STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055534	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reutlinger Community	4000 Camino Tassajara Danville, CA 94506

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50474 Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 7) was treated with respect and dignity when Resident 7 was not promptly assisted during lunch on 11/18/24. This failure had the potential to affect Resident 7's psychosocial well-being and nutritional needs. Findings: During a record review of Resident 7's Admission Record (AR), printed on 11/21/24, the AR indicated Resident 7 was admitted to the facility in October 2024 with multiple diagnoses that included sepsis (life-threatening complication of infection) and metabolic encephalopathy (damage or disease that affects the brain). During a record review of Resident 7's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 10/29/24, Resident 7's Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) was 3 out of 15, which indicated severely impaired mental status. During a record review of Resident 7's MDS record, dated 11/6/24, Resident's 7 assessment for Eating indicated Resident 7 needed supervision or touching assistance (helper provides verbal cues and/or touching assistance as resident completes activity). During a record review of Resident 7's Care Plan, revised on 10/21/24, the care plan indicated, Resident 7 is at nutrition/hydration risk related to missing/broken teeth requiring mechanically altered diet, chewing/swallowing difficulty, depression, needs occasional-frequent assistance in feeding. During a concurrent observation and interview on 11/18/24, at 12:03 p.m., in the dining room, Resident 7 was observed sitting at the table with other residents. Assistant Director of Nursing (ADON) and Certified Nurse Assistant (CNA) 2 were observed serving the trays to the residents. Resident 7 received her tray. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/18/24, at 12:06 p.m., Resident 7 was observed not eating. Resident 7 stated she was ready to eat her lunch and would like to eat the fish that was served to her. During another observation on 11/18/24, at 12:10 p.m., Resident 7 was not touching her food and did not have anybody assisting her while the resident sitting next to her was already eating. During a concurrent observation and interview on 11/18/24, at 12:22 p.m., CNA 1 started assisting Resident 7. CNA 1 stated he did not know that Resident 7 needed assistance because Resident 7 used to eat by herself. During an interview on 11/20/24, at 9:40 a.m., CNA 6 stated Resident 7 required assistance from staff to encourage and provide verbal cues during mealtimes. CNA 6 stated Resident 7 would have not eaten and would have fallen asleep if no one assisted her in eating. CNA 6 stated Resident 7's nutrition would have been affected. During an interview on 11/20/24, at 12:28 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 7 needed cueing and prompting when eating otherwise Resident 7 would have been distracted and would have not eaten. ADON stated Resident 7 should have been assisted in the dining room because the food was getting cold. During an interview on 11/21/24, at 11:52 a.m., with the Director of Nursing (DON), the DON stated the CNAs assigned to the dining room should have asked Resident 7 the reason why she was not eating, and they should have encouraged Resident 7 to eat her lunch. During a record review of the facility's P&P titled, Supervision of Resident Nutrition, dated 7/1/2020, the P&P indicated, 5. Residents needing assistance in eating must be promptly assisted upon being served. During a record review of the facility's P&P titled, Necessary Care and Services: Activities of Daily Living, dated 11/2024, the P&P indicated, Based on the comprehensive assessment of a resident and consistent with resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish .This includes the facility ensuring that a resident is given appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living: .Dining, eating, including meals and snacks

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 51636 Based on interview and record review, the facility failed to complete annual performance review and maintain competency/skills records for 17 of 17 sampled Licensed Nurses (LN's). A licensed nurse is a healthcare professional who has met requirements by state board of nursing to practice nursing skills within defined scope. This failure placed residents residing at the facility at risk to receive care from incompetent LN's. Findings: During a concurrent interview and record review with Director of Staff Development (DSD) on 11/20/24, at 12:17 p.m., an untitled, undated facility's document with facility's active employee names, date of hire, job title, employee ID was reviewed. The document indicated facility had 17 LN's including: nine (9) active Licensed Vocational Nurses (LVNs) and eight (8) active Registered Nurses (RNs). The DSD then provided a binder containing wound competency checklist completed for all LNs on 7/11/24. The DSD stated she was able to locate LN's