedule another care conference at a later date. However, the SSD was not able to confirm that for a period of three months, a care conference had ever been scheduled for Resident 8 since 5/17/2024. - The SSD stated that she was not sure whether she should reschedule it or just schedule the next quarter care conference for Resident 8. - The SSD also stated that if a resident refused to attempt the care conference, they just canceled the care conference, because the resident had the right to refuse, and the team won't continue with the care conference. While asked how the disciplinary team communicate with each other to ensure that the resident had the care they need if the care conference was canceled. The SSD answered, that is a good question. 43755 3. A record review of Resident 303's Admission Record (undated), indicated Resident 303 was originally admitted on [DATE] and then readmitted on [DATE] after a brief hospital stay. Resident 303's diagnoses included fracture (broken bone) of right leg, lung disease, muscle weakness, anxiety disorder, dependence on oxygen, and depression. (continued on next page)

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	055489	A. Building B. Wing	08/15/2024

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 303's Physician Orders dated 8/9/24, indicated Resident 303 could understand rights, responsibilities, and informed consent. During an interview on 8/6/24 at 3:42 am, Resident 303 indicated she had not talked with anyone about a care plan or what her discharge plans were, and she wanted to. During a concurrent interview and record review on 8/9/24 at 3:40 pm, with the SSD, Resident 303's care plan was reviewed. SSD indicated there was no Discharge Care Plan developed for Resident 303 and there should have been. The SSD stated, I would expect to have this done within the first 72 hours of admission and discussed with her (Resident 303). It (Discharge Care Plan) should have absolutely been in (developed) and it was not. I could be more organized. The SSD indicated the Discharge Care Plan informed everyone what the discharge plan was for Resident 303 to help her achieve her goal. 50363 4. During a review of Resident 12's admission record, indicated Resident 12 was admitted on [DATE] with diagnoses that included type 2 diabetes (high blood sugar), epilepsy (seizures), neuromuscular dysfunction of bladder (nerves and muscles of urinary systems do not work together due to damage to the nervous system), and suprapubic catheter. Review of document Orders 12/14/2023 indicated an active order for Resident 12 to receive a urology consult evaluation and treatment with follow up as indicated. No further documentation noted to show a consult occurred. Review of document Care Plan 1/1/2024 indicated Resident 12 had an indwelling suprapubic catheter due to neuromuscular dysfunction of her bladder. Resident 12's care plan indicated urology eval and treatment with follow up appointments as indicated. There was no indication of a urology referral or consult for Resident 12. Review of document IDT - Interdisciplinary Post Event Note 7/29/2024 indicated medications were reviewed, no urology consult discussed. Review of document IDT - Interdisciplinary Post Event Note 8/7/2024 indicated redness to abdominal fold, no urology consult discussed. During a concurrent interview and record review with SSD on 8/13/2024 at 10:00 am, SSD stated she was unaware Resident 12 had a referral to urology upon admission. SSD confirmed there was no documentation found in the record that Resident 12 had a urology consult.

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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** 43755 Based on observation, interview, and record review, the facility failed to ensure pain medication was administered as per physician order for one of nine residents (Resident 303), sampled for medication administration, when gabapentin (a pain medication) was not administered as prescribed by the physician. This failure placed Resident 303 at risk for poor pain control and a decrease in health and well-being. Findings: A review of the facility's policy titled, Medication Administration (undated), indicated Medications are administered by licensed nurses . as ordered by the physician and in accordance with professional standards of practice A record review of Resident 303's Admission Record (undated), indicated Resident 303 was originally admitted on [DATE] and then readmitted on [DATE] after a brief hospital stay. Resident 303's diagnoses included fracture (broken bone) of right leg, lung disease, muscle weakness, anxiety disorder, dependence on oxygen, and depression. During a concurrent observation and interview, on 8/8/24 at 8:18 am, Licensed Vocational Nurse (LVN) B was observed dispensing medications to Resident 303. LVN B obtained a medication blister card (A ridged card that has a see-through plastic film over the front, forming a bubble-shaped space for holding a drug) that had Resident 303's gabapentin's pills in it. The pharmacy label instructions on the blister card indicated to give gabapentin capsule 100 mg (milligrams, a form of measurements) by mouth every 8 hours. The Medication Administration Record (MAR, an electronic version of the report that serves as a record of drugs administered to a patient.) indicated to give gabapentin capsule 100 mg by mouth every 4 hours. LVN B confirmed that the pharmacy label and the MAR instructions were not the same and they should be. LVN B indicated the gabapentin order should be clarified by the physician due to the discrepancy. A review of Resident 303's Interfacility Transfer Report (admitting Physician Orders received from the hospital) dated 7/3/24, reflected a Physician Order for gabapentin 100 mg capsule by mouth every 8 hours. A review of Resident 303's transcribed (to transfer data from admitting orders to the facility computer system) Physician Order dated 7/3/24, reflected an order for gabapentin oral capsule 100 mg, give 1 capsule three times a day for neuropathy (weakness, numbness, and pain, usually in the hands and feet). Gabapentin was scheduled to be given at 8:00 am, 12:00 pm, (4 hours apart) and 8:00 pm.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and record review, the facility failed to store drugs under proper temperature controls and failed to label drugs in accordance with professional standards when: 1. The medication room (where medications were stored) had temperatures that exceeded manufacturer's recommendations. This failure had the potential to compromise the medications stored in the medication room. 2. One of nine resident's (Resident 302), sampled for medication administration, had physician's instructions on the Medication Administration Record (MAR) for potassium chloride to be given with a full glass of water and the pharmacy label instructions for administration of the medication to be given with food. This failure had the potential for Resident 302 to experience abdominal discomfort if potassium chloride was not given as indicated by the manufacture instructions. Findings: 1. A review of the facility's policy titled, Medication Storage (undated), indicated It is the policy of this facility to ensure all medication housed on our premises will be stored in the pharmacy and or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. During an observation on 8/8/24 at 9:43 am, with the Clinical Resources Nurse Consultant (CRNC), the medication storage room was inspected. There was a portable air conditioner in the room blowing cold air and a vent on the ceiling was blocked with a cover. The room temperature was 70 degrees Fahrenheit (F). Medication instructions were inspected for four Naloxone HCL (emergency treatment of opioid overdose) nasal Sprays 4 mg (milligrams a measurements), 20 Nicotine (medication to treat nicotine addiction) 14 mg patches, four Athletes Foot Cream (Terbinafine Hydrochloride Cream 1 %) and four Hemorrhoidal (to treat swollen, painful areas of the rectum) ointment. The instructions indicated to store at temperatures between 68 F. to 77 F. During an interview and record review on 8/8/24 at 10:01 am, the facility's document titled Medication Room Temperature Log for August, was reviewed with the CRNC. The August temperature log indicated that the temperatures in the storage room should be maintained from 68-77 F. The CRNC confirmed that the temperature log identified that the medication storage room temperature from 8/1/24 through 8/7/24 ranged from 78 - 82 F. for all 7 days. The CRNC confirmed that these temperatures were above the required temperature for the medication room. During an interview on 8/8/24 at 10:17 am, the Pharmacist (Pharm) indicated that the above-mentioned medications were stored at temperatures that were out of compliance and should be disposed of. The Pharm indicated the efficacy (effectiveness) of the medication could not be guaranteed because they were not stored at the required temperature. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 11:37 am, Licensed Vocational Nurse (LVN) B indicated it had gotten warm in the medication storage room during the middle of the day. During an interview on 8/8/24 at 11:55 am, the Maintenance Supervisor (MS) indicated he had not checked the temperatures in the medication storage room, but he thought the nurses did. The MS indicated he had done some work on the heating and air conditioner system in there recently. During an interview on 8/8/24 at 11:58 am, the Director of Nursing (DON) indicated that two to three weeks ago it was identified that the medication storage room was too hot, so she asked the MS to do some work in there and cover the vent that was blowing out warm air into the medication storage room. During an interview on 8/8/24 at 12:00 pm, the CRNC indicated the air conditioner was put in the medication room sometime that week. She was unsure of the day. During a review of the facility's documents titled, Medication Room Temperature Log for June 2024 and July 2024, the logs identified that there were temperatures ranging from 78 - 88 F, recorded every day, from 6/21/24 to 7/31/24, a total of 41 out of 41 days. 34 of those days it was 80 F and over. 2. During a review of the facility's policy titled, Labeling of Medications and Biological's (undated), the policy indicated All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. During a review of the Internet site Drugs.com, review date 2/26/23, the manufacture instructions for potassium chloride (a medication to treat low potassium in the blood) was reviewed. The instructions indicated Take with meals and with a glass of water or other liquid. This product should not be taken on an empty stomach because of its potential for gastric (stomach) irritation. A review of Resident 302's Admission Record, undated, indicated Resident 302 was admitted on [DATE] with diagnoses including Gastro-Esophageal Reflux Disease (stomach acid flows back up into the esophagus [the tube that carries food from mouth to stomach] causing irritation and damage), depression and heart disease. A review of Resident 302's Physician Orders dated 8/7/24, indicated an order for Potassium Chloride Give 1 tablet by mouth one time a day for supplement. Administer with a full cup of water. During an observation and interview on 8/8/24 at 7:53 am, LVN B was observed dispensing potassium chloride for Resident 302. The MAR's (Medication Administration Record) instructions (the MAR instructions come directly from the Physician orders) indicated to give potassium chloride with a full glass of water. The pharmacy label on the medication packaging indicated to give potassium chloride with food and no mention of water. LVN B indicated she was unaware that this medication had to be given with food because she had not noticed the label instructions. LVN B indicated this was a discrepancy with instructions between the Physician Order and the Label on the medication packaging from the pharmacy and the instructions should have been the same. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 8/9/24 at 4:30 pm, the DON indicated their system for imputing orders will automatically populate for potassium to be given with a full glass of water, but it did not automatically populate the instructions to give with food. The DON confirmed that the pharmacy recommends potassium chloride to be given with food and does not say anything about water.

