STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Placerville Healthcare Center	1040 Marshall Way Placerville, CA 95667

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 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

45770

Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS- a federally mandated resident assessment tool) for two of 25 sampled residents (Resident 18 and Resident 48), when:

1. Resident 18's use of narcotic pain medication was not coded in the MDS admission assessment; and

2. Resident 48's pressure ulcers (PUs; localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) were not accurately coded in her admission assessment.

This failure decreased the facility's potential to provide residents with appropriate care and interventions.

Findings:

1. A review of Resident 18's Admission Record, indicated she was admitted to the facility in September 2024 with diagnoses including compression fracture of the vertebra (a break in the bone at the bottom of the spine).

A review of Resident 18's Order Summary Report, dated 9/30/24, indicated an order for tramadol hydrochloride (pain killer) 25 milligrams (mg; a unit of measurement) every eight hours as needed for pain.

A review of Resident 18's MDS admission assessment, dated 10/3/24, indicated Resident 18 had no order for an opioid (narcotic pain killer) medication.

During a concurrent interview and record review on 10/24/24 at 11:10 a.m. with the Director of Nursing (DON), Resident 18's Order Summary Report and MDS admission assessment were reviewed. DON confirmed Resident 18 had an order for an opioid pain medication but was not coded in her MDS admission assessment.

2. A review of Resident 48's Admission Record, indicated she was admitted to the facility in September 2024 with diagnoses including intertrochanteric left femur fracture (fracture of the left upper part of the thigh bone).

