STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055612	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Feather River Care Center	1 Gilmore Lane Oroville, CA 95966

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49934 Based on interview and record review, the facility failed to ensure residents' right to privacy were protected for five out of 13 residents sampled for patient rights, (Resident 33, Resident 18, Resident 22, Resident 8, and Resident 5), when Resident 20 entered their room uninvited. This had the potential to make Resident 33, Resident 18, Resident 22, Resident 8, and Resident 5 feel unsafe in their room, and their privacy to be disrespected. Findings: The facility's policy, undated, titled Resident [NAME] of Rights, Sec. 483.10 Resident Rights (e), indicated personal privacy is a right and (1) personal privacy includes accommodations. A review of Resident 33's clinical record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following cerebral infarct affecting left side (nervous system disorders that cause weakness on one side of the body), frontal lobe and executive function deficit following cerebral infarction (complications after a stroke that can effect muscle strength, speech/language, thinking skills, and behavior and personality changes), dysphagia following cerebral infarction (difficulty swallowing after a stroke). A review of the most recent Minimum Data Set (MDS, a resident assessment tool), for Resident 33 dated 1/24/25, indicated that Resident 33 had a severe cognitive deficit, with a brief interview for mental status (BIMS) score of 7 out of 15. A review of Resident 33's Admission Record, dated 3/21/25, indicated that the Resident's daughter is the Responsible Party, indicating Resident 33 is unable to make healthcare decisions for herself. During an interview on 3/19/25 1:22 pm, Resident 33 stated that Resident 20 comes into the room every day or two and will go through her drawers and will dig through things. Resident 33 stated, He doesn't take anything, but I wish he wouldn't dig through my belongings. A review of Resident 18's clinical record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that include Chronic Obstructive Pulmonary Disease (a lung disease), fracture of right femur (broken right leg bone), fracture of lateral end of right clavicle, (broken right collarbone) primary osteoarthritis (protective lining of joints that is worn down). (continued on next page)

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	A review of the most recent MDS For Resident 18 dated 3/01/25, indicated that Resident 18 had no cognitive deficit, with a BIMS score of 15 out of 15. A review of Resident 18's Admission Record, dated 3/21/25, indicated that the Resident was her own responsible party, and able to make healthcare decisions for herself. During an interview on 3/19/25 at 1:23 pm, Resident 18 stated that Resident 20 comes into the room day or night. Resident 18 stated, He comes in about 3 to 4 times a month. He is nice but I don't want him in the room. During an interview on 3/21/25 at 8:41 am, the Director of Nursing (DON), confirmed that Resident 20 will enter other residents' rooms uninvited. The DON stated, Yes, he wonders into other residents' rooms, and this does become a residents' rights issue for all involved. During a concurrent interview on 3/21/25 at 8:41 am, the Resource Nurse (RSN), confirmed the statement of the DON that Resident 20 does enter other resident's rooms and stated, As a team we have discussed how better to provide care and safety for him, and the other residents. We have discussed fidget boards and are planning on purchasing one or two. This is something we will finish discussing at our next IDT meeting. Resident 20 was also a painter, and we are working on getting supplies for him to work with. During an interview on 3/21/25 at 11:01 am, Certified Nursing Assistant (CNA) K stated Resident 20 is a wanderer. CNA K stated, Yes, he does wander and will go into other residents' rooms. No one has complained and the other residents are kind to him. Although, a couple of residents do wish he would not go in their rooms. During an interview on 3/21/25 at 11:08 am, CNA L stated that Resident 20 wanders the halls and keeps busy doing his thing. CNA L stated, And yes, he does go into other residents' rooms. No one has stated that they are scared or anything like that. It's just some residents don't want him in their room. 40425 Resident 22's record was reviewed. Resident 22 was admitted to the facility on [DATE], with a diagnosis that included, Joint Replacement Surgery, Pancreatic Cancer, Palliative Care, Type 2 Diabetes Mellitus, Stroke with left sided weakness, Difficulty in Walking, Difficulty Swallowing, Depression, Hepatitis C, Low Back Pain, Anxiety, And History of Falling. The most recent MDS dated [DATE] indicated, that Resident 22 was cognitively intact. During an interview on 3/18/25 at 11:04 am, with Resident 22, Resident 22 stated, Resident 20 comes in her room all the time and tried to go through her things a couple times a week. During an interview on 3/18/25 at 11:00 pm, with CNA C, CNA C said Resident wonders in other residents' rooms daily. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 8's record was reviewed. Resident 8 was admitted to the facility on [DATE], with diagnosis that included, arthritis (joint inflammation and pain), chronic respiratory failure, type 2 diabetes, dizziness, depression, acid reflux, and heart disease. The most recent MDS dated [DATE] indicated, Resident 8 was cognitively intact. During an interview on 3/19/25 at 9:11 am, with Resident 8, Resident 8 stated, Resident 20 comes into her room and goes through her stuff and tries to take things daily. During an interview on 3/19/25 at 10:05 am, with CNA B, CNA said, Resident 20 goes into residents rooms and takes stuff. The residents get mad when he does. Resident 5's record was reviewed. Resident 5 was admitted to the facility on [DATE], with a diagnosis that included, chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), high blood pressure, anxiety (fear of unknown), and depression. The most recent MDS dated [DATE] indicated, Resident 5 was cognitively intact. During an interview on 3/19/25 at 12:00 pm, with Resident 5, Resident 5 stated, Resident 20 comes into her room and tries to go through my things all the time. During an interview on 3/19/25 at 12:01 pm, with CNA A, CNA A said, Resident 20 goes into residents rooms and tries to go through their things.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to provide foot care and treatment to one out of 13 sampled residents (Resident 201) when Licensed Nursing (LN) did not accurately assess the condition of Resident 201's feet, create a care plan (written plan that described needed care and how care would be provided), and the physician was not notified of the condition of Resident 201's feet. This failure had the potential to negatively impact resident health status and psychosocial well-being. Findings: A review of the facility's undated policies and procedures (P&P) titled, Skin Integrity-Foot Care, indicated, residents would receive proper foot care .to maintain mobility and good foot health. The P&P indicated, The comprehensive assessment will include an assessment of the feet for disorders which may require treatment The P&P indicated, Medical conditions will be managed, and interventions will be implemented in accordance with professional standards of practice to prevent complications of medical conditions. A review of the facility's undated P&P titled, Admission Assessment and Follow Up: Role of the Nurse, indicated, when a resident was admitted to the facility, the LN would perform an assessment of the resident that included the skin. The P&P indicated, LN would contact the physician to communicate any abnormal findings, and LN would document their findings. A review of the facility's undated P&P titled, Baseline Care Plans, indicated, within 48 hours of admission to the facility, a care plan would be developed to Include the minimum healthcare information necessary to properly care for a resident A review of the facility's undated P&P titled, Facility Daily Stand-up Meeting, indicated the interdisciplinary team (IDT, a group of department managers that met to discuss resident care needs and goal) met daily to communicate necessary information to meet the resident's needs. A review of the Admission Record, dated 3/7/25, indicated Resident 201 was admitted to the facility on [DATE] with the diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (paralysis and weakness after having a stroke) and difficulty in walking. Resident 201 was his own responsible party (made own decisions). A review of the admission Minimum Data Set (MDS, a resident assessment tool), dated 3/18/25, indicated, that Resident 201 was cognitively intact (ability to think, reason and make decisions), with a brief interview for mental status (BIMS) score of 15 out of 15, which indicated good cognition. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/19/25 at 8:01 am, located in Resident 201'a room, Resident 201 stated, It hurts when I walk and removed his socks. The toenails on both feet were long, thick, and yellow in color. The large toe and the toe immediately next to it, on the left foot, and the toenail on the right large toe was growing straight up. Resident 201 stated, the pressure from the socks, shoes, and blankets hurt. Resident 201 pointed to his feet, and stated feeling mad that facility staff had not communicated with him regarding when [his] feet would be taken care of. The skin on both of Resident 201's feet and toes appeared to be red and purple in color, had a buildup of flakey, dried, thick, skin, and there was a circular cluster of brown growths on the inside left ankle. During a concurrent observation, interview, and record review, on 3/20/25 at 11:55 am, with LN J, Resident 201's feet were observed. LN J confirmed, having cared for Resident 201 in the past, and stated, I perform a daily head to toe assessment at the end of my shift on my residents. LN J stated, she had not performed an assessment of Resident 201 on today and recalled Resident 201 as having long toenails and dry flakey feet and Nothing could be done about [Resident 201's] feet until 3/25/25 when the Podiatrist (foot doctor) comes in. LN J observed Resident 201's feet and described the skin as dry and scaley. LN J described the toenails as yellow, browning, thick with deformity, and long. LN J described the inside of the left ankle as scabs. LN J reviewed Resident 201's physician orders and stated, there were no foot care treatments ordered and there should be. During a concurrent interview and record review on 3/21/25 at 10:59 am, with Director of Nursing (DON) photos of Resident 201's feet were reviewed. DON stated, I was not notified of the condition of [Resident 201's] feet and should have been. DON reviewed Nursing-Clinical Admission Evaluation (admission assessment), dated 3/7/25, and stated, the admission assessment indicated, [Resident 201] had scabs and dry heels. DON stated, the admission assessment did not accurately describe the condition of [both] feet and should have. DON stated, the condition of [Resident 201's] feet should have been caught during the admission assessment, the physician should have been notified, and LN should have initiated a care plan. DON reviewed the base line care plan (developed within 48 hours of admission) and confirmed, there was no care plan developed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and record review, the facility failed to ensure the safety of one of one sampled resident (Resident 20) when: 1. The shower room door was left unlocked which resulted in Resident 20 wandering into the shower room unsupervised and having a fall. 2. Resident 20 was not on one-to-one supervision every 30 min as described as an intervention in his care plan. 3. Resident 20 was exhibiting wandering behavior, and it was not captured on his Minimum Data Set (MDS, a data driven clinical assessment) assessment. These failures resulted in Resident 20 being unsupervised and falling out of his wheelchair and wandering in other resident rooms which had the potential to cause a decline in Resident 20's physical and social wellbeing. Findings: A review of the facility's policy titled Elopements and Wandering Residents (undated), indicated This facility ensures that residents who exhibit wandering (random or repetitive locomotion [movement] that may be goal-directed or aimless) behavior and/or are at risk for elopement (occurs when a resident leaves the premises or a safe area without authorization . and or any necessary supervision to do so) receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. A review of the facility's policy titled Safety and Supervision of Residents revised July 2017, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. A review of Resident 20's Admission Record indicated he was readmitted on [DATE] with diagnoses that included dementia (poor memory, problem solving and safety awareness) with severe with agitation, overactive bladder (the need to pass urine many times in a day), osteoarthritis (degeneration of the bone which causes chronic pain) of the left hip, anxiety depression, and history of falling. He was unable to make his own health care decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 20's Annual MDS dated [DATE], section C indicated Resident 20's Brief Interview for Mental Status (BIMS, an assessment for cognition, thinking, memory recall and decision making) score was 99 (resident was unable to finish evaluation due to his mental condition). Section GG: indicated Resident 20 required maximum assistance (helper does most of the work) with toileting (cleaning private areas after going to the bathroom), upper and lower body dressing, personal hygiene (washing face, hands and brushing teeth), putting on foot ware, and transferring to the toilet. Resident 20 required moderate assistance (helper does part of the work) with sitting to standing, transferring from chair to bed or bed to chair, and walking 10 feet. Resident 20 used a wheelchair (w/c) and was independent with wheeling self around the facility. Section E- Behavior, indicated Resident 20 had no