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and record review the facility failed to ensure a full time Registered Dietician (RD) or a clinically qualified nutritional professional (CDM) to provide direct oversight of dietary staff to deliver safe and sanitary food service for 49 of 49 residents when: 1. Dietary staff did not follow safe and sanitary food service practices. Refer to F 802 and F 812. 2. RD, Unqualified Dietary Manager (UDM), and CDM did not ensure all dietary staff had required state and federal competencies to work in the kitchen upon hire. Refer to F 802 3. RD did not ensure all identified issues in the kitchen/sanitation audits were acted upon and resolved. Refer to F 812 4. RD, UDM, and CDM members of the facility weight committee, did not ensure one of two residents (Resident 22) reviewed for weight loss, received interventions to prevent severe weight loss. Refer to F 692. These failures resulted from lack of qualified oversight to do daily kitchen inspections, provide feedback to staff, ensure staff is doing their job which had the potential to cause foodborne illness to 49 of 49 residents who were medically compromised. An Immediate Jeopardy situation (IJ, a situation in which facility noncompliance has placed the health and safety of a resident at risk for serious harm, injury, serious impairment or death) was declared on 8/6/2024 at 12:40 pm in the presence of Administrator 1 (ADMIN), Director of Nursing (DON), Certified Dietary Manager (CDM), Clinical Resources Nurse Consultant (CRNC) and Governing Body (GB) for not having full-time, competent oversight in the Food and Nutrition department which left staff, who were not competent or with the skill sets to carry out to the necessary tasks within the department safely. An acceptable plan of removal was provided by the ADMIN on 8/9/2024 at 5:30 pm which included hiring a full time qualified CDM to provide supervision to Food and Nutrition services staff starting in the afternoon on 8/7/24, plans to repair the freezer/dishwasher, remove all food that had potential to cause food borne illness, buy 2 freezers and train all dietary staff in dietary policies and procedures. During an onsite verification on 8/8-8/9/24, the IJ was removed on 8/9/2024 at 6 pm. Findings: (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a review of the Food and Drug Administration (FDA) Federal Food Code 2022, indicates Except as specified in (B) of this section, the permit holder (entity that: (1) Is legally responsible for the operation of the food establishment such as the owner, the owner's agent, or other person; and (2) Possesses a valid permit to operate a food establishment) shall be the person in charge or shall designate a person in charge and shall ensure that a person in charge is present at the food establishment during all hours of operation. Designation of a person in charge during all hours of operations ensures the continuous presence of someone who is responsible for monitoring and managing all food establishment operations and who is authorized to take actions to ensure that the Code's objectives are fulfilled. During the day-to-day operation of a food establishment, a person who is immediately available and knowledgeable in both operational and Code requirements is needed to respond to questions and concerns and to resolve problems. In addition, The designated person in charge who is knowledgeable about foodborne disease prevention, Hazard Analysis and Critical Control Point (HACCP) principles, and Code requirements is prepared to recognize conditions that may contribute to foodborne illness or that otherwise fail to comply with Code requirements, and to take appropriate preventive and corrective actions. During a review of the FDA Food Safety.gov, last reviewed July 2020, the document indicated, Good food safety practices are vital in long term care facilities, as seniors are at an increased risk for hospitalization and death from foodborne illnesses. Seniors living in nursing homes face 10 times the risk of dying from bacterial gastroenteritis (an infection or inflammation in the stomach and intestine) than people in the community. The gastrointestinal tract (mouth, esophagus, stomach, and intestines) holds onto food for a longer period of time, allowing bacteria to grow. The liver and kidneys may not properly rid the body of foreign bacteria and toxins. The stomach may not produce enough acid. The acidity helps to reduce the number of bacteria in our intestinal tract. Underlying chronic conditions, such as diabetes and cancer, may also increase a person's risk of foodborne illness. 1. During a concurrent observation and interview on 8/6/24 at 9 am, during an initial tour of the kitchen, there were only two employees present, [NAME] (CK I) and Dietary Aide (DA H). There was no Certified Dietary Manager (CDM) present. CK I confirmed the garbage can top had dirt and it was not hands free. She confirmed you had to touch the top of the can to open and dispose of paper towels after washing hands at sink. -at 9:10 am observed dishwasher area had many dirty dishes with no active dishwashing happening. The dry storage area had multiple items without received dates or use by dates, for quick creamy wheat, sugar free individual sized grape jelly, dry breakfast cereals and ranch salad dressing. There was a dirty mixing bowl amongst the food in dry storage. -at 9:25 am CK I confirmed flies in the kitchen. A review of instructions titled Steps for 3-Compartment Washing dated 2023, posted to the far left of the sink area of the kitchen indicated there should be 3 sinks, one for washing, one for rinsing, and one for sanitizing. Sink Bay 1 for washing should have detergent (no amount listed) and hot water at a temperature of at least 110 degrees Fahrenheit (F). Sink Bay 2 clean and clear water with a temperature of at least 110 F. Sink Bay 3 add two ounces of sanitizer per 8 ounces of water, check with test strip sanitizer solution for 60 seconds must read 200-400 PPM. Immerse all wash items for one minute. The 3-compartment sink had colored lines where the water should be filled to. (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- at 9:15 am, DA H was observed washing dishes in a 3-compartment sink. DA H removed food from dirty plates, then started putting plates in first compartment filled with water, then moved the dishes to the middle sink (no water) and used the overhead hand faucet to rinse quickly then dip in sanitizer, then immediately put into drying rack. DA H was unable to verbalize the key steps to the 3-compartment sink. DA H did not know where to look to verify the correct sink set up. The instructions were to the left of the sink on a poster board, not in clear sight. DA H redemonstrated the procedure. Observed the middle Sink Bay 2 had no water up to the required line and DA H did not ensure the dishes were placed in the sanitizer sink for a full minute. DA H stated she had been doing this a few days since the dishwasher was not working. DA H was asked if she tested the water temperature of the water used in the sink or the sanitizer levels. DA H stated, I never do that. DA H had not tested the water temperature or sanitizer level, and there was no 3-compartment sink washing log to document the results. CK I was unable to verbalize the steps of the 3-compartment sink. CK I stated she had been off for the past three days. CK I and DA H both thought the dishwasher had been out about a week. DA H continued to clean the dirty dishes and took multiple food plate covers stacked together to the 3-compartment sink. DA H did not wash them one at a time. DA H confirmed the liquids could not touch all the surface areas doing it this way. - at 9:30 am, multiple delivery boxes in the refrigerator were not unpacked. Multiple undated items observed throughout the area, shredded white cheese, sour cream, and jelly. A 24-pound pork loin roast was completely soft to touch on lower rack defrosting dated 8/5/24 for meal 8/8/24. CK I warned the surveyors of fall risk due to liquids on the refrigerator and freezer floor. CK I did not know when this started or what the cause of the liquids on the floor meant. CK I confirmed the freezer temperature was 35 F, not at required temperature of 0 F or below. Freezer had items that were not hard to touch, ice cream, cheese, deli meat, and two 10 pound rolls of hamburger soft to touch. Melted liquids throughout the freezer floor. At 9:35 am, CK I had logged 0 F for the freezer. Asked how long freezer was out of range, she was unaware and had not contacted anyone about the issue, due to being unaware of the issue. -at 9:40 am, went to ADMIN and requested to speak with CDM. ADMIN stated he requested her to come to facility. ADMIN stated CDM works at another long-term facility 45 minutes away. -at 9:50 am, went back into the kitchen to have DA H test the level of sanitizer in the bucket. Returned to the kitchen with ADMIN and Plant Operation Supervisor (POS). Requested DA H to test the level of sanitizer in the bucket they use for sanitizing kitchen surfaces. DA H could not find the test strips or the instructions for the correct level of sanitizer parts per million (PPM). DA H was unable to verbalize or reference instructions on how long test strip needed to be submerged into the sanitizer. DA H put the test strip into the sanitizer, which indicated a bluish-purple which according to the instructions indicated more than 400 ppm (over the allowed limit). ADMIN and POS were both unaware that the walk-in freezer was not at the required temperatures. A review of refrigeration service company invoices dated 8/2/24, indicated the service call was that the walk-in freezer was too warm. Service to correct the issue with the defrost (free the freezer of accumulated ice) timer due to an evaporator (heat exchanger where the refrigerant circulating inside the refrigeration circuit absorbs the thermal energy from the environment, which is then cooled) coil having ice buildup. (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of of refrigeration service company invoices dated 8/3/24, indicated the service call was that the walk-in freezer temperature was 30 degrees F upon arrival and the freezer temperature when they left was 40 degrees F. The service call identified the defrost clock not energizing, evaporator needs to be replaced. Need to order new timer. During a concurrent observation and interview on 8/6/24 at 10:41 am, CDM was interviewed about all the findings in the kitchen. CDM confirmed she works part time at the facility in the dietary department on the weekends mainly. CDM stated she worked at another facility during the week, and it was very difficult with the long drive back and forth. CDM confirmed the previous UDM was not qualified, had been working there since January 2024. CDM stated she was hired part time in April 2024 due to the RD coming one to two days a week as needed. CDM confirmed they staff the kitchen traditionally one dietary aid and one cook. When inquired if that was enough with having no dishwasher, since the 3-compartments are a lot of work? CDM stated UDM was in dietary manager school, and she did not finish, and had been in the laundry department. CDM stated the problem with the walk-in freezer started on 8/2/24 and the issue was the defrost cycle and timer. CDM was here on the weekend 8/3-8/4/24. CDM confirmed the dishwasher thermostat (measures water temperature) was not working for about a week and a half and a new electrical breaker was needed to fix it. CDM confirmed no one notified her this morning the freezer was not to at the required temperatures. CDM confirmed the multiple items in the dry storage and refrigerator were not dated as per policy. CDM confirmed the walk-in freezer was not at required temperature, the ice cream, deli meat, two 10-pound hamburger package rolls were soft to touch and not frozen. CDM stated she cannot confirm the pork roast was frozen (hard upon touch) when put in refrigerator for defrosting. CDM stated she was not sure how often RD was onsite at the facility, and she has not seen him. CDM explained the RD comes as needed and should perform monthly kitchen/sanitation audits and mock survey to get ready for the recertification survey. CDM did not state what actions would be taken to resolve these issues. CDM stated she would talk to ADMIN about getting two freezers. During an interview on 8/8/24 at 12:30 pm, CDM was unable to find all the kitchen logs for monitoring temperatures for the refrigerator, walk-in freezer, dishwasher temperatures, and sanitizer testing for the months of January, February, and March of 2024. CDM confirmed the bluish-purple color of the test strip of the sanitizer bucket on 8/6/24, indicated the level was above the recommended 400 PPM testing strip. CDM stated this meant too much sanitizer and would want dietary staff to inform someone of this finding. CDM stated not having the freezer maintain temperatures put all residents at risk for food borne illness. CDM stated she has no clinical corporate dietary consultant available; they are to access the clinical nursing consultant. Tray line observation on 8/9/24: - at 10:25 am, CDM confirmed multiple flies in the kitchen. CDM stated the back screen door where there were gaps on the top and bottom of the door was just fixed. CDM stated these gaps allowed flies to enter the kitchen. - at 12:30 pm, observed CK F preparing peanut butter and jelly using #40 scoop. The scoop was not clean, it had a dried substance in the scoop. CK F confirmed it was dirty and removed the scoop from the area. -at 12:40 pm, CK J was plating food during tray-line, one of the lids had a black bug crawling on the inside, she removed lid. Flies were observed landing on resident food trays. (continued on next page)

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Shasta View Care Center	1795 Walnut Street Red Bluff, CA 96080