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 48's Baseline Care Plan, dated 9/16/24, indicated Resident 48 had pressure ulcers to the left heel and coccyx (tail bone) upon admission. A review of Resident 48's Wound Physician Consultation Note, dated 9/17/24, indicated Resident 48 had stage three PU (Full-thickness loss of skin. Dead and black tissue may be visible) to the coccyx and an unstageable wound to the left heel. During a concurrent interview and record review on 10/23/24 at 10:30 a.m. with the MDS coordinator (MDSC), Resident 48's MDS admission assessment, dated 9/21/24, wound consultation notes and baseline care plan were reviewed. MDSC stated she was not aware Resident 48 had PUs and confirmed she missed coding the PUs in Resident 48's MDS admission assessment. During an interview on 10/24/24 at 11:10 a.m. with the DON, DON stated her expectation was the nurse assigned to do the residents' assessments should have completed the task accurately so that appropriate care and interventions would have been provided to the residents. A review of the facility's policy and procedure, titled Resident Assessments, revised 2023, stipulated, The resident assessment coordinator is responsible for ensuring that the . team conducts timely and appropriate resident assessments.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47465 Based on observation, interview, and record review, the facility failed to revise in a timely manner the care plans for one of 25 sampled residents (Resident 30), when: 1. Resident 30's anticoagulant care plan was not revised and updated since 3/23/24; and These failures decreased the facility's potential to provide resident-centered care plans and evaluate its effectiveness. Findings 1. A review of an admission record indicated, Resident 30 was admitted to the facility in November 2022 with a diagnosis of hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). A review of Resident 30's clinical record included the following documents: An anticoagulant (medication that prevent or reduce blood clotting) care plan, dated 3/23/24, indicated Resident 30 was receiving rivaroxaban (blood thinner that treats or prevents blood clots). A physician's order listing report indicated rivaroxaban 20 milligrams (mg; a unit of measurement) was discontinued on 9/9/24 and apixaban (blood thinner that treats or prevents blood clots) 10 mg was started on 9/9/24. During an interview and record review on 10/23/24 at 9:45 a.m. with the Assistant Director of Nursing (ADON), Resident 30's anticoagulant care plan was reviewed. ADON confirmed rivaroxaban was discontinued on 9/9/24 and stated the care plan was not updated to apixaban. ADON further stated her expectation was care plans should have been reviewed and revised every 90 days or as soon as a new order was received; otherwise, not having up to date care plans could affect Resident 30's care. A review of the facility's policy and procedure (P&P) titled, Care Plan Revision, revised 8/2024, indicated, Care plans shall be reviewed/revised to incorporate goals and objectives to meet resident's individual needs. P&P further indicated, Goals and objectives are reviewed and/or revised . at least quarterly.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45770 Based on observation, interview, and record review, the facility failed to provide respiratory care services according to professional standards of quality for two of 25 sampled residents (Resident 19 and Resident 40), when: 1. Resident 19's administered oxygen was not consistent with the physician's order; and 2. Resident 40 missed nebulizer (a liquid medication turned into a mist by a machine and inhaled through a mask used to treat lung diseases) treatments on 10/4/24 and 10/15/24. These failures decreased the facility's potential to safely follow the physician's order when providing respiratory services. Findings: 1. A review of Resident 19's Admission Order, indicated she was admitted to the facility in February 2024 with a diagnosis of chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a concurrent observation and interview on 10/21/24 at 8:45 a.m. with Resident 19, Resident 19 was observed in bed holding her oxygen tubing and not using it. Resident 19 stated she only used oxygen at night when sleeping with her continuous positive airway pressure machine (CPAP-a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in). A review of Resident 19's Order Summary Report (OSR), dated 4/16/24, indicated an order for a continuous use of oxygen via nasal cannula at two liters per minute. During an observation on 10/21/24 at 11 a.m., Resident 19 was observed by the hallway propelling herself in the wheelchair and going towards the rehabilitation gym without using her oxygen. During a concurrent interview and record review on 10/22/24 at 1:04 p.m. with Licensed Nurse 2 (LN 2), Resident 19's OSR was reviewed. LN 2 confirmed the order for Resident 19's oxygen use was written as continuous and not as needed. During a concurrent observation and interview on 10/22/24 at 1:06 p.m. with the Infection Preventionist (IP), Resident 19 was observed inside her room with no oxygen in use. The IP verified Resident 19 was not on oxygen and stated Resident 19 only used oxygen as needed at night with the CPAP machine. During an interview on 10/24/24 at 11:10 a.m. with the Director of Nursing (DON), DON stated she expected her nursing staff to follow physician orders accordingly. DON further stated if the order needed revision, then it should have been revised immediately to help minimize errors in the delivery of care. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Physician Orders, revised 2024, stipulated, The licensed staff shall carry out physician/nurse practitioner's orders as prescribed. 2. A review of an admission record indicated, Resident 40 was admitted to the facility in 2019 with a diagnosis of COPD. A review of Resident 40's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/11/2024, indicated Resident 40 had no cognitive impairment. During an interview on 10/21/24 at 10:05 a.m. with Resident 40, Resident 40 stated she did not always get her scheduled nebulizer treatments which caused her to be short of breath. During an interview on 10/22/24 at 2:59 p.m. with Resident 40, Resident 40 stated, I did not get nebulizer treatments multiple times this month. Resident 40 further stated, when nebulizer was not given, I can't breathe, there's phlegm in my throat, and the air can't get through. I feel angry and stressed out because I know if I would get my treatment, I wouldn't have so much trouble, so I get mad. I get scared because I can't breathe. A review of Resident 40's medication administration record (MAR, a document used to record when medications or doctor's orders are administered to residents), indicated there was no documentation for the 5:00 p.m. doses of ipratropium bromide inhalation (medication used to treat lung conditions) on 10/4/24 and 10/15/24. During a concurrent interview and record review on 10/22/24 at 10:06 a.m. with LN 6, Resident 40's MAR for October 2024 was reviewed. LN 6 acknowledged the MAR for ipratropium bromide inhalation was incomplete and stated Resident 40 might have not got the medication because there was no charting. During an interview on 10/22/24 at 2:49 p.m. with LN 7, LN 7 stated the expectation regarding medication administration documentation was nurses should have documented that Resident 40 took medication as soon as they came out of room. During an interview on 10/22/24 at 4:16 p.m. with the DON, DON stated if a resident missed a nebulizer treatment, then the patient could have increased shortness of breath or . COPD exacerbation . increased anxiety. DON further stated nurses are expected to sign out nebulizer treatment when given . Documentation is best practice . if blank hole, they forgot to sign out or it was not given. During an interview on 10/22/24 at 4:30 p.m. with the Director of Saff Development (DSD), DSD stated, If you don't document it, it didn't happen . Accurate and timely documentation is part of ethics training. A review of the facility's P&P titled, Conformity with Laws and Professional Standards of Care, dated 8/2024, indicated, Our facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45770 Based on observation, interview, and record review, the facility failed to ensure one of 25 sampled residents (Resident 11) received dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) care and services consistent with professional standards of practice, when Resident 11's order for fluid restriction was not followed as per physician's order. This failure increased Resident 11's risk to develop fluid overload. Findings: A review of Resident 11's Admission Record, indicated he was admitted in January 2017 with a diagnosis of stage four chronic kidney disease. During an observation on 10/21/24 at 9:40 a.m. inside Resident 11's room, three water pitchers were placed on Resident 11's bedside table. A review of Resident 11's Order Summary Report (OSR), dated 5/31/24, indicated an order for fluid restriction of 1000 milliliters per day (ml/day; a unit of measurement), 700 ml/day for dietary and 300 ml/day for nursing. A review of Resident 11's OSR, dated 8/16/24, indicated Resident 11 had an order for dialysis three times a week on Mondays, Wednesdays, and Fridays, in the morning at 9 a.m. A review of Resident 11's care plan, dated 10/15/24, indicated an intervention to educate Resident 11 and or representative the importance of following dietary and fluid restriction orders. During a concurrent observation and interview on 10/23/24 at 9:40 a.m. with Licensed Nurse 2 (LN 2) inside Resident 11's room, LN 2 confirmed there were three water pitchers placed on Resident 11's bedside table. LN 2 stated Resident 11 should not have water pitchers in his room because he had an order for fluid restriction and was on dialysis. During a concurrent interview and record review on 10/23/24 at 10 a.m. with the Assistant Director of Nursing (ADON), Resident 11's OSR and input/output records were reviewed. ADON confirmed Resident 11 had an order for fluid restriction because of his dependence on dialysis. ADON stated it was her expectation for nurses to follow the physician's order regarding fluid restrictions. ADON further stated nurses must be able to explain and implement order for residents to prevent fluid overload and other complications that might lead to hospitalization . A review of the facility's policy titled, Encouraging and Restricting Fluids, reviewed 2024, indicated, Residents with fluid restriction will be informed that water pitcher will not be placed to allow for fluid to be restricted per MD [Medical Doctor] order.