wandering behaviors. A review of Resident 20's Care Plan revised on 10/24/24, indicated a focus area of The resident is an elopement risk/wanderer r/t (related to) history of attempts to leave facility unattended, impaired safety awareness. Interventions included: * Activities Assistant/Director to offer outdoor activities Date initiated 1/8/24. * Alarms placed at exit doors Date initiated 1/9/24. * Distract resident from wandering by offering pleasant diversions Date initiated 1/8/24. * Every 30-minute staff assigned as one-to-one supervision daily. Date initiated 8/4/24. * Resident will be placed on every 15-minute observations as indicated for safety-PRN (as needed). Date initiated: 01/09/24. *Wanderguard (a bracelet worn by a resident that will trigger an alarm when they get close to an outside door.) Date initiated 11/8/24. A review of Resident 20's Interdisciplinary (IDT, group of health care disciplines that discuss resident care needs) Post Event Notes dated 12/7/24 indicated Resident 20 experienced an unwitnessed fall. Details: CNA found the resident lying on the shower floor on their left side, with the wheelchair behind them. Interventions included keypad will be put on shower door. 1.During a concurrent observation and interview with Certified Nursing Assistant (CNA) F on 3/18/25 at 3:35 pm, the hallway and Resident 20's room was observed. Resident 20 was not in his room or in the hallways. CNA F indicated that Resident 20 was in the dining room. An observation of the dining room revealed that Resident 20 was not in the dining room. During an observation on 3/18/25 at 3:40 pm, Resident 20 was observed sitting on the floor in the shower room. His wheelchair (w/c) was behind him and the w/c brakes were unlocked. Licensed Nurse (LN) G indicated Resident 20 had gotten into the shower room by himself unnoticed and then had an unwitnessed fall. A keypad lock was observed on the shower room door. LN G indicated that a code was needed to unlock the door, but it had been left unlocked. LN G indicated that the door was supposed to be locked but it wasn't, and Resident 20 was able to get into the room unsupervised and should not have been able to. LN G indicated Resident 20 was assessed to have no injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/25 at 3:54 pm, Maintenance Director (MTD) indicated the shower room was to be kept locked so residents would not get into the room by themselves. During a concurrent interview with the Director of Nursing (DON) and record review on 3/21/25 at 10:03 am, Resident 20's IDT meetings were reviewed. DON indicated that Resident 20 had a fall in the shower room on 12/7/24 and their intervention at that time was to put a lock on the shower room door to keep wanderers out of the room for safety reasons. DON confirmed that Resident 20 had gotten in the shower room a second time on 3/18/25 due to the shower room door being left unlocked and it should not have been unlocked. 2. During an interview with the Minimum Data Set Nurse (MDS) and record review on 3/19/25 at 2:30 pm, Resident 20's elopement/wandering risk care plan was reviewed. MDS Nurse confirmed that Resident 20's care plan included the documented intervention that every 30-minute, staff was assigned as one-to-one supervision, daily, and Resident 20 would be placed on every 15-minute observations as indicated for safety prn. MDS Nurse indicated she was unable to find documentation in Resident 20's medical record that every 30 min one-to-one supervision was being done daily by staff or 15-minute observations were being conducted. During a concurrent interview with the DON and record review on 3/21/25 at 10:03 am, Resident 20's monitoring for one-to-one supervision and every 15 min was reviewed. DON indicated Resident 20's one-to-one supervision monitoring was documented on paper but was inconsistent. DON was unable to find documentation of wandering and supervision for the month of March and indicated there should have been. 3. A review of Resident 20's Quarterly MDS dated [DATE], Section E- Behavior, indicated Resident 20 had no wandering behaviors. During an interview on 3/18/25 at 3:47 pm, CNA F stated (Resident 20) wanders quite a bit. During an interview on 3/19/25 at 2:47 pm, Social Service Director (SS) indicated that Resident 20 liked to touch door handles and tried to get into doors. During an interview on 3/19/25 at 2:58 pm, the Activity Director (AD) indicated that some residents had complained to her about Resident 20 going into their rooms and touching their belongings. AD indicated she had brought this subject up to the DON and the Administrator (Admin) and they had talked about it in their IDT meetings. AD indicated We try to keep him (Resident 20) from that hallway. During an interview on 3/19/25 at 3:08 pm, CNA F indicated Resident 20 would wheel himself around the facility and just go back and forth down the hallway. CNA F indicated that if Resident 20 went near the exit doors they would go get him and redirect him. During a concurrent interview with the MDS Nurse and record review on 3/21/25 at 9:20 am, Resident 20's Quarterly MDS dated [DATE] was reviewed. MDS Nurse indicated that she had coded section E of Resident 20's MDS's as not exhibiting wandering behaviors when he had had those behaviors. MDS Nurse indicated she had marked section E incorrectly and would fix it.