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-12:45 pm, DA G came in to get coffee for a resident and did not wash hands upon entering or leaving kitchen preparation area. A freezer repairman with hair/beard came in through the kitchen while CK J was preparing food, he did not have his hair or beard covered with a hairnet when he came in and out of the kitchen multiple times. 2. A review of a Dietary Manager job description dated 2022, indicated the minimum requirements include one of the following certifications as a dietary manager, food service manager national certification for food service management from national certifying body, associate degree or higher in food service management and has two or more years in the position of director of food and nutrition services in a nursing facility. Must also meet the State requirements for food service managers. Major duties include maintains clean and sanitary environment, oversees safe timely meal preparation and food storage. Trains and coach's employees that work in the dietary department. Ensures adequate staff. Supports Registered Dietician duties as needed. A review of dietary staff employee files indicated: -CDM 1 had a Date of Hire (DOH) of 9/26/23, terminated on 12/22/23. -UDM, was hired at the facility on 3/1/22, as the Director of Environmental Services. On 2/1/24, started as Dietary Supervisor in the kitchen. UDM had no required Food Handler certificate training. UDM had no verification of job competency verbal and or demonstration for the kitchen duties and equipment in the dietary department. UDM did not complete her required Dietary Manager training and was terminated 6/3/24. -CDM Date of Hire (DOH) 4/9/24, part time, then full time 8/7/24. CDM did not have required Title 22 (California State Regulations) six-hour CDM training until 8/3/24, four months after hire. A review of a Dietary Aide job description dated 2023, indicated the DA works with the facility's RD and CDM as necessary. DA provided assistance in all food functions as directed/instructed in accordance with established food policies and procedures. DA assisted in daily cleaning duties, washes and cleans utensils, dishes, and cooking items following policy and procedures. A review of a facility policy titled Demonstrating Food Safety and Job Competency for Food and Nutrition Services Employees Dated 2023, indicated each Food and Nutrition employee must be able to demonstrate competency in the food and safety principles and job skills the facility requires. Verification of demonstrated job and equipment competencies. The Director of Food and Nutrition Services or Registered Dietician will sign off each skill after demonstrated properly on the competency forms. -DA G had a DOH of 10/31/23, as an Environmental Services Laundry worker. DA G had the California Food Handlers Certification dated 8/29/22. DA G did not have any verification of job competency verbal or demonstration for the kitchen duties and equipment for the dietary department. -DA C had a DOH of 6/19/24. DA C had Food Handlers Certificate dated 8/8/24, two months after hire. DA C had Dietary Aide Competency Demonstration and kitchen equipment on 8/6/24, two months after hire. (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-DA H had a DOH of 4/15/24, had no Food Handlers Certificate in her file. DA H did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment for the dietary department until 8/6/24. -DA E had a DOH of 11/21/23, had no Food Handlers Certificate in her file. DA E did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment for the dietary department until 8/6/24. -DA D had a DOH of 10/20/23, had a Food Handlers Certificate dated 1/10/24, three months after hire. DA D did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment in the dietary department until 8/6/24. A review of a Dietary [NAME] job description dated 2023, indicated ensures prepares food in accordance with applicable federal, state, and local standards guidelines, regulations, and policies/procedures. Works with RD, CDM as necessary and implements changes as required. -CK F had a DOH of 7/24/24, had Food Handlers Certificate dated 7/26/24. CK F did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment for the dietary department until 8/6/24. -CK I had a DOH of 1/26/24, had Food handlers Certificate on 7/26/22, six months after hire. CK I did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment for the dietary department until 8/6/24, six months after hire. During a concurrent interview and record review on 8/13/24 at 12 pm, CDM confirmed the dietary personnel files did not have the required trainings and competencies. CDM confirmed she did not have the required 6-hour Title 22 CDM training until 8/3/24 of this year. 3. A review of a job description for Dietician dated 2023, indicated the RD was responsible for planning, organizing, developing, and directing the nutritional care of the resident in accordance with current federal, state, and local standards, guidelines, and regulations. Performs regular inspections of food service areas for sanitation, order, safety, and proper performance of assigned duties. Monitors residents for weight changes, nutrition support, and makes recommendations as needed. Participates in inspections surveys, ensuring compliance with nutritional and dietary policies. A review of a sanitation audit dated 2/14/24 at 10:44 am, and emailed to ADMIN and GB, the RD identified issues in the kitchen: -debris in kitchen drawers -mold found in ice machine -crumbs found in toaster -garbage dumpster open upon arrival -ice buildup on sprinkler pipe in walk in fridge (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-no received date on turkey in walk in freezer A review of an RD inspection of the kitchen on 5/1/24 at 8:29 pm, emailed to ADMIN and GB, indicated findings for the audit: -.gap under screen door in kitchen, this door will be an issue with flies as weather heats up. -oven is not working to heat foods up -steam table not working to keep food hot -old debris found in toaster -food left in microwave -garbage dumpsters were overfilled -logs not being used for sanitation buckets or for dishwasher -dishwasher not reaching temperature for rinse -supplies not being stored correctly in dry storage -gasket to fridge is not adhered to door -freezer has buildup of frost and ice -recipe for thickening liquids not followed -boxes stored on top shelves in dry storage no under 18 inches from ceiling A review of a follow up email dated 5/1/24 at 8:43 pm, written by RD and sent to ADMIN and GB indicated: -RD observed non-dietary staff seem to be coming into the kitchen walk around, grab items. Please ensure staff they must not cross the red line in the kitchen. -During my visits, Unqualified Dietary Manager (UDM) was found out on the floor, in her office, and not involved in the kitchen. UDM informed RD that she is still helping with housekeeping. UDM was the Director of Environmental Services prior to starting in kitchen 2/1/24. -RD wrote I am glad a CDM is coming in on the weekends to help with the kitchen. A review of sanitation findings on 5/30/24 at 8:41 am, emailed to ADMIN and GB, RD indicated: -no current CDM full time in kitchen -spider webs and fly in kitchen (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-gaps on bottom of door by manager's office -oven was dirty -debris on shelf above stove and toaster -steam table not working -kitchen drawers with utensils had debris -vents on air conditioner dirty -gaps in logs for sanitation bucket -no thermometer in dry storage area to monitor room temperatures -temperature in kitchen/storage area not being regulated -boxes stored on top shelves in dry storage no under 18 inches from ceiling -gaps in freezer log -ice buildup in freezer -staff not wearing facial hair net -staff not using gloves when getting ice throughout the facility -gaps in log with resident refrigerator and above 40 degrees Fahrenheit (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a concurrent interview and record review on 8/9/24 at 3:09 pm, RD stated he had been at the facility since it opened in October 2023. RD explained he comes to the facility in person based on needs of the kitchen and residents. RD stated he has a long drive and works for another facility as well. RD stated he comes to the facility usually one to two days a week, but it does vary based on the needs. RD stated the kitchen staff were struggling. RD stated he spent most of his time training new staff and correcting identified issues in the kitchen. RD stated it was always a challenge in the kitchen with UDM who was unqualified and in school. RD explained the facility did not have a consistent CDM and were struggling to find a qualified CDM. RD confirmed he suggested to the ADMIN about adding more staff for the kitchen since they could not keep up with the required tasks. RD stated the freezer and dishwasher had been an ongoing issue. RD stated he noticed a few months ago the freezer was staying at or below the required temperature and he had concerns then about food borne illness. RD stated he had concerns about sanitary and safe conditions in the kitchen due to dishwasher, freezer, multiple new staff and inconsistent CDM oversight. Reviewed RD's sanitation audits and he confirmed he only had three, for 2/14/24, 5/1/24 and 5/30/24. RD stated he could not provide any other kitchen audits due to mainly giving verbal reports not written. RD stated UDM was not in the kitchen in April 2024, no record of logging the required levels of sanitizer for the buckets (used to sanitize surfaces in kitchen), no logs for required temperature for dishwasher, supplies not being dated and stored correctly, gap in the back kitchen door which allows pests to enter kitchen, gaps in documenting freezer temperature on logs, and no qualified full time CDM to oversee the kitchen staff. RD was asked if any of these issues were being tracked and who was responsible for ensuring these were acted upon. RD stated the ADMIN was made aware. RD stated he struggled to keep the kitchen working. 4. Record review of facility policy Weight Monitoring 2023 indicated: -A weight monitoring schedule will be developed upon admission for all residents. Residents with weight loss - monitor weight weekly. A significant change in weight is defined as 5% change in weight in 1 month (30 days). -The physician should be informed of a significant change in weight and may order nutritional interventions .if the interdisciplinary care team desires to explore specific meal consumption information for a resident, the Registered Dietician, Dietary Manager, or the nursing department may initiate this process .the registered Dietician or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress note. Record review of document Weight Summary indicated Resident 22 weighed 153.4 pounds upon admission on 10/19/2023. Record review of document Weight Summary indicated on1/4/2024, Resident 22 weighed 141.0 pounds, which is a -6.62 % loss, a severe loss. Record review of document Weight Summary indicated Resident 22 weighed 140.0 pounds on 2/9/2024, down one pound. On 3/5/2024, Resident 22 weighed 139.0 pounds, down one pound. Record review of Physician Readmission Diet Orders 3/28/2024 indicated small portions, pureed texture, nectar-thick liquids, discontinued 4/19/2024. (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of document Progress Note 4/11/2024 13:53 RD indicated Resident 22 had a gradual weight loss since October 2023. RD documented Resident 22's intake was 75% of meals with small portions. RD recommended discontinuing small portions to promote weight stabilization and ordered weekly weights for 4 weeks to monitor weight. Record review of document IDT - Care Conference Summary 5/2/2024 indicated Resident 22's weight was 132.0 pounds. A weight loss of 10% over 180 days was identified. Resident 22 was eating 76-100% of her meals. Resident was working on trials to upgrade diet with additional assistance. Diet orders were listed as regular, puree, honey-thick liquids, no fortified meals, or health shakes. Present at care conference were Resident 22, Responsible Party (residents decision maker), Social Services Director, and UDM. No change in dietary orders. This was the last documented IDT Care Conference. Record review of document Weight Summary indicated Resident 22 weighed 135.0 pounds on 4/2/2024, 134. 7 pounds on 4/8/2024, 129.0 pounds on 4/22/2024, and 132.0 pounds on 5/1/2024. Record review of document Weight Summary indicated on 8/9/2024, Resident 22 weighed 119.0 pounds, which is a -8.46 % loss from 7/2/2024 to 8/9/2024, severe weight loss. During a concurrent interview with RD on 8/9/2024 at 3:40 pm, RD stated Resident 22 was on altered textures, thickened liquids, and small portions were discontinued. RD stated Resident 22 stabilized around April 2024, but had a history of going in and out of the hospital. RD stated he could not get to the weight committee meetings on time during time frame when Resident 22 was losing weight. RD stated weight meetings restarted when current Director of Nursing (DON) was hired at facility in April 2024. RD stated issue is when someone goes in and out of hospital, orders don't get restarted. RD stated he would not restart orders because I don't like to restart what they're currently on. I like to have a blank slate. RD stated accuracy of Activities of Daily Living (ADL) charting was hit or miss. RD stated Resident 22 was eating 75% or more. RD stated his process was to look at intakes in chart, and follow-up with staff to determine if residents were eating well. RD stated if resident was stable then he assumes they're eating. RD stated he was not a proponent of nutritional shakes. RD stated facility used nutritional supplements. RD stated if he wanted to, he could make recommendation for nutritional supplements. RD stated even if a resident was on comfort care, they are weighed weekly. RD stated he would expect a monthly weight for Resident 22. RD stated expectation was for staff to document if any resident refused weight checks. RD stated at beginning of [AGE] year, We had a DON that didn't want to be involved in my work so a lot of it were my own findings. RD discussed his role in the weight committee. RD confirmed that not having a consistent IDT and DON made it a challenge along with having to spend so much time in the kitchen when he was onsite at the facility correcting issues.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 32797 Based on observation, interview, record review, the facility failed to ensure the kitchen had sufficient and competent dietary staff in the position to perform their related duties when: 1. Eight out of 10 kitchen staff did not have the required competencies and training to peform their job duty requirements. 