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49821 Based on interview and record review, the facility failed to ensure controlled substance medications (medications that the use and possession of are controlled by the federal government) for four residents (Resident 33, Resident 37, Resident 51, and Resident 73) of a census of 91 were accurately accounted on the Medication Administration Record (MAR) and Controlled Drug Record (CDR). This failure decreased the facility's potential to ensure accurate accountability for residents' controlled medications and prevent its misuse. Findings: A review of an admission record indicated, Resident 33 was admitted to the facility on [DATE] with a diagnosis of chronic pain syndrome. A review of Resident 33's Order Summary Report, dated 10/22/24, indicated an order for hydrocodone-acetaminophen (an opioid medication used to treat pain) 5/325 milligrams (mg; a unit of measurement), two tablets every four hours as needed for severe pain and one tablet every four hours as needed for moderate pain. A review of Resident 33's CDR and MAR, dated 10/24, indicated hydrocodone-acetaminophen was given on 10/19/24 at 3:34 p.m. and 6:34 p.m. in the CDR and not noted as given in the MAR. The MAR also indicated the drug was given on 10/19/24 at 8 p.m., but it was not listed as administered in the CDR. A review of an admission record indicated, Resident 51 was admitted to the facility on [DATE] with diagnoses including primary osteoarthritis (a chronic disease that breaks down cartilage and tissues in joints, causing pain and stiffness) and chronic pain. A review of Resident 51's Order Summary Report, dated 10/22/24, indicated there was an order for hydrocodone-acetaminophen 5/325 mg, one tablet every 24 hours as needed for moderate to severe pain and one tablet three times a day for pain. A review of Resident 51's CDR and MAR, dated 10/24, indicated hydrocodone-acetaminophen was given on 10/19/24 at 12 a.m. in the MAR, but not listed as administered in the CDR. The CDR also indicated the medication was given on 10/16/24 at 4 a.m. and 10/17/24 at 4 a.m. and was not listed as given in the MAR. A review of an admission record indicated, Resident 37 was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease (PVD-a slow and progressive disorder of the blood vessels causing pain) and abnormal posture. A review of Resident 37's Order Summary Report, dated 10/22/24, indicated there was an order for hydrocodone-acetaminophen 5/325 mg, one tablet every six hours as needed for moderate to severe pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 37's CDR and MAR, dated July-October 2024, indicated hydrocodone-acetaminophen doses were documented in the CDR and not in the MAR on the following dates: 7/17/24 at 8 p.m., 9/13/24 at 3:02 p.m. and 9:02 p.m., and 9/20/24 at 3 p.m. A review of an admission record indicated, Resident 73 was admitted to the facility on [DATE] with diagnoses including primary osteoarthritis of hip and malignant neoplasm (cancerous tumor) of bladder. A review of Resident 73's Order Summary Report, dated 10/22/24, indicated there was an order for lorazepam (a medication to treat anxiety) one mg tablet every eight hours as needed for anxiety and agitation, two mg tablet three times a day for behavior, and two mg tablet at bedtime for anxiety, hallucinations, and restlessness. The report also indicated lorazepam one mg, two tablets by mouth every four hours as needed for moderate to severe anxiety and agitation and one tablet every four hours as needed for mild anxiety and agitation. A review of Resident 73's CDR and MAR, dated August-September-October 2024, indicated lorazepam doses were documented in the CDR, but not in the MAR on 8/17/24 at 12:30 a.m., 8/23/24 at 8 a.m., 8/29/24 at 1:20 p.m., 8/30/24 at 4 p.m., 9/11/24 at 1 p.m. and 9 p.m. Lorazepam doses were also documented in the MAR, but not in the CDR on 8/31/24 at 6 a.m. and 2 p.m., 9/8/24 at 6 a.m., 9/9/24 at 2 p.m., 9/25/24 at 2 p.m. , 10/1/24 at 2 p.m., and 10/2/24 at 2 p.m. During a concurrent interview and record review on 10/22/24 at 10:05 a.m. with the Director of Nursing (DON), Resident 33's, 37's, 51's, and 73's CDRs and MARs were reviewed. DON stated the times the medications were given must be within the same timeframe for both the CDR and the MAR and nurses should have documented administration times in the CDR and MAR at the same time after they obtained the controlled drug from the bubble pack (a form of medication packaging where individually sealed pills are pushed through foil). DON also stated correct documentation was important for accountability and for nurses to know when to give the next dose. A review of the facility's policy and procedure titled, Controlled Medications, revised 8/24, indicated, When a controlled medication is administered, the licensed nurse administering the medication enters the following information on the accountability record and the medication administration record . Date and time of administration . Amount administered . Signature of the nurse administering the dose, completed after the medication is actually administered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49821 Based on interview and record review, the facility failed to adequately monitor behaviors for quetiapine (a drug that treats mental health disorders) administration to one resident (Resident 35) of a census of 91. This failure had the risk for residents' ineffective medication management and inadequate decision-making for medications' gradual dose reduction (GDR). Findings: A review of an admission record indicated, Resident 35 was admitted to the facility on [DATE] with a diagnosis of dementia (a progressive state of decline in mental abilities) with behavioral disturbance. A review of Resident 35's hospitalization record titled, History and Physical: Orders, dated 9/11/24, indicated Resident 35 was admitted on [DATE] for dementia with agitation and combativeness and was prescribed quetiapine 25 milligrams (mg-a unit of measurement) at bedtime. A review of Resident 35's Order Summary Report, dated 10/22/24, indicated nursing staff were to monitor Resident 35's behaviors of agitation and combativeness every shift. A review of Resident 35's Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 9/1/24 - 10/22/24, indicated Resident 35 started quetiapine 25 mg at nighttime on 9/15/24. The MAR assigned behavior monitoring to include agitation and combativeness during every shift (day, evening, and night), indicated a yes or no options for whether behaviors occurred or not, but did not have a section for the night shift to count behaviors. During an interview at 10/22/24 at 1:45 p.m. with Licensed Nurse (LN) 4, LN 4 stated the expectations were Resident 35's behaviors should have been counted to make sure the medication was effective. LN 4 confirmed the day and evening shift had boxes for the nurses to indicate the number of behaviors exhibited during the shift, but the night shift only had yes or no options to indicate whether behaviors occurred during that shift. LN 4 further stated the yes or no options were not effective, because these descriptors could not be quantified. During an interview on 10/22/24 at 2:01 p.m. with the Director of Nursing (DON), DON stated to keep track of Resident 35's behaviors while taking quetiapine, the doctor needed the number of behaviors quantified on the MAR every shift to ascertain the effectiveness of the medication, determine if dosage adjustments need to be made, and to plan for GDR. DON also stated there should have been a section to quantify the resident's behaviors during the night shift. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Antipsychotic Medication Use, revised 8/24, indicated, The staff will observe, document, and report to the Attending Physician pertinent information regarding effectiveness of any interventions, including antipsychotic medications [drugs used to treat mental disorders characterized by a disconnection from reality].