competency checks completed for skin and wound care only. During a review of facility's undated document titled Licensed Nurse Competency Checklist, the document indicated to add facility's name, employee name, date of hire, if employee met the criteria of a specific task or not, date & initials of the reviewer and comments/training needs. The checklist indicated to assess LN's competency in the following areas: Cardiac (heart), Pulmonary (respiratory system), Gastrointestinal (digestive), Genitourinary (urinary), Orthopedic (bones), Neurological (brain functions), Integumentary (skin), Metabolic, Nutrition/Dietary systems; Care planning/Documentation, and Infection Prevention techniques. The checklist indicated to add date and signature of the evaluator and LNs who was being evaluated. During an interview with DSD on 11/21/24, at 12:23 p.m., the DSD stated facility was required to use a checklist titled Licensed Nurse Competency Checklist to assess LN's competencies. The DSD stated she checked facility's storage, her office and other possible locations at the facility but was unable to find skills/competency checks completed for all 17 LN's. The DSD stated LNs were supposed to have the competency check when they are newly hired, as well as in 90-day period and annual basis. DSD stated competency checks were used to make sure the LNs had the skills and knowledge, essential to have competent people working in the facility. The DSD stated if facility did not complete and retain competency/skills for LNs, it placed residents receiving care from them at risk to have problems awaiting to happen, including lack of care, and hospitalization s. DSD stated she herself, Director of Nursing (DON), and Assistant Director of Nursing (ADON) would be responsible to have the competency check and completed for all LN's. During an interview and record review with the DON on 11/21/24, at 12:32 p.m., in DON's office, personnel records were reviewed. The DON stated she did not complete any competency/skills assessments for any LN's working at the facility within last one year. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of facility's Policy and Procedure (P&P) titled, Competency of Nursing Staff, dated 11/2024, the P&P indicated, Ensure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet resident needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being . Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50474 Based on observation, interview, and record review, the facility failed to ensure Drug Regimen Reviews (DRR- review of all medications the residents were using in order to optimize therapy, identify any potential drug reactions, ineffective drug therapy or duplicate drug therapy) by the Consultant Pharmacist (CP, a pharmacist with specialized training to review safety aspects of medication use) were acted upon on a monthly basis for two of four sampled residents (Residents 4 and Resident 34). This failure had the potential to result in not addressing medication safety irregularities in a timely manner and/or help optimize the drug therapy for Resident 4 and Resident 34. Findings: During a review of the facility's document titled, Drug Regimen Review (DRR) binder, the DRR binder did not include the CP's monthly recommendations for June through October 2024. During an interview on 11/21/24, at 8:09 a.m., with the Director of Nursing (DON), the DON stated she did not have the DRR for the months of June through October 2024 because she did not receive them from the CP. During a phone interview on 11/21/24, at 8:50 a.m., with the CP, the CP stated DRR documents were emailed to the DON and the Administrator (ADM) on a monthly basis. The CP stated the DON was responsible for making sure his recommendations were reviewed and implemented accordingly. The CP stated he had noticed that some recommendations were not addressed, and he had to keep repeating them for consideration. During a follow up phone interview on 11/21/24, at 12:50 p.m., with the CP, the CP stated the monthly DRR was re-sent to the DON's email. During a record review of the DRR for the months of August 2024 and September 2024, the DRR indicated the CP's recommendations for Resident 4 and Resident 34 were not addressed as follows: 1. DRR for August 2024 and September 2024 for Resident 4, indicated, The resident is currently receiving the following antibiotic - Doxycycline 100 milligrams/mg (anti-infective medication) once a day for chronic right arm infection, give 1 hour prior to milk products or calcium medications (start date: 2/5/24). The DRR document also indicated, Under Department of Health Services/Centers for Medicare and Medicaid Services please comply with the Antibiotic Stewardship program (a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multi-drug resistant organisms) per guidelines - STOP DATE IS NEEDED. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 4's Order Summary Report dated 11/21/24, the document indicated Resident 4 had an order of Doxycycline Hyclate Oral Tablet 100 mg for chronic right arm infection. Give 1 hour prior to milk products or calcium medications. Started from 2/6/24. The order summary report further indicated, Communication Method - Verbal, with Order Status that indicated Active, and Start Date of 6/12/24. The order summary report End Date was blank. 