2. Two of 10 kitchen staff were unable to verbalize and demonstrate how to test the sanitizing solution and how to set up an emergency 3-compartment sink (wash by hand) according to the manufacturer guidelines. 3. One of 10 kitchen staff did not know the correct temperature of walk-in freezer and did not report the issues to adminstrative staff. These failures had the potential to result in foodborne illnesses from cross contamination or the growth of microorganisms for the 49 residents eating food prepared in the facility. Findings: 1. A review of a Dietary Manager job description dated 2022, indicated the minimum requirements include one of the following certifications as a dietary manager, food service manager national certification for food service management from national certifying body, associate degree or higher in food service management and has two or more years in the position of director of food and nutrition services in a nursing facility. Must also meet the State requirements for food service managers. Major duties include maintains clean and sanitary environment, oversees safe timely meal preparation and food storage. Trains and coach's employees that work in the dietary department. Ensures adequate staff. Supports Registered Dietician duties as needed. A review of dietary staff employee files indicated: -Certified Dietary Manager (CDM 1) had a Date of Hire (DOH) of 9/26/23, terminated on 12/22/23. -An Unqualified Dietary Manager (UDM) was hired at the facility on 3/1/22, as the Director of Environmental Services. On 2/1/24, started as Dietary Supervisor in the kitchen. UDM had no required Food Handler certificate training. UDM had no verification of job competency verbal and or demonstration for the kitchen duties and equipment in the dietary department. UDM did not complete her required Dietary Manager training and was terminated 6/3/24. -CDM Date of Hire (DOH) 4/9/24, part time, then full time 8/7/24. CDM did not have required Title 22 (California State Regulations) six-hour CDM training until 8/3/24, four months after hire. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a Dietary Aide job description dated 2023, indicated the DA works with the facility's RD and CDM as necessary. DA provided assistance in all food functions as directed/instructed in accordance with established food policies and procedures. DA assists in daily cleaning duties, washes and cleans utensils, dishes, and cooking items following policy and procedures. A review of a facility policy titled Demonstrating Food Safety and Job Competency for Food and Nutrition Services Employees Dated 2023, indicated each Food and Nutrition employee must be able to demonstrate competency in the food and safety principles and job skills the facility requires. Verification of demonstrated job and equipment competencies. The Director of Food and Nutrition Services or Registered Dietician will sign off each skill after demonstrated properly on the competency forms. -Dietary Aide (DA G) had a DOH of 10/31/23, as an Environmental Services Laundry worker. DA G had the California Food Handlers Certification dated 8/29/22. DA G did not have any verification of job competency verbal or demonstration for the kitchen duties and equipment for the dietary department. -DA C had a DOH of 6/19/24. DA C had Food Handlers Certificate dated 8/8/24, two months after hire. DA C had Dietary Aide Competency Demonstration and kitchen equipment on 8/6/24, two months after hire. -DA H had a DOH of 4/15/24, had no Food Handlers Certificate in her file. DA H did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment for the dietary department until 8/6/24. -DA E had a DOH of 11/21/23, had no Food Handlers Certificate in her file. DA E did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment for the dietary department until 8/6/24. -DA D had a DOH of 10/20/23, had a Food Handlers Certificate dated 1/10/24, three months after hire. DA D did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment in the dietary department until 8/6/24. A review of a Dietary [NAME] job description dated 2023, indicated ensures prepares food in accordance with applicable federal, state, and local standards guidelines, regulations, and policies/procedures. Works with RD, CDM as necessary and implements changes as required. -Cook (CK F) had a DOH of 7/24/24, had Food Handlers Certificate dated 7/26/24. CK F did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment for the dietary department until 8/6/24. -CK I had a DOH of 1/26/24, had Food handlers Certificate on 7/26/22, six months after hire. CK I did not have any verification of job competency verbal and or demonstration for the kitchen duties and equipment for the dietary department until 8/6/24, six months after hire. During a concurrent interview and record review on 8/13/24 at 12 pm, CDM confirmed the dietary personnel files did not have the required trainings and competencies. CDM confirmed she did not have the required 6-hour Title 22 CDM training until 8/3/24 of this year. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent observation and interview on 8/6/24 at 9 am, during an initial tour of the kitchen, there were only two employees present CK I and DA H. There was no CDM present in the kitchen. A review of instructions titled Steps for 3-Compartment Washing dated 2023, posted to the far left of the sink area of the kitchen indicated there should be 3 sinks, one for washing, one for rinsing, and one for sanitizing. Sink Bay 1 for washing should have detergent (no amount listed) and hot water at a temperature of at least 110 F. Sink Bay 2 clean and clear water with a temperature of at least 110 F. Sink Bay 3 add two ounces of sanitizer per 8 ounces of water, check with test strip sanitizer solution for 60 seconds must read 200-400 PPM. Immerse all wash items for one minute. The 3-compartment sink had colored lines where the water should be filled to. - On 8/6/24 at 9:15 am, DA H was observed washing dishes in a 3-compartment sink. DA H removed food from dirty plates, then started putting them in first compartment filled with water, then moved dishes to middle sink (no water) and used the overhead hand faucet to rinse quickly then dip in sanitizer, then quickly put into drying rack. DA H was unable to verbalize the key steps to the 3-compartment sink. DA H did not know where to look to verify the correct sink set up. The instructions were to the left of the sink on a poster board, not in clear sight. DA H redemonstrated the procedure. Observed the middle Sink Bay 2 had no water up to the required line and DA H did not ensure the dishes were placed in the sanitizer sink for a full minute. DA H stated she had been doing this a few days since the dishwasher was not working. DA H was asked if she tested the water temperature of the water used in the sink or the sanitizer levels. DA H stated, I never do that. DA H had not tested the water temperature or sanitizer level, and there was no emergency 3-compartment sink washing log to document the results. CK I was unable to verbalize the steps of the 3-compartment sink. CK I stated she had been off for the past three days. CK I and DA H both thought the dishwasher had been out about a week. DA H continued to clean the dirty dishes and took multiple food plate covers stacked together to do the 3-compartment sink. DA H did not wash them one at a time. DA H confirmed the liquids could not touch all the surface areas doing it this way. During an interview on 8/6/24 at 9:40 am, went to Administrator (ADMIN) and requested to speak with CDM. ADMIN stated he requested her to come to facility. ADMIN stated CDM works at another long-term facility 45 minutes away. During a concurrent observation and interview on 8/6/24 at 9:50 am, went back into the kitchen to have DA H test the level of sanitizer in the bucket. Returned to the kitchen with ADMIN and Plant Operation Supervisor (POS). Requested DA H to test the level of sanitizer in the bucket they use for sanitizing kitchen surfaces. DA H could not find the test strips or the instructions for the correct level of sanitizer parts per million (PPM). DA H was unable to verbalize or reference instructions on how long test strip needed to be place into the sanitizer. DA H put the test strip indicated a bluish- purple which according to the instructions indicated more than 400 ppm (over the allowed limit). Unable to answer. ADMIN and POS were both unaware that the walk-in freezer was not at the required temperatures. (continued on next page)

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	055489	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta View Care Center	1795 Walnut Street Red Bluff, CA 96080

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During a concurrent observation and interview on 8/6/24 at 9:30 am, a 24-pound pork loin roast was completely soft to touch on lower rack defrosting dated 8/5/24 for meal 8/8/24. CK I warned the surveyors of fall risk due to liquids on the refrigerator and freezer floor. CK I did not know when this started or what the cause of the liquids on the floor meant. CK I confirmed the freezer temperature was 35 degrees F, not at required temperature of 0 or below F. Freezer had items that were not hard to touch, ice cream, cheese, deli meat, and two 10 pound rolls of hamburger soft to touch. Melted liquids throughout the freezer floor. At 9:35 am, CK I had logged 0 for the freezer. Asked how long freezer was out of range, CK I stated she was unaware and not contacted anyone about the issue. During a concurrent observation and interview on 8/6/24 at 10:41 am, CDM was interviewed about all the findings in the kitchen. CDM confirmed she works part time at the facility in the dietary department on the weekends mainly. CDM stated she worked at another facility during the week, and it was very difficult with the long drive back and forth. CDM confirmed the previous UDM was not qualified, had been working there since January 2024. CDM stated she was hired part time in April 2024 due to the RD coming one to two days a week as needed. CDM confirmed they staff the kitchen traditionally one DA and one CK. and 1 cook, inquired if that was enough with having no dishwasher? 3-compartments since a lot of work. CDM stated UDM was in dietary manager school, and she did not finish, and had been in the laundry department. CDM stated the problem with the walk-in freezer started on 8/2/24 and the issue was the defrost cycle and timer. CDM was here on the weekend 8/3-8/4/24. CDM confirmed the dishwasher thermostat (measures water temperature) was not working for about a week and a half and a new electrical breaker was needed to fix it. CDM confirmed no one notified her this morning the freezer was not to at the required temperatures. CDM confirmed the multiple items in the dry storage and refrigerator not dated as per policy. CDM confirmed the walk-in freezer was not at required temperature, the ice cream, deli meat, two 10-pound hamburger package rolls were soft to touch and not frozen. CDM stated she cannot confirm the pork roast was frozen (hard upon touch) when put in refrigerator for defrosting. CDM stated was not sure how often RD was onsite at the facility, and she has not seen him. CDM explained the RD comes as needed and should perform monthly kitchen/sanitation audits and mock survey to get ready for the recertification survey. CDM did not state what actions would be taken to resolve these issues. CDM stated she would talk to ADMIN about getting two freezers. A review of a follow up email dated 5/1/24 at 8:43 pm, written by RD and sent to ADMIN and GB indicated: -RD observed non-dietary staff seem to be coming into the kitchen walk around, grab items. Please ensure staff they must not cross the red line in the kitchen. -During my visits, Unqualified Dietary Manager (UDM) was found out on the floor, in her office, and not involved in the kitchen. UDM informed RD that she is still helping with housekeeping. UDM was the Director of Environmental Services prior to starting in kitchen 2/1/24. -RD wrote I am glad a CDM is coming in on the weekends to help with the kitchen. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 8/9/24 at 3:09 pm, Registered Dietician (RD) stated he had been at the facility since it opened in October 2023. RD explained he comes to the facility in person based on needs of the kitchen and residents. RD stated he has a long drive and works for another facility as well. RD stated he comes to the facility usually one to two days a week, but it does vary based on the needs. RD stated the kitchen staff were struggling. RD stated he spent most of his time training new staff and correcting identified issues in the kitchen. RD stated it was always a challenge in the kitchen with UDM who was unqualified and in school. RD explained the facility did not have a consistent CDM and were struggling to find a qualified CDM. RD confirmed he suggested to the ADMIN about adding more staff for the kitchen since they could not keep up with the required tasks. RD stated the freezer and dishwasher had been an ongoing issue. RD stated he noticed a few months ago the freezer was staying at or below the required temperature and he concerns then about food borne illness. RD stated he had concerns about sanitary and safe conditions in the kitchen due to dishwasher, freezer, multiple new staff and inconsistent CDM oversight. and safety in the kitchen due to dishwasher, freezer, inconsistent CDM coverage, new staff etc. Reviewed RD's sanitation audits and he confirmed he only had three, for 2/14/24, 5/1/24 and 5/30/24. RD stated he could not provide any other kitchen audits due to mainly giving verbal reports not written. RD stated UDM was not in the kitchen in April 2024, no record of logging the required levels of sanitizer for the buckets (used to sanitize surfaces in kitchen), no logs for required temperature for dishwasher, supplies not being dated and stored correctly, gap in the back kitchen door which allows pests to enter kitchen, gaps in documenting freezer temperature on logs, and no qualified full time CDM to oversee the kitchen staff. RD was asked if any of these issues were being tracked and who was responsible for ensuring these were acted upon. RD stated the ADMIN was made aware. RD stated he struggled to keep the kitchen working.