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49821

Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent (%) for four residents (Resident 3, Resident 38, Resident 55, and Resident 67) of a census of 91, when seven medication errors out of 39 opportunities were observed during medication pass.

This failure resulted in medication error rate of 17.95% for the facility.

Findings:

A review of an admission record indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses including gastro-esophageal reflux disease (GERD-a condition in which stomach acid flows back into the tube connecting the mouth and stomach) and glaucoma (increased eye pressure that can cause blindness).

During a medication pass observation on 10/21/24 at 8:24 a.m., Licensed Nurse 1 (LN 1) was observed administering the following medications to Resident 3:

1. One capsule of delayed release omeprazole (a medication used to treat conditions with too much acid in the stomach) 20 milligrams (mg-unit of measurement);

2. One tablet of vitamin D3, 25 micrograms (mcg-unit of measurement); and

3. Dorzolamide/timolol (eye drops used to treat increased eye pressure) 22.3/6.8 mg/ml (milligram-a unit of weight; milliliter-a unit of volume) eye drops. LN 1 asked Resident 3 to look up toward the ceiling and then administered one drop right below each eyeball. No medication contacted the eyes.

A review of Resident 3's Order Summary Report, dated 10/22/24, indicated the physician orders were omeprazole delayed release 20 mg, one capsule by mouth two times a day for reduced stomach acid, vitamin D3 50 mcg, one tablet by mouth one time a day, and dorzolamide hydrochloride-timolol maleate 2-0. 5 %, to instill one drop in each eye two times a day.

A review of Resident 3's Medication Administration Record (MAR), dated 10/22/24, indicated omeprazole was given on 10/21/24 at 8:27 a.m.

During an interview on 10/21/24 at 11:38 a.m. with LN 1, LN 1 stated she was supposed to administer omeprazole to Resident 3 between 6 a.m. and 7 a.m. LN 1 further stated, I was late on that one.

During an interview and record review on 10/21/24 at 11:44 a.m. with LN 1, Resident 3's MAR was reviewed. LN 1 stated she might have administered 25 mcg of vitamin D3 to Resident 3.

During an interview on 10/21/24 at 11:45 a.m. with LN 1, LN 1 stated Resident 3 sometimes pulled down his lower eyelid to make administering the eye drops easier and she thought she got the eye drops into Resident 3's eyes.