2. DRR for August 2024 and September 2024 for Resident 34, indicated, The resident currently receives long acting/slow-release medication Protonix (medication that reduces stomach acid) 40 mg once a day for gastroparesis (delayed gastric emptying).This medication should never be crushed or altered in any form. The medication has a protective enteric coating that is designed to dissolve in a certain area of the gastro-intestinal tract .Crushing the medication destroys this mechanism and thus alters its bioavailability in the body .Please note medication on MAR (Medication Administration Record) with Do Not Crush. During a record review of Resident 34's Order Summary dated 11/21/24, the order summary indicated, Protonix Tablet Delayed Release 40 mg (Pantoprazole Sodium) Give 1 tablet by mouth one time a day for GERD (gastroesophageal reflux, a condition where acid from the stomach comes up into the esophagus) start date 3/31/2024. The order summary did not include a Do Not Crush note as per CP's recommendation. During an observation, interview and record review on 11/21/24, at 2:02 p.m., with the DON, the DON stated she was responsible in reviewing the monthly DRR and implementing the CP's recommendations accordingly. The DON was observed scanning the DRR binder and stated whatever was included in the DRR binder, were the only documents she had reviewed. The DON stated the DRR binder only included CP's recommendations until May 2024. The DON stated she did not receive the rest of the monthly DRR from the CP. During a follow up interview on 11/21/24, at 3:15 p.m., with the DON, the DON stated it was important to review the DRR and the CP's recommendations every month because some of residents' medications needed correct indications per regulation and/or special instructions. The DON stated some recommendations from the CP also included residents' lab test to know if the medications were working or needed adjustment. The DON stated the physician should have reviewed the monthly DRR and would have written on the DRR binder if the physician agreed or disagreed to the CP's recommendations. The DON stated if she saw an order for antibiotic that did not have a stop date, she would have informed the physician. The DON stated if an antibiotic medication did not have a stop date, the licensed nurses would have given it continuously and it could have given side effects to the residents. The DON stated she made an error because she did not follow up with the CP when she did not receive the DRR from June to October 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's policy and procedure (P&P), titled, Medication Regimen Review and Reporting, dated 11/17/24, the P&P indicated, Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors or other irregularities .8. The consultant pharmacist and the other nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon within 30 calendar days .c. For recommendations that do not require physician intervention, the director of nursing with licensed designee will address the recommendations.

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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** 45091 Based on observation, interview, and record review, the facility failed to properly store drugs for one out of 12 sampled Residents (Resident 18). These failures had the potential for Resident 18 to take expired, less effective and discontinued medication. Findings: During a review of Resident 18's Admission Record, printed [DATE], indicated, Resident 18 was admitted to the facility in 2024 with multiple diagnosis which included, Pneumonitis (swelling and irritation of lung tissue) due to inhalation of food and vomit, and Type 2 diabetes mellitus (a long-term disease in which the body cannot regulate the amount of sugar in the blood) with diabetic chronic kidney disease (when diabetes damages the kidneys, causing them to filter waste less effectively). During a concurrent observation and interview on [DATE], at 12:23 p.m., with Registered Nurse (RN) 2, Medication Cart A was observed. The medication cart had Residents 18's Lantus (a long-acting insulin that helps control blood sugar levels in people with diabetes 100 unit/ml (milliliter) inject 25 units Sub-Q (subcutaneous - under the skin) at bedtime for diabetes mellitus with an open date of [DATE]. The Lantus container indicated Discard 28 days after opening. RN 2 stated it was beyond 28 days, it was expired, and it should have been destroyed. During an interview on [DATE], at 12:02 p.m., with Assistant Director of Nursing (ADON), ADON stated their policy was to destroy insulin 28 days after it was opened. ADON stated insulin that was beyond 28 days from the date it was opened was expired and was a risk to the resident because it may have been less effective and may not have provided the appropriate action. During a review of Resident 18's Doctor's Order, dated [DATE], the order indicated Resident 18 had a doctor's order for Lantus Glargine (a long-acting insulin that helps control blood sugar levels in people with diabetes) 100 U (units)/ml inject 25 units Sub-Q at bedtime for diabetes mellitus, that was discontinued on [DATE]. During a review of Resident 18's Doctor's Order, dated [DATE], the order indicated Resident 18 had a doctor's order for Insulin Glargine Solution (a long-acting insulin that helps control blood sugar levels in people with diabetes) 100 unit/ml inject 18 unit subcutaneously at bedtime for diabetes. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, revised [DATE], the P&P indicated, The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51636 Based on observation, interview and record review, the facility failed to intervene for one of the sampled residents (Resident 34), when his dentures were not fitting properly for over a month. This failure resulted in Resident 34 feeling frustrated, awful, and placed him at risk for unintended weight loss. Findings: During a review of Resident 34's Admission Record (a document used to communicate basic information about a resident) printed on 11/20/24, the record indicated Resident 34 was admitted to the facility on [DATE] and was readmitted on [DATE]. A review of Resident 34's Minimum Data Set (MDS, an assessment used to plan care), dated 11/8/24, indicated, Resident 34 was able to understand others and was able to make himself understood. During a review of Resident 34's Order summary report, dated 3/30/24, the order indicated to perform dental exam and treatment as indicated. A review of Resident 34's Nutrition/Hydration care plan, revised on 11/8/24, indicated Resident 34 was at high risk for nutrition/hydration issues related to edentulous [no teeth in mouth], ill-fitting dentures, chewing/swallowing difficulty . During a concurrent observation and interview with Resident 34 on 11/18/24, at 10:57 a.m., Resident 34 was sitting in the wheelchair, drooling. Resident 34 had no teeth and was not wearing any dentures. Resident 34 stated having no dentures made him feel completely awful, frustrated and he felt like, breaking his fingers. During an interview with Resident 34 on 11/21/24, at 12:06 p.m., in the dining room, Resident 34 stated he was not happy without his dentures for the last 3 months. During an interview with the Certified Nursing Assistant (CNA) 1 on 11/19/24, at 11:29 a.m., CNA 1 stated Resident 34 had upper and lower dentures. CNA 1 stated he offered Resident 34 to wear dentures during mealtimes, but he did not like wearing them. CNA 1 stated he did not know why Resident 34 did not prefer wearing dentures. During a concurrent observation and interview with Registered Nurse (RN) 1 on 11/19/24, at 11:47 a.m., in Resident 34's room, RN 1 stated she did not know Resident 34 had dentures. RN 1 stated Resident 34 was on mechanical soft diet. RN 1 opened Resident 34's nightstand top drawer and found a denture cup with both upper and lower dentures. RN 1 then asked Resident 34 to put them on, Resident 34 repeatedly stated, not correct and refused to wear them. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with Minimum Data Set Coordinator (MDSC) on 11/21/24, at 01:39 p.m., Resident 34's Dentist Progress Notes dated 7/12/24 and MDS assessment dated [DATE] were reviewed. MDSC stated the dentist note indicated Resident 34's new dentures were delivered on that day. MDSC stated ill-fitting dentures could cause soreness, pain, cavity, chewing and swallowing problems. The MDSC stated she completed Resident 34's MDS assessment on 11/8/24 and was supposed to check his oral status along with denture status as part of the assessment. The MDSC stated, however she did not physically assess Resident 34's oral cavity and did not ensure if his dentures were fitted or not. During a concurrent interview and record review with Social Services Director (SSD) on 11/19/24, at 2:05 p. m., Resident 34's progress notes, dated 10/10/24, were reviewed. SSD stated she called the dentist office and informed that Resident 34 was complaining about dentures not fitting well. SSD stated she was unable to find any documentation if facility ever followed up with the dentist office after 10/10/24 until 11/19/24. During an interview on 11/21/24, at 12:01 p.m., SSD stated she talked to the dentist office on that day and Resident 34's dentures needed to be grinded for proper fitting. During an interview with Director of Nursing (DON) on 11/20/24, at 12:44 p.m., DON stated staff needed to act on dentures related issues as soon as possible, within 72 hours, and document their attempts to address the issue in residents' progress notes. During an interview with Minimum Data Set Coordinator (MDSC) on 11/21/24, at 02:26 p.m., MDSC stated wearing dentures was important for residents to eat, chew and speak better. MDSC stated dentures should be well-fitted to avoid pain in the mouth and to maintain residents' dignity. During a review of facility's Policy and Procedures (P&P) titled, Dental Services, dated 07/01/20, the P&P indicated, In the event that the resident's dentures are damaged, broken, chipped, ill-fitting or lost, nursing will work with Social Services and the attending Physician to obtain a referral for dental services timely; referral made within 3 business days for an appointment.