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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. 32797 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in a sanitary manner in accordance with professional standards for food service safety when: 1. Freezer temperatures were not maintained within range. 2. Food was improperly dated in refrigerator and dry storage. 3. Two of 10 kitchen staff were unable to verbalize and demonstrate how to test the sanitizing solution and how to set up an emergency 3-compartment sink (wash by hand) according to the manufacturer guidelines. 4. Flies and other pests throughout the kitchen during cooking and plating food (tray-line). 5. Dirty scoop, mixing bowl and garbage can lid. 6. Dietary staff did not wash hands before handling food in kitchen. 7. Non dietary staff service vendor entered tray-line cooking area multiple times during meal preparation without hair and face net. These failures had the potential to result in foodborne illnesses from cross contamination or the growth of microorganisms for the 49 residents eating food prepared in the facility. Findings: 1. A review of a facility policy titled Cold Storage Temperature Monitoring and Record Keeping dated 2023, indicated freezer temperatures standards are 0 degrees Fahrenheit (F) or below. If not within standards notify the food nutrition services director, maintenance and administrator. Food Nutrition services staff will check inside temperatures of freezers. During a concurrent observation and interview on 8/6/24 at 9 am, during an initial tour of the kitchen, there were only two employees present [NAME] (CK I) and Dietary Aide (DA H). There was no Certified Dietary Manager (CDM) present. At 9:15 am the refrigerator and walk-in freezer was observed. A 24-pound pork loin roast was completely soft to touch on lower rack defrosting dated 8/5/24 for meal 8/8/24. CK I warned the surveyors of fall risk due to liquids on the refrigerator and freezer floor. CK I did not know when this started or what the cause of the liquids on the floor meant. CK I confirmed the freezer temperature was 35 degrees F, not at required temperature of 0 or below F. Freezer had items that were not hard to touch, ice cream, cheese, deli meat, and two 10 pound rolls of hamburger soft to touch. Melted liquids throughout the freezer floor. At 9:35 am, CK I had logged 0 for the freezer. Asked how long freezer was out of range? She was unaware and not contacted anyone about the issue. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. A review of a facility policy titled Labeling and Dating of Foods dated 2023, indicated food delivered to the facility needs to be marked with a received date. Newly opened food items will need to be labeled with an open date and used by date. During an observation on 8/6/24 at 9:10 am, the dry storage area had multiple items without received dates or use by dates, for quick creamy wheat, sugar free individual sized grape jelly, dry breakfast cereals and ranch salad dressing. At 9:30 am, multiple delivery boxes in the refrigerator not unpacked. Multiple undated items throughout the area shredded white cheese, sour cream, and jelly. 3. A review of a facility policy titled Sanitation dated 2023, indicated the food nutrition service director is responsible for instructing employees in the fundamentals of sanitation (process of keeping places clean and free of disease) in food service and to use appropriate techniques. During a concurrent observation and interview on 8/6/24 at 9:15 am, DA H was observed washing dishes in a 3-compartment sink. DA H removed food from dirty plates, then started putting them in first compartment filled with water, then moved dishes to middle sink (no water) and used the overhead hand faucet to rinse quickly then dip in sanitizer, then quickly put into drying rack. DA H was unable to verbalize the key steps to the 3-compartment sink. DA H did not know where to look to verify the correct sink set up. The instructions were to the left of the sink on a poster board, not in clear sight. DA H redemonstrated the procedure. Observed the middle Sink Bay 2 had no water up to the required line and DA H did not ensure the dishes were placed in the sanitizer sink for a full minute. DA H stated she had been doing this a few days since the dishwasher was not working. DA H was asked if she tested the water temperature of the water used in the sink or the sanitizer levels. DA H stated, I never do that. DA H had not tested the water temperature or sanitizer level, and there was no emergency 3-compartment sink washing log to document the results. CK I was unable to verbalize the steps of the 3-compartment sink. CK I stated she had been off for the past three days. CK I and DA H both thought the dishwasher had been out about a week. DA H continued to clean the dirty dishes and took multiple food plate covers stacked together to do the 3-compartment sink. DA H did not wash them one at a time. DA H confirmed the liquids could not touch all the surface areas doing it this way. During a concurrent observation and interview on 8/6/24 at 9:50 am, went back into the kitchen to have DA H test the level of sanitizer in the bucket. Returned to the kitchen with ADMIN and Plant Operation Supervisor (POS). Requested DA H to test the level of sanitizer in the bucket they use for sanitizing kitchen surfaces. DA H could not find the test strips or the instructions for the correct level of sanitizer parts per million (PPM). DA H was unable to verbalize or reference instructions on how long test strip needed to be place into the sanitizer. DA H put the test strip indicated a bluish- purple which according to the instructions indicated more than 400 PPM (over the allowed limit). Unable to answer. ADMIN and POS were both unaware that the walk-in freezer was not at the required temperatures. 4. During a concurrent observation and interview on 8/6/24 at 9:25 am, CK I confirmed flies in the kitchen. During a concurrent observation and interview at 10:25 am, CDM confirmed multiple flies in the kitchen. CDM stated the back screen door where there were gaps on the top and bottom of the door was just fixed. CDM stated these gaps allowed flies to enter the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview at 12:30 pm, observed CK F preparing peanut butter and jelly using #40 scoop. The scoop was not clean, it had a dried substance in the scoop. CK F confirmed it was dirty and removed the scoop from the area. During a concurrent observation and interview on 8/9/24 at 12:40 pm, CK J was plating food during tray-line, one of the lids had a black bug crawling on the inside, she removed lid. Flies were observed landing on resident food trays. 5. During a concurrent observation and interview on 8/6/24 at 9 am, CK I confirmed the garbage can top had dirt and it was not hands free. She confirmed you had to touch the top of the can to open and dispose of paper towels after washing hands at sink. During an observation on 8/6/24 at 9:10 am, there was a dirty mixing bowl amongst the food in dry storage. 6. During an observation on 8/6/24 at 12:45 pm, DA G came in to get coffee for a resident and did not wash hands upon entering or leaving kitchen preparation area. 7. During an observation at 1:15 pm, a freezer repairman with hair/beard came in through the kitchen while CK J was preparing food, he did not have his hair or beard covered with a hairnet when he came in and out of the kitchen multiple times. During a concurrent observation and interview on 8/6/24 at 10:41 am, CDM was interviewed about all the findings in the kitchen. CDM confirmed she works part time at the facility in the dietary department on the weekends mainly. CDM stated she worked at another facility during the week, and it was very difficult with the long drive back and forth. CDM confirmed the previous UDM was not qualified, had been working there since January 2024. CDM stated she was hired part time in April 2024 due to the RD coming one to two days a week as needed. CDM confirmed they staff the kitchen traditionally one DA and one CK. and 1 cook, inquired if that was enough with having no dishwasher? 3-compartments since a lot of work. CDM stated UDM was in dietary manager school, and she did not finish, and had been in the laundry department. CDM stated the problem with the walk-in freezer started on 8/2/24 and the issue was the defrost cycle and timer. CDM was here on the weekend 8/3-8/4/24. CDM confirmed the dishwasher thermostat (measures water temperature) was not working for about a week and a half and a new electrical breaker was needed to fix it. CDM confirmed no one notified her this morning the freezer was not to at the required temperatures. CDM confirmed the multiple items in the dry storage and refrigerator not dated as per policy. CDM confirmed the walk-in freezer was not at required temperature, the ice cream, deli meat, two 10-pound hamburger package rolls were soft to touch and not frozen. CDM stated she cannot confirm the pork roast was frozen (hard upon touch) when put in refrigerator for defrosting. CDM stated was not sure how often RD was onsite at the facility, and she has not seen him. CDM explained the RD comes as needed and should perform monthly kitchen/sanitation audits and mock survey to get ready for the recertification survey. CDM did not state what actions would be taken to resolve these issues. CDM stated she would talk to ADMIN about getting two freezers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/8/24 at 12:30 pm, CDM was unable to find all the kitchen logs for monitoring temperatures for the refrigerator, walk-in freezer, dishwasher temperatures, and sanitizer testing for the months of January, February, and March of 2024. CDM confirmed the bluish-purple color of the test strip of the sanitizer bucket on 8/6/24, indicated the level was above the recommended 400 PPM testing strip. CDM stated this meant too much sanitizer and would want dietary staff to inform someone of this finding. CDM stated not having the freezer maintain temperatures put all residents at risk for food borne illness. CDM stated she has no clinical corporate dietary consultant available; they are to access the clinical nursing consultant. A review of a sanitation audit dated 2/14/24 at 10:44 am and emailed to ADMIN and GB, the RD identified issues in the kitchen: -debris in kitchen drawers -mold found in ice machine -crumbs found in toaster -garbage dumpster open upon arrival -ice buildup on sprinkler pipe in walk in fridge -no received date on turkey in walk in freezer A review of an RD inspection of the kitchen on 5/1/24 at 8:29 pm, emailed to ADMIN and GB, indicated findings for the audit: -.gap under screen door in kitchen, this door will be an issue with flies as weather heats up. -oven is not working to heat foods up -steam table not working to keep food hot -old debris found in toaster -food left in microwave -garbage dumpsters were overfilled -logs not being used for sanitation buckets or for dishwasher -dishwasher not reaching temperature for rinse -supplies not being stored correctly in dry storage -gasket to fridge is not adhered to door -freezer has buildup of frost and ice (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-recipe for thickening liquids not followed -boxes stored on top shelves in dry storage no under 18 inches from ceiling A review of sanitation findings on 5/30/24 at 8:41 am, emailed to ADMIN and GB, RD indicated: -no current CDM full time in kitchen -spider webs and fly in kitchen -gaps on bottom of door by manager's office -oven was dirty -debris on shelf above stove and toaster -steam table not working -kitchen drawers with utensils had debris -vents on air conditioner dirty -gaps in logs for sanitation bucket -no thermometer in dry storage area to monitor room temperatures -temperature in kitchen/storage area not being regulated -boxes stored on top shelves in dry storage no under 18 inches from ceiling -gaps in freezer log -ice buildup in freezer -staff not wearing facial hair net -staff not using gloves when getting ice throughout the facility -gaps in log with resident refrigerator and above 40 degrees Fahrenheit (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 8/9/24 at 3:09 pm, RD stated he had been at the facility since it opened in October 2023. RD explained he comes to the facility in person based on needs of the kitchen and residents. RD stated he has a long drive and works for another facility as well. RD stated he comes to the facility usually one to two days a week, but it does vary based on the needs. RD stated the kitchen staff were struggling. RD stated he spent most of his time training new staff and correcting identified issues in the kitchen. RD stated it was always a challenge in the kitchen with UDM who was unqualified and in school. RD explained the facility did not have a consistent CDM and were struggling to find a qualified CDM. RD confirmed he suggested to the ADMIN about adding more staff for the kitchen since they could not keep up with the required tasks. RD stated the freezer and dishwasher had been an ongoing issue. RD stated he noticed a few months ago the freezer was staying at or below the required temperature and he concerns then about food borne illness. RD stated he had concerns about sanitary and safe conditions in the kitchen due to dishwasher, freezer, multiple new staff and inconsistent CDM oversight. and safety in the kitchen due to dishwasher, freezer, inconsistent CDM coverage, new staff etc. Reviewed RD's sanitation audits and he confirmed he only had three, for 2/14/24, 5/1/24 and 5/30/24. RD stated he could not provide any other kitchen audits due to mainly giving verbal reports not written. RD stated UDM was not in the kitchen in April 2024, no record of logging the required levels of sanitizer for the buckets (used to sanitize surfaces in kitchen), no logs for required temperature for dishwasher, supplies not being dated and stored correctly, gap in the back kitchen door which allows pests to enter kitchen, gaps in documenting freezer temperature on logs, and no qualified full time CDM to oversee the kitchen staff. RD was asked if any of these issues were being tracked and who was responsible for ensuring these were acted upon. RD stated the ADMIN was made aware. RD stated he struggled to keep the kitchen working.