(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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 9:46 a.m. with the Director of Nursing (DON), DON stated nurses should have given medications like omeprazole 30 minutes before eating or two hours after a meal. DON also stated omeprazole was usually given at 6 a.m. or 7 a.m. before the breakfast meal. A review of the facility's procedure titled, Administering Ophthalmic Medications, revised 8/24, indicated, Pull the lower eyelid down and away from the eyeball to form a pocket . Hold the dropper tip directly over the eye . A review of an admission record indicated, Resident 38 was admitted to the facility on [DATE] with diagnoses including atherosclerosis (the build-up of fats on the artery walls) of arteries on the left leg and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). During a medication pass observation on 10/21/24 at 9:11 a.m., LN 1 was observed administering one tablet of cilostazol (a medication that improves blood flow through the blood vessels) 100 mg to Resident 38. A review of Resident 38's Order Summary Report, dated 10/22/24, indicated, cilostazol 100 mg, one tablet 30 minutes before or two hours after a meal. During an interview on 10/21/24 at 11:49 a.m. with LN 1, LN 1 confirmed cilostazol was given within a meal timeframe. During an interview on 10/22/24 at 9:48 a.m. with the DON, DON stated nurses should have administered medications like cilostazol either 30 minutes before eating or two hours after eating. DON also stated residents were usually given these medications before meals between 6 a.m. and 7 a.m. A review of an admission record indicated, Resident 55 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (a condition in which blood flow to the brain is blocked, causing brain tissue to die). During a medication pass observation on 10/21/24 at 9:23 a.m. with LN 2, LN 2 was observed administering one tablet of enteric coated acetylsalicylic acid-aspirin (ASA, a drug that reduces pain, fever, inflammation, and blood clotting) 81 mg to Resident 55. LN 2 crushed the medication along with other medications, poured them into a medication cup, and mixed them with a table spoonful of chocolate pudding. A review of Resident 55's Order Summary Report, dated 10/22/24, indicated to give 81 mg of chewable aspirin tablet by mouth in the morning for stroke prevention. During an interview on 10/21/24 at 11:57 a.m. with LN 2, LN 2 confirmed as per order, aspirin was chewable and stated the enteric coated aspirin was not crushable. A review of an admission record indicated, Resident 67 was admitted to the facility on [DATE] with diagnoses including atrophy (wasting away of an organ) of the kidney and hydronephrosis (a condition where kidneys swell due to buildup of urine). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication pass observation and interview on 10/21/24 at 9:23 a.m. with LN 2, LN 2 administered one capsule of omeprazole 20 mg to Resident 67 at 9:41 a.m. LN 2 stated Resident 67 was to receive phenazopyridine (an analgesic pain reliever used to treat increased urination, and increased urge to urinate) 100 mg as ordered, but it was not given because it was not available in the medication cart. A review of Resident 67's Order Summary Report, dated 10/22/24, indicated, omeprazole delayed release 20 mg: Give 1 capsule by mouth one time a day for GERD. Take on an empty stomach . The report further indicated one tablet of phenazopyridine 100 mg to be given by mouth two times a day for dysuria (painful urination) for three days. A review of Resident 67's MAR, dated 10/24, indicated omeprazole to be given daily at 7:30 a.m. During an interview and record review on 10/21/24 at 12 p.m. with LN 2, Resident 67's MAR was reviewed. LN 2 confirmed Resident 67 did not receive omeprazole before her meal and stated Resident 67 usually got this medication around 8 a.m. LN 2 confirmed giving Resident 67 phenazopyridine at 11:13 a.m. on 10/21/24 and stated, I think she's supposed to not take it with meals. During an interview on 10/22/24 at 9:46 a.m. with the DON, DON stated omeprazole should have been given at 7:30 a.m. before breakfast and confirmed it was given late. During an interview on 10/22/24 at 9:57 a.m. with the DON, DON stated Resident 67 should have eaten food while taking phenazopyridine and if she just ate, then she could take phenazopyridine, or she could take it with a snack. DON also stated medication administration directions should be on the MAR and if an unfamiliar drug was ordered for a resident, then nurses needed to check the administration directions in a drug manual or ask another nurse. A review of an undated drug manufacturer prescription titled, Pyridium-phenazopyridine tablet, film coated/Amneal Pharmaceuticals LLC, indicated, Dosage and Administration: 100 mg Tablets: Average adult dosage is two tablets 3 times a day after meals. A review of the facility's policy titled, Administering Medications, revised 8/24, indicated, Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders, including any required time frame.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49821 Based on observation, interview, and record review, the facility failed to ensure two medications in a medication cart were properly labeled with open dates (dates residents start using a product) for a census of 91. This failure increased the facility's potential to administer expired medications to residents. Findings: During a concurrent observation and interview on 10/21/24 at 12:15 p.m. with Licensed Nurse 3 (LN 3), LN 3 confirmed two respiratory treatment medications were found unsealed without open dates in medication cart three: 1. An opened and undated foil pouch of budesonide (a medicine for asthma, a long-term lung disease) nebulization (a method of delivering medication into the lungs by turning liquid medicine into a mist that is inhaled through a mouthpiece or mask) suspension. LN 3 stated nursing staff were expected to write open dates on pouches containing respiratory medications. LN 3 also stated when she first opened a drug foil packet, she would write the date on the packet, and 2. A box, dated 9/17/24, with Advair Diskus (a medication used to prevent asthma attacks) inhaler (a handheld device that delivers medicine directly to the lungs in the form of a spray, mist, or powder that is inhaled through the mouth or nose) dispenser, dated 10/10/24. LN 3 stated the dates for the medication and box were confusing. During an interview on 10/22/24 at 9:46 a.m. with the Director of Nursing (DON), DON stated her expectation of nursing staff was to label medications with open dates. DON added nurses should have written the open date on the budesonide pouch so they would know when to discard the remaining vials two weeks following the opening date. DON also stated the open date for inhalers was written on the dispensers and if the dispenser was not labeled then no one would know the expiration date. A review of the facility's policy titled, Medication Labeling, revised 8/24, indicated, The facility labels medications appropriately . Follow the manufacturer's expiration date for inhalers.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40830 Based on observation, interview, and record review, the facility failed to ensure the menu was followed for the therapeutic diet during the lunch meals on 10/21/23 and 10/22/23 when: A. Dining observation on 10/21/24: 1. Two residents (Resident 18 and 58) with consistent or controlled carbohydrate (CCHO) diet (diet for people need to control their blood sugar or to manage diabetes) received one slice of garlic bread instead of half (1/2) slice; 2. Resident 35 with dysphagia mechanical (DM) texture diet (diet for people with trouble chewing, swallowing, or fully breaking down food and usually ground, pressed, or strained to pudding like consistency) with thin liquids (regular liquid consistency) received pudding instead of ice-cream as dessert, and 3. Resident 54 with finger food (FF) diet (diet that provides food in appropriate size and shape to be eaten without utensils but rather with fingers, it allows residents to maintain independence, dignity, and quality of life) received spaghetti instead of bowtie or twister pasta and did not receive dessert. B. Meal service distribution on 10/22/24: 1. Three residents (Resident 8, 35, and 62) with DM texture diet received regular rice and bean instead of puree rice and bean, and puree apple bread pudding instead of soaked chopped bread pudding; 2. Two residents (Resident 6 and 72) with renal diet (diet is for people to manage chronic kidney disease) and CCHO diet received white rice and regular dessert instead of brown rice and diet dessert, and 3. Two residents (Resident 16 and 54) with FF diet received pork cut in slices, penne pasta and diced pear dessert, instead of port cut in bite size, diced potato with margarine and apple bread pudding cut in four pieces. These failures had the potential to result in compromising the medical and nutritional status of nine out of 88 residents who received meals from the facility kitchen. Findings: A. During a dining observation for lunch meal on 10/21/24, beginning at 12:54 p.m., it was noted as followed: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident 18 and 58 with CCHO diet received one slice of garlic bread. A concurrent review of facility spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) titled, Fall Menus, Week 4 Monday, indicated CCHO diet should have received 1/2 slice of garlic bread. 2. Resident 35 with DM texture diet with thin liquid received pudding as dessert. A concurrent review of facility spreadsheet titled, Fall Menus, Week 4 Monday, indicated DM texture diet with thin liquid should have received ice-cream as dessert. 3. Resident 54 with FF diet received spaghetti and no dessert. A concurrent review of facility spreadsheet titled, Fall Menus, Week 4 Monday, indicated FF diet should have received bowtie, [NAME], or twisties pasta with the entree and popsicle or ice-cream bar as dessert. B. During the lunch meal distribution on 10/22/24, beginning at 12:21 p.m., it was noted as followed: 1. Resident 8, 35 and 62 with DM texture diet received regular texture rice and bean with entree dish and puree apple bread pudding as dessert. A concurrent review of facility spreadsheet titled, Fall Menus, Week 4 Tuesday, indicated DM texture diet should have received puree rice and bean and soaked chopped bread pudding. 2. Resident 6 and 72 with Renal and CCHO diet received white rice and regular apple bread pudding. A concurrent review of facility spreadsheet titled, Fall Menus, Week 4 Tuesday, indicated Renal and CCHO diet should have received brown rice and diet sliced apples with cinnamon. 3. Resident 16 and 54 with FF diet received pork roast in slices, penne pasta, and diced pear dessert. A concurrent review of facility spreadsheet titled, Fall Menus, Week 4 Tuesday, indicated FF diet should have received pork roast cut in bite (cube) size, diced potato with margarine and apple bread pudding cut in four pieces. During an interview on 10/22/24 at 2:09 p.m. with Dietary Supervisor (DS), DS acknowledged and confirmed the observation findings for lunch meals on 10/21/24 and 10/22/24. He stated his expectation for the kitchen staff should provide accurate food items on the meal distribution and follow the menu or spreadsheet. He added the staff needed to pay more attention to put together the meal before delivery. During an interview on 10/23/24 at 11:52 a.m. with Registered Dietitian (RD), RD stated the kitchen staff needed to follow the menu or spreadsheet during the meal distribution. She added the kitchen staff needed to make the meal right to match the therapeutic diets with their nutrition analysis. RD further stated if staff gave more starch to resident with CCHO diet then that might lead to increased blood sugar level. RD added if staff gave incorrect food texture then that might put the residents at risk for choking or aspiration. A review of the facility's policy and procedure titled, Menu Planning, dated 2023, indicated, . menus are planned to meet nutritional needs of residents in accordance with established national guidelines . the facility's diet manual and diets are ordered by the physician should mirror the nutritional care provided by the facility . menus are written for regular and therapeutic diets in compliance with the diet manual . (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's document titled, Job Description: Cook, dated 2/2024, indicated, . essential duties . to follow prepared menus . to prepare special diets accurately . A review of the facility's document titled, Job Description: Dietary Supervisor, dated 2/2024, indicated, . essential duties . check trays for accuracy before they are delivered .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 40830 Based on observation, interview, and record review, the facility failed to accommodate the food preferences (food items under the standing order) on the meal tickets (tickets including resident's diet, date, allergies, specific food and beverage items, dislikes, likes) for five residents (Resident 1, 2, 4, 8, and 81) out of 88 residents who received meals from the facility's kitchen. These deficient practices had the potential to result in meal dissatisfaction and decreasing meal intake that may lead to further compromising medical and nutrition status and/or weight loss of the residents. Findings: During an observation of lunch meal service distribution with concurrent review of residents' meal tickets on 10/22/24, beginning at 12:21 p.m., it was noted as followed: 1. Resident 1 with Regular diet did not receive cottage cheese when the meal ticket indicated Resident 1 should have received cottage cheese as standing order; 2. Resident 2 with Regular, two grams (g; a unit of measurement) Na (sodium) diet (diet with consumption of limited amount of sodium to 2,000 milligrams (mg; a unit of measurement) per day, usually to manage variety of health condition, such as heart disease or kidney disease) did not receive side salad with blue cheese dressing when the meal ticket indicated Resident 2 should have received side salad with blue cheese dressing as standing order; 3. Resident 4 with Regular mechanical soft texture diet (diet with modified texture by chopping or grinding to be soft that allows people who experience chewing or swallowing limitations) did not receive cottage cheese, half (1/2) of tuna salad sandwich, and chicken noodle soup when the meal ticket indicated Resident 4 should have received those food items as standing order; 4. Resident 8 with Regular dysphagia mechanical texture diet (diet is for people with trouble chewing, swallowing, or fully breaking down food and usually ground, pressed, or strained to pudding like consistency) did not receive ice-cream when the meal ticket indicated Resident 2 should have received ice-cream as standing order, and 5. Resident 81 with regular no added salt (NAS) fortified (added calories and/or protein) diet did not receive cottage cheese when the meal ticket indicated Resident 81 should have received cottage cheese as standing order. During an interview on 10/22/24 at 2:09 p.m. and 10/23/24 at 8:28 a.m. with Dietary Supervisor (DS), DS acknowledged and confirmed the findings above. DS stated the food items under the standing order on the meal tickets meant the kitchen needed to provide those food items to the residents. He stated he expected for the kitchen staff to follow and provide the food preferences (standing orders on the meal tickets) for the residents. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 11:52 a.m. with Registered Dietitian (RD), RD stated and verified standing orders on the meal tickets meant food preferences for the residents. RD further stated the kitchen staff needed to provide those food items and honored residents' food preferences. A review of the facility's policy and procedure titled, Food Preferences, dated 2023, indicated, . Resident's food preferences will be adhered . A review of the facility's document titled, Job Description: Dietary Supervisor, dated 2/2024, indicated, . essential duties . assess resident food preferences . check trays for accuracy before they are delivered .