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51636 Based on observation, interview, and record review, the facility failed to ensure the therapeutic diet ordered by the physician were followed for two of four sampled residents (Resident 7 and Resident 35) during a dining observation when: 1. Resident 35, who was on mechanical soft diet (a texture-modified diet that consists of foods that are easy to chew and swallow) with ground meats received a piece of meat, not in bite size as indicated on the meal ticket. 2. Resident 7, who was on a mechanical soft diet received a regular texture of snap peas vegetable. This failure had the potential for Resident 7 and Resident 35 to choke and/or aspirate (inhalation of a foreign object into the airway or lungs). Findings: 1. During a review of Resident 35's Admission Record (AR) (a document used to communicate basic information about a resident), dated 11/18/24, AR indicated Resident 35 was admitted to the facility on [DATE]. During a concurrent observation and interview in Resident 35's room on 11/18/24, at 12:07 p.m., Resident 35 was sitting at the edge of her bed, Certified Nurse Assistant (CNA) 2 served the lunch tray to Resident 35, which had a dessert, cooked rice, cooked whole peas, and a whole piece of meat. CNA 2 stated the meat was fish. The meal ticket on Resident 35's tray indicated to serve, Mechanical Soft diet w/ground meats, and bite size entree. Resident 35 started eating her dessert and attempted to cut the meat. Resident 35 was not able to cut the meat and then refused to eat the rest of the meal. CNA 2 stated licensed nurse should have checked Resident 35's meal tray to ensure Resident 35 received correct meal tray before meal was served but was unable to state if a nurse checked Resident 35's meal tray that day. When asked if Resident 35 received correct meal tray in terms of ground meat, and bite size entree, CNA 2 stated no and took the tray away for replacement. During a concurrent interview and record review with Registered Nurse (RN) 2 and Assistant Director of Nursing (ADON) on 11/18/24, at 02:24 p.m., Resident 35's diet orders were reviewed. RN 2 stated Resident 35's diet order, dated 8/25/23, indicated to serve Mechanical Soft with Ground meat texture, Regular consistency. RN 2 stated she was assigned to check meal trays for accuracy that day, however she did not check Resident 35's meal tray before her lunch was served that day. ADON stated she was also involved in serving meal trays but did not check Resident 35's tray. RN 2 stated serving a big piece of meat placed Resident 35 at risk for choking. During an interview with Registered Dietitian (RD) 2 on 11/19/24, at 11:58 a.m., RD expected the kitchen staff to plate correct type and texture of foods on residents' meal trays and licensed nurses were to perform another check before meals were distributed to the residents. (continued on next page)

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	055534	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reutlinger Community	4000 Camino Tassajara Danville, CA 94506

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Dietary Manager (DM) on 11/21/24, at 10:23 a.m., DM stated the cook should cut the piece of meat into bite size according to the notes in the meal ticket. 50474 2. During a record review of Resident 7's Admission Record (AR), printed on 11/21/24, the AR indicated Resident 7 was admitted to the facility in October 2024 with multiple diagnoses that included sepsis (life-threatening complication of infection) and metabolic encephalopathy (damage or disease that affects the brain). During a record review of Resident 7's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 10/29/24, Resident 7's Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) was 3 out of 15, which indicated severely impaired mental status. During a record review of Resident 7's care plan, dated 10/21/24, the care plan indicated, Resident 7 is at nutrition/hydration risk related to missing/broken teeth requiring mechanically altered diet, chewing/swallowing difficulty, needs occasional-frequent assistance in feeding. The care plan further indicated, Provide diet as ordered: regular diet, mechanical soft texture with ground meat and finely chopped vegetables, thin liquids (liquids that take little or no effort to drink), no straws. During a concurrent observation, interview and record review on 11/18/24, at 12:03 p.m., in the dining room, a staff served Resident 7's lunch tray that included regular snap peas vegetables that were not finely chopped. Resident 7's meal ticket dated 11/18/24 indicated, Diet Order: Mechanical soft with ground meats, thin liquids. The meal ticket also indicated alerts for finely chopped vegetables, ground meat and no straws. Resident 7 stated she was ready to eat her lunch. During a concurrent observation and interview on 11/18/24, at 12:22 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 was observed