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview, and record review, the facility's Administrator (ADMIN) failed to ensure effective oversight and necessary resources to ensure resident care services were met to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident when: 1. The ADMIN failed to ensure a full time Registered Dietician (RD) or a Certified Dietary Manager (CDM) to provide direct oversight of dietary staff to deliver safe and sanitary food service for 49 of 49 residents. a. Dietary staff did not follow safe and sanitary food service practices. Refer to F 802 and F 812. b. RD, Unqualified Dietary Manager (UDM), and CDM did not ensure all dietary staff had required state and federal competencies to work in the kitchen upon hire. Refer to F 802 c. RD did not ensure all identified issues in the kitchen/sanitation audits were acted upon and resolved. Refer to F 812 This resulted in an Immediate Jeopardy (IJ - a situation where a provider's noncompliance with requirements has, or could, result in serious harm, injury, impairment, or death to a resident) for failure to provide qualified oversight to perform daily kitchen inspections, provide feedback to staff, ensure kitchen staff is competent in performing their job duties effectively. Refer to F 801. 2. Dietary services did not follow national standards and guidelines for kitchen cleanliness, and the safety of the food storage. Refer to F 812. These failures had the potential for the spread of infection, and foodborne illness to occur in residents. Refer to F812. 3. The ADMIN failed to ensure the staff identify insidious weight loss (gradual, unintended, progressive weight loss over time), and maintain acceptable parameters of nutritional status for Resident 22. These failures resulted in severe weight loss and put Resident 22 at risk for further health decline. Refer to F 692, F 801. 4. The ADMIN failed to ensure Social Services provide the care that meet the needs for Resident 6,8,12, and 303. These failures resulted in a. Resident 6 received unnecessary medical treatment. b. Residents 8 did not receive quarterly care conferences. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. Resident 303 did not receive Discharge Care Plan. d. Resident 12 did not receive Urology consult and had potential for further infections and complications related to suprapubic catheter (a hollow flexible tube that is used to drain urine from the bladder through a cut in the abdomen). Refer to F 745. 5. The ADMIN failed to ensure Fall care plans were initiated for Resident 15, Resident 330, and revised timely for Resident 15 and 52. These failures had the potential for staff to not be fully informed of the residents' health status to determine the need for further assessment and intervention. Refer to F 655, and F 657. Findings: During a review of the facility undated job description titled, Administrator, indicated: The purpose of the position is to lead, guide, and direct the operations of the healthcare facility in accordance with local, state, and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents. The major duties and responsibilities: - Plans, develops, organizes, implements, evaluates, and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations. - Plans, develops, organizes, implements, evaluates, and directs the facility's programs and activities in accordance with guidelines issued by the governing body. - Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indicators. Establishes an ongoing system to monitor these key indicators such as the Quality Assurance and Performance Improvement process throughout the facility. - Evaluates key performance indicator outcomes with department heads to determine the need for action from leadership and/or management such as re-education or revisions related to the facility's outcomes, regulatory compliance and/or customer satisfaction. - Leads and coordinates daily, weekly, bi-monthly, or monthly management team meetings to discuss priorities and develop solutions with facility leaders such as census, collections, clinical health, survey readiness, customer service satisfaction, activity participation, etc. - Evaluates work performance of department heads and maintains accountability across all departments in concert with Human Resources for expected performance outcomes in each respective department. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta View Care Center	1795 Walnut Street Red Bluff, CA 96080

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Knows and understands general nursing practices and procedures, OBRA regulations (The Omnibus Budget Reconciliation Act (OBRA) of 1987 established federal nursing home safety regulations that nursing homes must comply with if they accept Medicare or Medicaid funding), Code of Federal Regulations, Appendix PP state Operations Manual, reimbursement processes, Life Safety Code regulations, applicable labor relations laws, and all other regulatory entities that may apply. - Ensures delivery of compassionate quality care and services across an interdisciplinary team approach as evidenced by adequate, and competent facility staff, employee turnover, general cleanliness, physical plant conditions, and optimal resident functioning-physically and psychosocially. - Identifies and collaborates with members of the interdisciplinary team, physicians, consultants, and community agencies to identify opportunities for enhanced services to the residents and/or resolves issues. 1. During a review of a sanitation audit, dated 2/14/24 at 10:44 am, and emailed to the ADMIN and Governing Body (GB, legally responsible for establishing and implementing facility policies), indicated that the RD identified issues in the kitchen: -debris in kitchen drawers -mold found in ice machine -crumbs found in toaster -garbage dumpster open upon arrival -ice buildup on sprinkler pipe in walk in fridge -no received date on turkey in walk in freezer During a review of an RD inspection of the kitchen on 5/1/24 at 8:29 pm, emailed to the ADMIN and GB, indicated findings for the audit: - gap under screen door in kitchen, this door will be an issue with flies as weather heats up. -oven is not working to heat foods up -steam table not working to keep food hot -old debris found in toaster -food left in microwave -garbage dumpsters were overfilled -logs not being used for sanitation buckets or for dishwasher -dishwasher not reaching temperature for rinse (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-supplies not being stored correctly in dry storage -gasket to fridge is not adhered to door -freezer has buildup of frost and ice -recipe for thickening liquids not followed -boxes stored on top shelves in dry storage no under 18 inches from ceiling During a review of a follow up email, dated 5/1/24 at 8:43 pm, written by RD and sent to the ADMIN and GB, indicated: -RD observed non-dietary staff seem to be coming into the kitchen walk around, grab items. Please ensure staff they must not cross the red line in the kitchen. -During my visits, Unqualified Dietary Manager (UDM) was found out on the floor, in her office, and not involved in the kitchen. UDM informed RD that she is still helping with housekeeping. UDM was the Director of Environmental Services prior to starting in kitchen 2/1/24. -RD wrote I am glad a CDM is coming in on the weekends to help with the kitchen. During a review of sanitation findings on 5/30/24 at 8:41 am, emailed to the ADMIN and GB, the RD indicated: -no current CDM full time in kitchen -spider webs and fly in kitchen -gaps on bottom of door by manager's office -oven was dirty -debris on shelf above stove and toaster -steam table not working -kitchen drawers with utensils had debris -vents on air conditioner dirty -gaps in logs for sanitation bucket -no thermometer in dry storage area to monitor room temperatures -temperature in kitchen/storage area not being regulated -boxes stored on top shelves in dry storage no under 18 inches from ceiling (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-gaps in freezer log -ice buildup in freezer -staff not wearing facial hair net -staff not using gloves when getting ice throughout the facility -gaps in log with resident refrigerator and above 40 degrees Fahrenheit During a concurrent interview and record review on 8/9/24 at 3:09 pm, a. RD stated the kitchen staff were struggling. RD stated he spent most of his time training new staff and correcting identified issues in the kitchen. b. RD stated it was always a challenge in the kitchen with UDM who was unqualified and in school. RD explained the facility did not have a consistent CDM and were struggling to find a qualified CDM. c. RD confirmed he suggested to the ADMIN about adding more staff for the kitchen since they could not keep up with the required tasks. d. RD stated the freezer and dishwasher had been an ongoing issue. RD stated he noticed a few months ago the freezer was staying at or below the required temperature and he concerns then about food borne illness. RD stated he had concerns about sanitary and safe conditions in the kitchen due to dishwasher, freezer, multiple new staff and inconsistent CDM oversight. and safety in the kitchen due to dishwasher, freezer, inconsistent CDM coverage, new staff etc. e. Reviewed RD's sanitation audits and he confirmed he only had three, for 2/14/24, 5/1/24 and 5/30/24. RD stated he could not provide any other kitchen audits due to mainly giving verbal reports not written. f. RD stated UDM was not in the kitchen in April 2024, no record of logging the required levels of sanitizer for the buckets (used to sanitize surfaces in kitchen), no logs for required temperature for dishwasher, supplies not being dated and stored correctly, gap in the back kitchen door which allows pests to enter kitchen, gaps in documenting freezer temperature on logs, and no qualified full time CDM to oversee the kitchen staff. g. RD was asked if any of these issues were being tracked and who was responsible for ensuring these were acted upon. RD stated the ADMIN was made aware. h. RD stated he struggled to keep the kitchen working. 2. During a concurrent observation and interview on 8/6/24 at 9 am, during an initial tour of the kitchen, there were only two employees present [NAME] (CK I) and Dietary Aide (DA H). There was no Certified Dietary Manager (CDM) present. CK I confirmed the garbage can top had dirt and it was not hands free. She confirmed you had to touch the top of the can to open and dispose of paper towels after washing hands at sink. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-at 9:10 am observed dishwasher area had many dirty dishes with no active dishwashing happening. The dry storage area had multiple items without received dates or use by dates, for quick creamy wheat, sugar free individual sized grape jelly, dry breakfast cereals and ranch salad dressing. There was a dirty mixing bowl amongst the food in dry storage. -at 9:25 am CK I confirmed flies in the kitchen. - at 9:15 am, DA H was observed washing dishes in a 3-compartment sink. DA H did not know where to look to verify the correct sink set up. The instructions were to the left of the sink on a poster board, not in clear sight. DA H redemonstrated the procedure. Observed the middle Sink Bay 2 had no water up to the required line and DA H did not ensure the dishes were placed in the sanitizer sink for a full minute. DA H was asked if she tested the water temperature of the water used in the sink or the sanitizer levels. DA H stated, I never do that. DA H had not tested the water temperature or sanitizer level, and there was no emergency 3-compartment sink washing log to document the results. CK I was unable to verbalize the steps of the 3-compartment sink. - at 9:30 am, Multiple undated items throughout the area shredded white cheese, sour cream, and jelly. A 24-pound pork loin roast was completely soft to touch on lower rack defrosting dated 8/5/24 for meal 8/8/24. CK I warned the surveyors of fall risk due to liquids on the refrigerator and freezer floor. CK I confirmed the freezer temperature was 35 degrees F, not at required temperature of 0 or below F. Freezer had items that were not hard to touch, ice cream, cheese, deli meat, and two 10 pound rolls of hamburger soft to touch. Melted liquids throughout the freezer floor. At 9:35 am, CK I had logged 0 for the freezer. Asked how long freezer was out of range, she was unaware and not contacted anyone about the issue, due to being unaware of the issue. -at 9:40 am, went to ADMIN and requested to speak with CDM. ADMIN stated he requested her to come to facility. ADMIN stated CDM works at another long-term facility 45 minutes away. During an interview on 8/8/24 at 12:30 pm, CDM was unable to find all the kitchen logs for monitoring temperatures for the refrigerator, walk-in freezer, dishwasher temperatures, and sanitizer testing for the months of January, February, and March of 2024. CDM confirmed the bluish-purple color of the test strip of the sanitizer bucket on 8/6/24, indicated the level was above the recommended 400 PPM testing strip. CDM stated this meant too much sanitizer and would want dietary staff to inform someone of this finding. CDM stated not having the freezer maintain temperatures put all residents at risk for food borne illness. CDM stated she has no clinical corporate dietary consultant available; they are to access the clinical nursing consultant. 3. During a review of Resident 22's clinical record, indicated that Resident 22 was admitted to the facility on [DATE] with diagnoses which included Cerebral infarction (stroke) affecting right dominant side with resulting weakness on one side of her body, mild cognitive (mental) impairment of uncertain or unknown etiology (origin), anxiety disorder, and difficulty swallowing. During a review of Resident 22's weight record, indicated that Resident 22: - Weighed 152 pounds on 10/27/2023. - Weighed 141 pounds on 1/4/2024, which is a 6.62% (10 pounds) of weight loss. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Weighed 135 pounds on 4/2/2024. - Weighed 132 pounds on 5/2/2024, which is a 10 % (20 pounds) of weight loss over 180 days. - Weighed 130 pounds on 7/2/2024. - Weighed 119 pounds on 8/9/2024. Resident 22 had lost a total of 33 pounds in about 10 months since she was admitted to the facility. During a review of Resident 22's record: - The progress note, dated 11/2/2023 at 11:30 am, indicated that a 4 ounces of house supplement order twice a day order was received. - The Physician Order from 10/19/2023 to 8/9/2024, there's order for the 4 ounces of house supplement order twice a day could be located. During a concurrent interview and record review with Registered Dietician (RD) on 8/9/2024 at 3:40 pm, - RD stated that he could not get weight committee meetings on time before the Director of Nursing (DON) was hired in 4/2024. - RD stated, the issue is when someone goes in and out of hospital, orders don't get restarted. RD stated even if a resident was on comfort care, they are weighed weekly. RD stated he would expect a monthly weight for Resident 22. RD stated expectation was for staff to document if any resident refused weight checks. - RD stated at beginning of [AGE] year, we had a DON that didn't want to be involved in my work so a lot of it were my own findings. During an interview on 8/13/2024 at 9:25 am, with the Director of Nursing (DON), the DON stated that on comfort care, a resident is expected to lose weight and decline. The DON stated that she could not define facility standard for comfort care. 4. a. Resident 6 During a review of Resident 6's clinical records, indicated that Resident 6 did not exhibit any behavior symptoms. During a concurrent interview and record review on 8/8/2024 at 1:10 pm with Licensed Vocational Nurse (LVN) B, Resident 6's physician order was reviewed. LVN B stated that she took care of Resident 6 very often, 5 days/a week, and she had not noticed that Resident 6 had any behavioral issues. LVN B confirmed that Resident 6 was not taking any psychotropic medication, and LN B was not aware that Resident 6 had been seen by a psychologist weekly. LVN B stated, I don't know why she would have the psychological interview. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 8/9/24 at 3:40 pm, with the SSD, Resident 303's care plan was reviewed. SSD indicated there was no Discharge Care Plan developed for Resident 303 and there should have been. The SSD stated, I would expect to have this done within the first 72 hours of admission and discussed with her (Resident 303). It (Discharge Care Plan) should have absolutely been in (developed) and it was not. I could be more organized. The SSD indicated the Discharge Care Plan informed everyone what the discharge plan was for Resident 303 to help her achieve her goal. d. Resident 12 During a review of Resident 12'srecord, indicated Resident 12 had suprapubic catheter. During a review of Resident 12's physician order, dated 12/14/2023, indicated an active order for Resident 12 to receive a urology consult evaluation and treatment with follow up as indicated. No further documentation noted to show a consult occurred. During a review of Resident 12's Care Plan, dated 1/1/2024, indicated, urology eval and treatment with follow up appointments as indicated. There was no indication of a urology referral or consult for Resident 12. During a concurrent interview and record review with SSD on 8/13/2024 at 10:00 am, the SSD stated that she was unaware of Resident 12 having a referral to urology upon admission. SSD confirmed there was no documentation found in the record that Resident 12 had a urology consult. 5.a. Resident 15 During a review of Resident 15's records, Resident 15 was at moderate risk for falls, the resident had have fall on 1/1/2024, 4/1/2024, and 7/1/2024, there were no revised/or updated fall care plan could be foud. During an interview and record review on 8/9/24 at 10:19 am, with the Minimum Data Set Licensed Vocational Nurse (MDSLVN), Resident 15's care plans were reviewed. The MDSLVN confirmed that Resident 15 had a fall on 1/1/24, 4/1/24 and 7/2/24 and that there were no Fall Care Plans with interventions developed or revised for his falls on 1/1/24 and 4/1/24. MDSLVN indicated that everyone should have a Fall Care Plan on admission, and it should be reviewed with each new fall. b. Resident 52 During a review of Resident 52's record, Resident 52 had fall on 4/27/2024, 5/15/2024. There's no revised care plan to be found related to these incidents. During a concurrent interview and record review on 8/13/2024, at 11:19 am, with the DON, Resident 52's care plan and progress note were reviewed. The DON confirmed that there's no care plan created for these two incidents. The DON stated that the shift nurse should have initiated the short-term fall care plan for these incidents on the date that Resident 52 had the fall. c. Resident 303 (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 303's physical orders, dated 6/22/2024, indicated the resident at the risk of fall, a review of Resident 303's baseline care plan revealed there was no Fall Care Plan developed. During an interview with the Director of Nursing (DON) and record review on 8/13/24 at 11:02 am, Resident 303's admitting diagnoses, Physician Orders and care plans were reviewed. DON confirmed that Resident 303 was at risk for falls on admission and should have had a baseline care plan with interventions to prevent falls and there was not one. During a concurrent interview and record review on 8/13/2024 at 1:43 with the ADMIN, the Quality Assurance and Performance Improvement (QAPI) meeting minutes were reviewed, a. The ADMIN admitted that he was made aware of the issues with the dietary department by the RD. b. The ADMIN stated the RD was in the July QAPI meeting but was unable to provide RD's signature and RD's meeting minute note. and c. The ADMIN stated the CDM only came to the QAPI meeting on 6/17/2024. However, the ADMIN couldn't provide any QAPI meeting minutes record for 6/17/2024. d. The ADMIN admitted that there's no support and/or support for CDM, the ADMIN said the Clinical Resources Nurse Consultant does nursing, but no dietary support for her. e. The ADMIN acknowledged that he was aware of the condition in the kitchen, and RD did not make the ice buildup clearly in the report. The ADMIN also acknowledged that he was aware of the flies in the facility, ADMIN said people were going out of the sliding door, there were gaps in the door in the residents' room . f. While asked to review the plan of action - Performance Improvement Plan (PIP), the ADMIN admitted that the facility hasn't started any PIP yet, the ADMIN said, We do have a form that we filled out as far as serving and stuff like that, but it's not specific to it, it's just going over any issues

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 43739 Based on interview and record review, the facility's Governing Body (GB, legally responsible for establishing and implementing facility policies) failed to effectively manage the facility when: 1. The GB did not ensure adequate oversight and monitoring of the dietary department. Refer to F 801, F812. 2. The GB failed to ensure and effective Quality Assessment and Assurance Program to identify, implement corrective actions and evaluate their effectiveness. This resulted in an Immediate Jeopardy (IJ - a situation where a provider's noncompliance with requirements has, or could, result in serious harm, injury, impairment, or death to a resident) for failure to provide qualified oversight to perform daily kitchen inspections, provide feedback to staff, ensure kitchen staff is competent in performing their job duties effectively. Refer to F 801. Findings: During a review of the facility's undated policy titled, Governing Body, indicated: - The facility will have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. - The governing body is responsible and accountable for the Quality Assurance and Performance Improvement (QAPI) program. - The governing body will have a process in place by which the administrator (ADMIN): a. Reports to the governing body. b. Method of communication between administrator and governing body. c. How the governing body responds back to the administrator. d. What specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) are reported or not reported. e. How the administrator is held accountable and reports information about the facility's management and operation (i.e., audits, budgets, staffing supplies, etc.) f. How the administrator and the governing body are involved with the facility wide assessment. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of a sanitation audit, dated 2/14/24 at 10:44 am, and emailed to the ADMIN and GB, indicated that the Registered Dietician (RD) identified issues in the kitchen: -debris in kitchen drawers -mold found in ice machine -crumbs found in toaster -garbage dumpster open upon arrival -ice buildup on sprinkler pipe in walk in fridge -no received date on turkey in walk in freezer During a review of an RD inspection of the kitchen on 5/1/24 at 8:29 pm, emailed to the ADMIN and GB, indicated findings for the audit: - gap under screen door in kitchen, this door will be an issue with flies as weather heats up. -oven is not working to heat foods up -steam table not working to keep food hot -old debris found in toaster -food left in microwave -garbage dumpsters were overfilled -logs not being used for sanitation buckets or for dishwasher -dishwasher not reaching temperature for rinse -supplies not being stored correctly in dry storage -gasket to fridge is not adhered to door -freezer has buildup of frost and ice -recipe for thickening liquids not followed -boxes stored on top shelves in dry storage no under 18 inches from ceiling During a review of a follow up email, dated 5/1/24 at 8:43 pm, written by RD and sent to the ADMIN and GB, indicated: (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-RD observed non-dietary staff seem to be coming into the kitchen walk around, grab items. Please ensure staff they must not cross the red line in the kitchen. -During my visits, Unqualified Dietary Manager (UDM) was found out on the floor, in her office, and not involved in the kitchen. UDM informed RD that she is still helping with housekeeping. UDM was the Director of Environmental Services prior to starting in kitchen 2/1/24. -RD wrote I am glad a Certified Dietary Manager (CDM) is coming in on the weekends to help with the kitchen. During a review of sanitation findings on 5/30/24 at 8:41 am, emailed to the ADMIN and GB, the RD indicated: -no current CDM full time in kitchen -spider webs and fly in kitchen -gaps on bottom of door by manager's office -oven was dirty -debris on shelf above stove and toaster -steam table not working -kitchen drawers with utensils had debris -vents on air conditioner dirty -gaps in logs for sanitation bucket -no thermometer in dry storage area to monitor room temperatures -temperature in kitchen/storage area not being regulated -boxes stored on top shelves in dry storage no under 18 inches from ceiling -gaps in freezer log -ice buildup in freezer -staff not wearing facial hair net -staff not using gloves when getting ice throughout the facility -gaps in log with resident refrigerator and above 40 degrees Fahrenheit During a concurrent interview and record review on 8/9/24 at 3:09 pm, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta View Care Center	1795 Walnut Street Red Bluff, CA 96080

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. RD confirmed he suggested to the ADMIN about adding more staff for the kitchen since they could not keep up with the required tasks. 2. RD was asked if any of these issues were being tracked and who was responsible for ensuring these were acted upon. RD stated the ADMIN was made aware. During a concurrent interview and record review on 8/13/2024 at 1:43 with the ADMIN, the Quality Assurance and Performance Improvement (QAPI) meeting minutes were reviewed, 1. The ADMIN admitted that he was made aware of the issues with the dietary department by the RD. 2. The ADMIN stated the RD attended the July QAPI meeting but was unable to provide RD's signature and RD's meeting minute note. 3. The ADMIN stated the CDM only came to the QAPI meeting on 6/17/2024. However, the ADMIN couldn't provide any QAPI meeting minutes record for 6/17/2024. 4. The ADMIN admitted that there's no support and/or support for CDM, the ADMIN said, the Clinical Resources Nurse Consultant does nursing, but no dietary support for her. 5. The ADMIN acknowledged that he was aware of the condition in the kitchen, and RD did not make the ice buildup clearly in the report. The ADMIN also acknowledged that he was aware of the flies in the facility, the ADMIN said, people were going out of the sliding door, there were gaps in the door in the residents' room . 6. While asked to review the plan of action - Performance Improvement Plan (PIP), the ADMIN admitted that the facility hasn't started any PIP yet, the ADMIN said, We do have a form that we filled out as far as serving and stuff like that, but it's not specific to it, it's just going over any issues During an interview on 8/15/2024 at 10 am, with the Regional Director of Operations (RDO), 1. The RDO stated, there's been issues that have created deficiencies. We had to do some repairs as far as facility repairs. 2. The RDO acknowledged that she was aware the issues with the kitchen, the RDO stated, I know that right before you guys came in for survey, we had just discussed it and so we brought our vendor out there, to see how we can get it back up and functioning. 3. The RDO stated that RD, CDM and the administrator need to work diligently to be able to get the competencies in place.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 43739 Based on interview and record review, the facility failed to have an effective Quality Assurance Performance Improvement (QAPI) committee when they did not identify nor correct facility issues to ensure care and services met resident needs when: 1. There was no full time Registered Dietician (RD) or a Certified Dietary Manager (CDM) to provide direct oversight of dietary staff to deliver safe and sanitary food service for 49 of 49 residents. This resulted in an Immediate Jeopardy (IJ - a situation where a provider's noncompliance with requirements has, or could, result in serious harm, injury, impairment, or death to a resident) for failure to provide qualified oversight to perform daily kitchen inspections, provide feedback to staff, ensure kitchen staff is competent in performing their job duties effectively. Refer to F 801. 2. Dietary services did not follow national standards and guidelines for kitchen cleanliness, and the safety of the food storage. Refer to F 812. 3. The staff did not identify insidious weight loss (gradual, unintended, progressive weight loss over time), and maintain acceptable parameters of nutritional status for Resident 22. Refer to F 692, F 801. 4. The Social Services Department did not provide the care that meet the needs for Resident 6,8,12, and 303. Refer to F 745. 