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. 45770 Based on observation, interview, and record review, the facility failed to ensure assistance was provided to one of 25 sampled residents (Resident 48), when Resident 48 who had impaired vision was not assisted with eating as ordered. This failure decreased the facility's potential to meet Resident 48's nutritional needs. Findings: A review of Resident 48's Admission Record, indicated she was admitted to the facility in September 2024 with a diagnosis of dysphagia (difficulty swallowing) with no memory problem. During a concurrent observation and interview on 10/21/24 at 12:56 p.m. with Resident 48 during lunch in the dining room, Resident 48 was observed not eating after the tray was served to her. Resident 48 stated she needed help because she could not see what was on her tray. During an interview on 10/22/24 at 8:32 a.m. with Resident 48, Resident 48 stated breakfast was already done but she was not able to eat properly. Resident 48 added staff did not assist her whenever she ate, but she was told by one of the therapists that she should always be assisted when eating because she was blind. A review of Resident 48's Baseline Care Plan, dated 9/16/24, indicated Resident 48 had impaired vision, was blind to the left eye, partially blind with her right eye and assistance should be provided when eating. A review of Resident 48's Order Summary Report, dated 9/18/24, indicated Resident 48 had an order for feeding assistance. A review of Resident 48's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/21/24, indicated Resident 48's vision was highly impaired. During a concurrent interview and record review on 10/24/24 at 10:10 a.m. with the Director of Rehabilitation (DOR), Resident 48's occupational therapy admission evaluation and recent therapy notes were reviewed. DOR confirmed Resident 48 required assistance when eating mainly due to her visual deficits. During a concurrent interview and record review on 10/24/24 at 11:10 a.m. with the Director of Nursing (DON), Resident 48's clinical record was reviewed. DON acknowledged that feeding assistance should be provided to Resident 48 due to her vision impairment. DON stated Resident 48 should always be assisted when eating so that she will be able to eat well and receive proper nutrition needed to actively participate with care. A review of the facility's policy and procedure, titled, Assistance with Meals, revised 2024, indicated residents who require assistance and residents who cannot feed themselves will be assisted.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40830 Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety, when: 1. Two dietary staff had facial hair were not covered; 2. Juice machine was not clean; 3. Several various sizes of kitchen utensils were stacked wet stored at the clean and ready-to-use storage areas; 4. The raw shelled eggs were not pasteurized in the walk-in refrigerator; and 5. One dietary aide was not able to demonstrate and verbalize the correct process of manual dishwashing by using three-compartment sink. These failures had the potential to cause food borne illness in a medically vulnerable 88 out of 91 residents who consumed food in the facility. Findings: 1. During the initial tour in the kitchen on [DATE] at 8:42 p.m., observed Dietary Aide (DA) with beard but was not covered with any restraint. A follow up observation was conducted at 10:04 a.m., observed Dietary Supervisor (DS) with beard and side burn hair without any restraint. During a concurrent interview with DS, he confirmed DA and himself did not have restraint to cover the facial hair. DS stated they should have the beard guard on to cover the facial hair. During an interview on [DATE] at 11:52 p.m. with Registered Dietitian (RD), RD stated the kitchen staff had facial hair and should have covered them with restraint or beard guard. A review of the facility's policy and procedure (P&P) titled, Dress Code, dated 2023, indicated, . Proper Dress . beards and mustaches (any facial hair) must wear beard restraint . According to Food and Drug Administration (FDA) Food Code 2022, Section ,d+[DATE].11 Hair Restraint, . (B) The food employees shall wear hair restraints such as . beard restraints . that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent initial kitchen tour observation and interview on [DATE] at 8:52 a.m. with DS, the juice dispense machine was not clean with dry and sticky juice spilled at the interior upon opening the door panel where the juice concentrate bottles could be replaced and the removable juice dispenser nozzles. During further observation of the exterior of the machine, the vent on the side of the machine had significant amount of dust. DS confirmed and stated it was not clean and the vent was dusty. DS also stated the juice machine should usually be cleaned and sanitized daily. He further stated the kitchen staff needed to pay attention when they clean and sanitize the machine and as well as the vent. A review of the written instructions on the side panel of the juice dispenser machine indicated the machine should be cleaned daily and the interior and exterior should be wiped down daily. A review of the facility's P&P titled, Dispenser Beverage Machine Cleaning, dated 2023, indicated the maintenance and cleaning procedure of the juice machine was to follow the manufacturer's guidelines. A review of the facility's P&P titled, Sanitation, dated 2023, indicated, . All . equipment shall be kept clean, maintained in good repair . 3. During a concurrent initial kitchen tour observation and interview on [DATE] at 8:56 a.m. with DS, there were following food serving items/utensils found stacked wet and stored away at the clean and ready-to-use storage areas: -Seven of half sheet metal pans; -21 of full sheet metal pans; -Six of one-third (,d+[DATE]) sheet metal pans; -Nine of one-sixth (,d+[DATE]) sheet metal pans; -Two of eight quart (qt. - a measurement of fluid volume) of plastic containers; -Two of four qt. of plastic containers; -Five of two qt. of plastic containers; and -Two of plastic container lids. DS confirmed and stated all the dishes, pans and pots should be air-dried completely before stored away. During an interview on [DATE] at 11:52 a.m. with RD, RD stated her expectation for the dishes, pans, and pots should be fully dried before stored away. A review of the facility's P&P titled, Dishwashing, dated 2023, indicated, . Dishes are to be air dried in racks before stacking and storing . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to 2022 FDA Food Code, under section ,d+[DATE].11 Equipment and Utensils, Air-Drying Required, it stated, . Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow . 4. During an observation of the walk-in refrigerator on [DATE] at 9:27 a.m., there was a box of raw shelled eggs found and noted the eggs were not pasteurized stored on the rack. A concurrent interview with DS, he confirmed the eggs were unpasteurized. DS checked the invoice of the eggs and was delivered on [DATE]. DS stated he always order pasteurized eggs but not aware the vendor send them unpasteurized eggs for the order. He stated the staff who was responsible for receiving the eggs should pay more attention and checked. DS further stated the raw shelled eggs usually serve for breakfast and the eggs usually were fully cooked without running yolk even using the pasteurized eggs. During an observation of the breakfast for Resident 39 on [DATE] at 8:37 a.m., observed Resident 39 received over-easy egg with running yolk. During a follow up interview with Resident 39 at 10:30 a.m., Resident 39 stated he ate over-easy eggs with running yolks for breakfast usually every day. During an interview on [DATE] at 10:19 a.m. with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated she usually worked at morning shift and served breakfast to the residents. She stated she observed some residents got over-easy eggs for breakfast with running yolks sometimes. During an interview on [DATE] at 10:23 a.m. with Resident 38, Resident 38 stated he usually got over-easy eggs for breakfast with running yolk. During an interview on [DATE] at 10:31 a.m. with CNA 2, CNA 2 stated she usually worked at morning shift and served breakfast to the residents. She stated she sometimes saw residents getting over-easy eggs with running yolks. During an interview on [DATE] at 10:33 a.m. with Resident 53, Resident 53 stated he had over-easy eggs with running yolk with breakfast every day. During an interview on [DATE] at 10:40 a.m. with [NAME] (CK), CK acknowledged the photo of Resident 39's breakfast on [DATE] and confirmed Resident 39 received the over-easy eggs with running yolk. CK further stated he cooked the over-easy eggs on [DATE], [DATE] and [DATE]. During an interview on [DATE] at 10:45 a.m. with DS, DS stated he got the pasteurized eggs on [DATE] and started using them after they were delivered. He stated CK usually cooked the eggs fully cook and no running yolk even though for pasteurized eggs. Then he changed his answer to the pasteurized eggs could be cooked with running yolk. During an interview on [DATE] at 11:52 a.m. with RD, RD stated the kitchen needed to use pasteurized eggs and the eggs should be fully cooked, and the internal temperature of the eggs should be at least 165 degrees Fahrenheit (F; a unit of measure) without running yolk even though for pasteurized eggs. She further stated it was because the kitchen served the older population who were more susceptible for food borne illness. A review of the facility's P&P titled, Procedure for Refrigerated Storage, dated 2023, indicated raw eggs must be pasteurized. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Pines at Placerville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1040 Marshall Way Placerville, CA 95667	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to FDA Food Code 2022, Section ,d+[DATE].13 Pasteurized Eggs, showed, . pasteurized eggs or egg products must be substituted for raw eggs in the preparation of food . 