feeding Resident 7. CNA 1 stated he did not know why Resident 7 needed the vegetables to be finely cut. CNA 1 further stated according to the meal ticket, the snap peas should have been cut finely for Resident 7. During an interview on 11/19/24, at 2:19 p.m., with the Director of Dietary Services (DDS), the DDS stated during the tray line (kitchen staff assemble meals on trays), she was responsible for auditing the meal tickets and making sure the meals prepared for the residents were according to their diet orders. The DDS stated she stepped out for a while during the tray line on 11/18/24 and two diet aides took over while she was gone. The DDS stated the meal tickets should have been checked accurately before putting the trays in the meal delivery cart. The DDS further stated the nursing staff should have checked the meal tickets for Resident 7 and Resident 34 prior to serving their meals and the kitchen staff should have been notified of the discrepancies. During an interview on 11/19/24, at 2:23 p.m., with the Registered Dietician (RD), RD stated serving a regular texture diet, including the not finely chopped vegetables to the residents who needed mechanically soft diet could have potentially caused choking or aspiration. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24, at 11:52 a.m., with the Director of Nursing (DON), the DON stated she expected the licensed nurses to have checked the meal tickets for all the residents prior to serving their meals. During a record review of the facility's policy and procedure (P&P), titled, Therapeutic Diets/Texture Alterations, dated 7/1/2020, the P&P indicated, Therapeutic diets and texture alterations shall be prescribed and provided when necessary to support optimal nutritional status. The P&P indicated, A therapeutic diet or texture alteration must be prescribed by the resident's attending physician. During a record review of the facility's P&P, titled, Supervision of Resident Nutrition, dated 7/1/2020, the P&P indicated, 1. Nursing personnel are responsible for assuring that residents are served the correct diet. 2. Prior to serving the tray, check the diet card that it is correct. If there's a doubt, check the written physician's order. 3. If an error has been made, report it to the dietary supervisor so new food tray can be issued.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50474 Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared under sanitary conditions when: 1. Freezer had plant-based patties that were soft to touch and had beyond use date. 2. A tabletop can opener had brownish matter. 3. There was black matter on the ice sweep part of the residents' ice machine. These failures had potential to put residents at risk for food borne illness and cross-contamination (transfer of bacteria or other microorganisms from one substance to another) that could result in infection or spread of infection. Findings: 1. During a concurrent observation and interview on 11/18/24, at 9:39 a.m., with the Director of Dietary Services (DDS), the kitchen freezer had a bag of plant-based patties in a box that were soft to touch and had a label that indicated, Defrosting Food and Use by date: 11/2/24 at 8:11 a.m. The DDS touched the plant-based patties and stated they were completely defrosted. 2. During a concurrent observation and interview on 11/18/24, at 9:59 a.m., with the DDS, the tabletop can opener stored in a holder mounted on a table had accumulation of brownish matter. The DDS stated the can opener should have been kept cleaned. During an interview on 11/19/24, at 2:07 p.m., with the Registered Dietician (RD), the RD stated she would have expected everything in the freezer to be frozen and should not have any food that had beyond use by date. The RD stated the kitchen should have discarded the plant-based meat from the freezer. 3. During an interview on 11/21/24, at 9:55 a.m., with the DDS, the DDS stated the staff used the ice machine in the meeting room to provide for the residents. During an observation and interview on 11/21/24, at 9:57 a.m., the Lead Maintenance (LM) was observed opening the ice machine. There was black matter on the inside of the machine called the ice sweep part where the ice was made. During an interview on 11/21/24, at 10:04 a.m., with the DDS, the DDS stated the ice machine should not have had black matter inside where the ice was. DDS stated the black matter could have contaminated the ice and could have made the residents sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, revised January 2024, the P&P indicated, All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain safety and wholesomeness for the food for human consumption. The P&P indicated, Foods past the use by, sell-by, or enjoy by date should be discarded. The P&P indicated, Frozen foods must be held solidly frozen so that they are hard to touch. During a record review of the Food and Drug Administration (FDA) Federal Food Code 2022, the food code indicated, 4-601.11 .Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils . Equipment food-contact surfaces and Utensils shall be clean to sight and touch.