5. Fall care plans were not initiated for Resident 15, Resident 330, and revised timely for Resident 15 and 52. Refer to F 655, and F 657. Findings: During a review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Program, revised 2/2020, indicated: The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for the residents. The objectives of the QAPI Program are to: - Provide a means to measure current and potential indicators for outcomes of care and quality of life. - Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Reinforce and build upon effective systems and processes related to the delivery of quality care and services. - Establish systems through which to monitor and evaluate corrective actions. Authority The owner and/or governing board (body) of the facility is ultimately responsible for the QAPI programs. The governing board/owner evaluates the effectiveness of its QAPI program at least annually and presents findings to the QAPI. The administrator (ADMIN) is responsible for assuring that this facility's QAPI program complies with federal, state, and local regulatory agency requirements. The QAPI committee reports directly to the administrator. Implementation - The QAPI committee oversees implementation of the QAPI plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee. -The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of the process include: a. Tracking and measuring performance. b. Establishing goals and thresholds for performance c. Identifying and prioritizing quality deficiencies. d. Systematically analyzing underlying causes of systemic quality deficiencies. e. Developing and implementing corrective action or performance improvement activities. f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. -The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan. During a concurrent interview and record review on 8/9/24 at 3:09 pm, 1. RD confirmed he suggested to the administrator (ADMIN) about adding more staff for the kitchen since they could not keep up with the required tasks. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. RD was asked if any of these issues were being tracked and who was responsible for ensuring these were acted upon. RD stated the ADMIN was made aware. During a concurrent interview and record review on 8/13/2024 at 1:43 with the ADMIN, the Quality Assurance and Performance Improvement (QAPI) meeting minutes were reviewed, 1. The ADMIN admitted that he was made aware of the issues with the dietary department by the RD. 2. The ADMIN stated the RD was in the July QAPI meeting but was unable to provide RD's signature and RD's meeting minute note. 3. The ADMIN stated the CDM only came to the QAPI meeting on 6/17/2024. However, the ADMIN couldn't provide any QAPI meeting minutes record for 6/17/2024. 4. The ADMIN admitted that there's no support and/or support for CDM, the ADMIN said the Clinical Resources Nurse Consultant does nursing, but no dietary support for her. 5. The ADMIN acknowledged that he was aware of the condition in the kitchen, and RD did not make the ice buildup clearly in the report. The ADMIN also acknowledged that he was aware of the flies in the facility, ADMIN said people were going out of the sliding door, there were gaps in the door in the residents' room . 6. While asked to review the plan of action - Performance Improvement Plan (PIP), the ADMIN admitted that the facility hasn't started any PIP yet, the ADMIN said, We do have a form that we filled out as far as serving and stuff like that, but it's not specific to it, it's just going over any issues During an interview on 8/15/2024 at 10 am, with the Regional Director of Operations (RDO), 1. The RDO stated, there's been issues that have created deficiencies. We had to do some repairs as far as facility repairs. 2. The RDO acknowledged that she was aware the issues with the kitchen, the RDO stated, I know that right before you guys came in for survey, we had just discussed it and so we brought our vendor out there, to see how we can get it back up and functioning. 3. The RDO stated that RD, CDM and the administrator need to work diligently to be able to get the competencies in place.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43739 Based on interview, and record review, the facility failed to have an effective Quality Assessment and Assurance (QAA) program, when the QAA committee did not adequately identify, address, implement or monitor the effectiveness of implemented plans of action to correct deficiencies when: 1. There was no full time Registered Dietician (RD) or a Certified Dietary Manager (CDM) to provide direct oversight of dietary staff to deliver safe and sanitary food service for 49 of 49 residents. This resulted in an Immediate Jeopardy (IJ - a situation where a provider's noncompliance with requirements has, or could, result in serious harm, injury, impairment, or death to a resident) for failure to provide qualified oversight to perform daily kitchen inspections, provide feedback to staff, ensure kitchen staff is competent in performing their job duties effectively. Refer to F 801. 2. Dietary services did not follow national standards and guidelines for kitchen cleanliness, and the safety of the food storage. Refer to F 812. 3. The staff did not identify insidious weight loss (gradual, unintended, progressive weight loss over time), and maintain acceptable parameters of nutritional status for Resident 22. Refer to F 692, F 801. 4. The Social Services Department did not provide the care that meet the needs for Resident 6,8,12, and 303. Refer to F 745. 5. Fall care plans were not initiated for Resident 15, Resident 330, and revised timely for Resident 15 and 52. Refer to F 655, and F 657 Findings: During a concurrent interview and record review on 8/13/2024 at 1:43 with the ADMIN, the Quality Assurance and Performance Improvement (QAPI) meeting minutes were reviewed. While asked to review the Performance Improvement Plan (PIP), the ADMIN presented with a blank document titled. Performance Improvement Plan and stated that the facility hasn't started any PIP yet, the ADMIN said, We do have a form that we filled out as far as serving and stuff like that, but it's not specific to it, it's just going over any issues

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 43755 Based on observation, interview, and record review, the facility failed to ensure the essential facility equipment was maintained when: 1. Communication call light system was working for two rooms. This failure had the potential for residents with non-working call light systems to be at risk for accidents and their care needs not being met. 2. Walk-in freezer was not keeping food at the required 0 or below degrees Fahrenheit (F). 3. Dishwasher in the kitchen was not working. The dietary department equipment not in working order which had the potential for all residents to be at risk for food borne illness. Findings: A review of the facility's policy titled Call Lights: Accessibility and Timely Response (undated), indicated The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow resident to call for assistance. During a facility tour on 8/7/24 from 2:50 pm to 3:50 pm, with the Plant Operations Supervisor (POS), the call light system was observed. Residents in rooms 19 A and 11 B complained that their call light was not working and sometimes they had to wait a while for help. POS tested the systems and discovered that the lights would intermittently go on and off while the handheld push-button was pushed on. The POS indicated the lights should stay on when the button was pushed on. Both call systems were observed to have cord cables that had pulled away from the push-button base of the call light system and the black, blue, white, and red wires were visible. POS indicated the wires that connected the push-button base to the call cords had been pulled way and become disconnected, causing a break in the connection. Resident 154 indicated the wires to her push-button call light had been showing since she was admitted 6 weeks ago. POS confirmed that these call lights were not working correctly and needed fixing. 32797 2. A review of refrigeration service company invoices dated 8/2/24, indicated the service call was that the walk-in freezer was too warm. Service to correct the issue with the defrost (free the freezer of accumulated ice) timer due to an evaporator (heat exchanger where the refrigerant circulating inside the refrigeration circuit absorbs the thermal energy from the environment, which is then cooled) coil having ice buildup. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of of refrigeration service company invoices dated 8/3/24, indicated the service call was that the walk-in freezer temperature was 30 degrees F upon arrival and the freezer temperature when they left was 40 degrees F. The service call identified the defrost clock not energizing, evaporator needs to be replaced. Need to order new timer. During a concurrent observation and interview on 8/6/24 at 9:30 am, CK I warned the surveyors of fall risk due to liquids on the refrigerator and freezer floor. CK I did not know when this started or what the cause of the liquids on the floor meant. CK I confirmed the freezer temperature was 35 degrees F, not at required temperature of 0 or below F. Freezer had items that were not hard to touch, ice cream, cheese, deli meat, and two 10 pound rolls of hamburger soft to touch. Melted liquids throughout the freezer floor. CK I was unable to answer how long the walk-in freezer was out of temperature range and had not contacted anyone about the issue. During an interview on 8/6/24 at 9:40 am, Administrator and Plant Operation Supervisor were both unaware that the walk-in freezer was not at the required temperatures. 3. A review of an electrical service company invoice dated 7/31/24, indicated a service call was performed on the dishwasher. The invoice indicated an electrical breaker needed replacement and recommendation was to upgrade it due to age and safety. An electrical breaker was ordered, and delivery was expected in five days. A review of a dishwasher temperature log dated for August 2024, indicated the last entry was on 8/1/24. During a concurrent observation and interview on 8/6/24 at 10:41 am, Certified Dietary Manager (CDM) stated the problem with the walk-in freezer started on 8/2/24, and the issue was the defrost cycle and timer. CDM was here on the weekend 8/3-8/4/24. CDM confirmed the dishwasher thermostat was not working for about a week and a half and a new electrical breaker was needed to fix it. During an interview 8/9/24 at 3:09 pm, the Registered Dietician D stated he had concerns about sanitary and safe conditions in the kitchen due to issues with the dishwasher and freezer temperatures.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and document review, the facility did not provide 80 square feet per resident, as required by regulation, in 12 resident rooms (Rooms 1, 2, 3, 4, 5, 17, 18, 19, 20, 21, 22, and 23). This had the potential to result in inadequate space for care or services and impact a residents' right to an environment that meets the unique needs and preferences and prevents them from achieving independent functioning, dignity, and well-being. Refer to F558. Findings: During a review of a former recertifcation survey, a room waiver for the reduced bedroom sizes less than 80 sqaure feet was requested by the facility and granted by the Centers for Medicare & Medicaid services. There was no expansion since the last survey. A copy of the resident roster dated 8/6/24, indicated rooms 1, 2, 4, 5, 17, 18, 19, 20, 21, 22, and 23 had three residents per room. room [ROOM NUMBER] had no residents. During a concurrent observation and interview on 8/07/24 at 3:35 pm in room [ROOM NUMBER], Resident 35 stated he does not have enough room to get to his stuff. room [ROOM NUMBER] has three beds and three residents. Resident 35 stated the fan in front of the bathroom near his bed (Bed 2 in the middle) blows on him and does not like it. The fan was plugged into the bathroom outlet and the cord was not secured. Resident 35 was observed trying to get his personal belongings out of his bedside cabinet and there were incontinent pads on the floor blocking the drawer. Resident 35 almost fell out of his wheelchair trying to get to his bedside table. Resident 35 stated he cannot use the bathroom to clean and put in his dentures due to his wheelchair not fitting in the bathroom. Resident 35 stated he cannot move around his room and use his bedside table when cleaning his dentures (not enough space between the beds). room [ROOM NUMBER] had a portable air conditioner on the floor in the far corner of Bed 3 near the window and the exhaust tubing was vented out the window. There was another fan in the far corner by Bed 1 as well. Resident 45 who was in Bed 1 had a wheelchair.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797 Based on observation, interview, and record review the facility failed to ensure they maintained an effective pest control program when flies and other pests were observed throughout the building. This resulted in residents to experience flies landing on them during meals and did not honor their right to have a home environment free from pests. Findings: A review of a facility policy titled Pest Control Program dated 2024, indicated an effective pest control program was defined as measures to remove and contain any common household pests (e.g. flies, ants, and roaches). Facility will utilize a variety of methods in controlling the pests. These will involve indoor and outdoor methods. A review of a Registered Dietician (RD) inspection of the kitchen on 5/1/24 at 8:29 pm, emailed to Administrator (ADMIN) and Governing Body (GB), indicated findings for the audit: -.gap under screen door in kitchen, this door will be an issue with flies as weather heats up. A review of sanitation findings on 5/30/24 at 8:41 am, emailed to ADMIN and GB, RD indicated spider webs and fly in kitchen. During a concurrent observation and interview on 8/6/24 at 9:25 am, [NAME] I confirmed flies in the kitchen. During, resident confidential interviews on 8/7/24 at 10 am, 11 out of 14 residents felt there are flies everywhere and one resident stated, There is always flies on my food. During a concurrent observation and interview on 8/9/24:10:25 am, Certified Dietary Manager (CDM) confirmed multiple flies in the kitchen. CDM stated the back screen door where there were gaps on the top and bottom of the door was just fixed. CDM stated these gaps allowed flies to enter the kitchen. During a concurrent observation and interview on 8/9/24 at 12:40 pm, CK J was plating food during tray-line, and one of the plate lids had a black bug crawling on the inside, she removed the lid. Flies were observed landing on resident food trays. During an interview on 8/06/24 at 3:29 at pm, Resident 41 stated she had multiple flies all over her food at dinner. During an observation on 8/07/24 at 10:50 am, room [ROOM NUMBER] had flies in the room. During an observation on 8/7/23 at 3:19 pm, Resident 21 had flies all around him while lying in bed. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/08/24 at 8:47 am, Resident 36 was observed with a fly swatting device. Resident 36 stated he has a telescoping fly swatter that his daughter bought him three days ago and he has swatted 31 flies with it. During a concurrent observation an interview on 8/7/24 at 11:05 am, Plant Operations Supervisor (POS) stated he installed three flytraps, one in the entrance lobby on Monday, 08/05/2024, one in the main dining hall one week ago, and one in the kitchen about 1 month ago. POS stated he recently put some weather stripping around the top and bottom of the door to seal it.