5. During a concurrent observation for the manual dishwashing with three-compartment sink and interview on [DATE] at 9:35 a.m. with DA and DS, DA explained the process and stated the sequence of the steps started with washing, sanitizing, rinsing and air-dried. He stated he did not know the wash and rinse water temperatures and as well as the sanitizer solution temperature. DS confirmed and stated DA's answer was not correct. DS stated the correct sequence should be wash, rinse, sanitize, and air-dried. He further stated the wash and rinse water temperature should be 120 degrees F and the sanitizer solution temperature should be around 75 degrees F. During a concurrent observation of the three-compartment sink and interview on [DATE] at 10:09 a.m. with DS, it was noted three sinks were filled above the fill lines indicated on the sinks, and the wash water (with detergent), rinse water and sanitizer solution were overflowed, and all fused together. DS stated DA filled up the three-compartment sink and confirmed the water and solutions of the three compartments should not fill above the fill line as indicated and should not be overflowed. During an interview on [DATE] at 11:52 p.m. with RD, RD stated the dishwasher and dietary aides should have good knowledge for the manual dishwashing in case the dishwashing machine was not in working condition like on Monday ([DATE]) when the water heater was not working. A review of the facility's document titled, Dietary In-Service, Topic: 3-Compartment Sink, completed on [DATE], given by DS and RD, included the process of manual dishwashing with using of three-compartment sink and the policy and procedure, and the attendance for the in-service. During a concurrent interview with DS, DS stated the attendance showed DA did not attend the in-service for the three-compartment sink. A review of the facility's document titled, Job Description: Dietary Aide, dated ,d+[DATE], indicated the dietary aide should know the process of dishwashing and participate in on-going in-services. It also stated the job required to obtain and maintain the food handler's certificate. During a concurrent interview on [DATE] at 3:15 p.m. with DS, DS stated DA had a food handler's certificate but was expired. DS stated the employee file of DA did not have the copy of the certificate and DA could not provide the certificate for review. A review of the facility's P&P titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, indicated the washing water temperature should be at ,d+[DATE] degrees F, the rinse water temperature should be at ,d+[DATE] degrees F. The sanitizer should be tested with test strip with concentration of , d+[DATE] parts per million (ppm; a unit of measure) and the dishes would immerse in the sanitizer solution for 60 seconds. The last step was to let the dishes air-dried. A review of the facility's P&P titled, Sanitation, dated 2023, indicated the DS is responsible for instructing the kitchen staff in the use of equipment, and each kitchen staff must know how to operate and clean all equipment in their specific work area.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49821 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for a census of 91 when: 1. Nursing staff did not sanitize and disinfect medical equipment between resident use and did not change gloves after resident care and when cleaning equipment; 2. Nail care was not provided for Resident 8, Resident 14, Resident 38, Resident 39, and Resident 73; and 3. Certified Nurse Assistant 5 (CNA 5) did not wear the required personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) upon entering Resident 27's room who was on neutropenic precautions (a set of action to take to prevent infection if there's a low count of white blood cell in the blood that helps fight infection). These practices decreased the facility's potential to prevent the spread of infection among residents. Findings: 1. During a medication pass observation on 10/21/24 at 8:40 a.m., Licensed Nurse 1 (LN 1) used a blood pressure (BP) cuff and stethoscope to measure a resident's BP in a room with Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms using gowns and gloves during high contact resident care). After the resident's BP was taken, LN 1 removed the BP cuff and stethoscope and placed them on top of the medication cart without sanitizing and disinfecting them. At 9:02 a.m., LN 1 was then observed taking the BP of the resident's roommate with the same equipment. During an interview on 10/21/24 at 11:14 a.m. with LN 1, LN 1 confirmed she did not sanitize and disinfect the BP cuff and stethoscope and stated it should have been sanitized and disinfected between resident use. During a medication pass observation on 10/21/24 at 9:23 a.m., LN 2 used a BP cuff and stethoscope to measure a resident's BP. A pulse oximeter (a medical instrument used to measure oxygen saturation level - a measurement of how much oxygen the blood is carrying) was also placed on the resident's finger. After the resident's BP was taken, LN 2 removed the BP cuff and oximeter and placed them on top of the medication cart. She sanitized and disinfected the equipment without changing her gloves. During an interview on 10/21/24 at 11:40 a.m. with LN 2., LN 2 stated she should have removed her gloves after resident care and donned new gloves before cleansing the medical equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 9:46 a.m. with Director of Nursing (DON), DON stated the expectation of nursing staff was to sanitize and disinfect equipment between each use if used for multiple residents. DON added nursing staff needed to use hospital-quality bleach wipes and wait for time recommended by the wipes' manufacturer before using on the next resident. DON also stated nursing staff were expected to remove used gloves and replace them with new gloves before cleansing equipment used to take vital signs for multiple residents. A review of the facility's policy titled, Cleaning and Disinfection of Environmental Surfaces, revised 8/2024, indicated, Reusable items, including environmental surfaces, and Durable Medical Equipment (DME) will be cleaned and/or disinfected between residents according to manufacturer's instructions. A review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, revised 8/24, indicated, Hand hygiene is indicated . after touching a resident . after touching the resident's environment . immediately after glove removal. 36624 2. A review of Resident 8's Admission Record (AR), indicated Resident 8 had diagnoses which included dementia (a progressive state of decline in mental abilities) and generalized muscle weakness. During an observation on 10/21/24 at 9:04 a.m. and 10/22/24 at 1:44 p.m., Resident 8's fingernails were long, with jagged edges and black substance underneath the nailbeds. A review of Resident 14's AR indicated Resident 14 had diagnoses which included muscle weakness and left hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During an observation on 10/21/24 at 9:07 a.m. and 10/23/24 at 9:51 a.m., Resident 14's fingernails were long, with jagged edges and black substance underneath the nailbeds. During an interview on 10/23/24 at 9:51 a.m. with Resident 14, Resident 14 stated he wanted his fingernails trimmed. A review of Resident 38's AR indicated Resident 38 had diagnoses which included hemiplegia and aphasia (a disorder that makes it difficult to speak). During an observation on 10/21/24 at 11:27 a.m. and 10/22/24 at 11:28 a.m., Resident 38's fingernails were long, with jagged edges and had black substance underneath the nailbeds. A review of Resident 39's AR indicated Resident 39 had diagnoses which included muscle weakness and cognitive communication deficit. During an observation on 10/23/24 at 11:10 a.m., Resident 39 had long fingernails, with jagged edges and black substance underneath the nailbeds. A review of Resident 73's AR indicated Resident 73 had diagnoses which included bilateral osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the hip and muscle weakness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/22/24 at 3 p.m., Resident 73 had long fingernails, with jagged edges and black substance underneath the nailbeds. During an interview on 10/22/24 at 3 p.m. with Resident 73, Resident 73 stated he wanted his fingernails to be trimmed. During a concurrent observation and interview on 9/23/24 at 8:37 a.m. with LN 7, LN 7 confirmed Resident 8's, Resident 14's, Resident 38's, Resident 39's, and Resident 73's fingernails were long, with jagged edges and had black substances underneath the nailbeds. LN 7 stated residents' fingernails had to be cut and trimmed as scheduled to ensure residents would not scratch their skins and not get infected. LN 7 also stated long nails could harbor germs and when residents scratched, it could cut their sensitive skin and germs could go into the skin. During an interview on 10/23/24 at 10:24 a.m. with the DON, DON stated her expectations were residents' fingernails should be cut every Sunday by assigned staff. DON stated CNAs should provide nail care and nail trimming unless residents had diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), then nail trimming should be done by the podiatrist. DON also stated dirty and untrimmed fingernails could be an infection control issue and fingernails with jagged edges could also get stuck or caught on things and residents could scratch themselves. A review of the facility's document titled, Shower Schedule, updated 9/24, indicated, . Sunday: All Rooms: Nail Care . A review of the facility's P&P titled, Activities of daily living, Supporting, revised 5/24, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 45770 3. A review of Resident 27's Admission Record, indicated he was admitted to the facility in September 2024 with a diagnosis of multiple myeloma (a cancer that forms in the plasma cell a type of white blood cell). During an observation on 10/21/24 at 9:05 a.m. Resident 27's room was observed to be closed and had a sign that indicated neutropenic precautions, wear gown and mask, with PPEs neatly stacked on a rack by the door. A review of Resident 27's Order Summary Report, dated 9/21/24, indicated an order for neutropenic precautions due to critically low count of white blood cell and neutrophils (another type of white blood cell that helps fight infection) and staff should wear a gown and a mask before entering the room. During a concurrent observation and interview on 10/21/24 at 10 a.m. with CNA 5, CNA 5 was observed inside Resident 27's room talking with the resident. CNA 5 was not wearing a gown or a mask. CNA 5 confirmed she was not wearing any PPE inside the room and stated she will only wear the PPE when providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/21/24 at 11:20 a.m., a visitor was observed inside Resident 27's room not wearing a gown. During an interview on 10/24/24 at 9:38 a.m. with the Infection Preventionist (IP), IP verified that Resident 27 was on neutropenic precautions due to his cancer diagnosis which made him immune compromised. IP stated all staff and visitors are required to wear a gown and mask every time they enter the room and not only when providing care. IP also stated this practice should be followed by all staff to help protect Resident 27 from infection and minimize his risk of getting ill. During an interview on 10/24/24 at 9:55 a.m. with the IP, IP stated the facility did not have their own specific policy for neutropenic precautions. IP also stated the facility only followed the general guidelines for isolation precautions for the prevention of transmission of infection updated on 7/2019.

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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** 40841 Based on observation, interview, and record review, the facility failed to ensure 10 resident rooms (Rooms 3, 4, 5, 6, 7, 8, 9, 14, 15, and 16) met the required 80 square feet (sq. ft.) per resident when rooms 3, 4, 5, 6, 7, 8, 9, 15, and 16 were measured as 228.55 sq. ft. for a three residents occupancy or 76.2 sq. ft. per resident; and room [ROOM NUMBER] was measured as 159.38 sq. ft. for a two residents occupancy or 79.7 sq. ft. per resident. This failure had the potential to result in inadequate space for the provision of health care and services for 29 residents residing in these rooms for a census of 91 residents. Findings: The observations were made throughout the survey in rooms 3, 4, 5, 6, 7, 8, 9, 14, 15 and 16. The space was adequate to store assistive devices in the rooms (such as wheelchair and/or walker) and to facilitate provision of care and needs. During a concurrent interview and record review on 10/23/24 at 12:15 p.m. with the Administrator (ADM), the rooms' dimension were reviewed. ADM confirmed rooms 3, 4, 5, 6, 7, 8, 9, 15, and 16 were measured as 228.55 sq. ft. for a three residents' occupancy or 76.2 sq. ft. per resident; and room [ROOM NUMBER] was measured as 159.38 sq. ft. for a two residents' occupancy or 79.7 sq. ft. per resident. ADM confirmed each room should get 80 sq. ft. per resident. Interviews were conducted with available residents currently residing in the affected rooms. The residents verbalized the space was adequate for the provision of care. The Department recommends continuation of the waiver for the above-mentioned rooms.