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review the facility failed to ensure one out of one newly admitted sampled resident (Resident 201) was provided with medical related social services when a referral for a follow up appointment with vascular surgeon (a surgeon that specialized in diseases of the veins and arteries also known as blood vessels) was not done. This had the potential for a decline in health status for a resident that recently suffered a stroke (occurred when something blocked the blood vessel that supplied blood to the brain). Findings: A review of the facility's undated policy and procedure (P&P) titled, Social Services, indicated, The facility, regardless of size, will provide medically related social services to each resident, to assist in attaining or maintaining the resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated, the social worker would perform an initial assessment of each resident, identify needs, and document them in the medical record. A review of the Admission Record, dated 3/7/25, indicated Resident 201 was admitted to the facility on [DATE] with the diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (paralysis and weakness after having a stroke) and difficulty in walking. Resident 201 was his own responsible party (made own decisions). A review of the admission Minimum Data Set (MDS, a resident assessment tool), dated 3/18/25, indicated, Resident 201 was cognitively intact (ability to think, reason and make decisions), with a brief interview for mental status (BIMS) score of 15 out of 15, which indicated good cognition. During a concurrent interview and record review on 3/21/25 at 9:32 am, with Social Services, (SS), Resident 201's MD Discharge to SNF Post Acute Transfer (discharge documents, that was faxed from the hospital to the facility), dated 3/7/25 was reviewed. SS confirmed, the discharge documents indicated, Resident 201 needed a follow up appointment with the vascular surgeon in one week. SS stated, SS was not in the facility when Resident 201 was admitted and I don't know if it was done. SS stated, the Interdisciplinary Team (IDT, a group of department managers that discuss resident care and needs) looks at the admission order entered by nurse, we compare the orders to the referral orders, if there is a referral on the packet, IDT reviews it. SS reviewed progress notes in the electronic medical record and was not able to find any documentation that supported a referral had been made to the vascular surgeon. During a concurrent interview and record review on 3/21/25 at 10:59 am, with Director of Nursing (DON), Resident 201'a discharge documents, dated 3/7/25 was reviewed. DON confirmed, the discharge document indicated, Resident 201 needed a follow up appointment with the vascular surgeon in one week. DON stated, SS was responsible to ensure the referral was made and confirmed, SS was not in the facility when resident 201 was admitted . DON stated, due to SS not being in the building at the time Resident 201 was admitted , the IDT team was responsible to ensure the appointment was made, and it didn't happen. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission packet (documents the hospital provided to the facility), included a physician's progress note titled, Hospitalist [NAME] Progress Note, dated 3/2/25. The progress note indicated, Vascular surgery plan for left CEA outpatient (CEA, carotid endarterectomy, surgical procedure to remove built up plaque in the main blood vessel that carried blood and oxygen to the brain, face, and neck. Outpatient was to be done after discharge from the hospital and was performed by a vascular surgeon).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43755 Based on observation, interview and policy review, the facility failed to maintain a clean and orderly environment in the dietary department when there was an unlabeled storage bin and four storage bins with visible dust and adhesive tape residue accumulated on the lids. These failures had the potential to lead to the spread of infections, communicable diseases, and food borne illness to all residents who are served out of this kitchen. Findings: A review of the facility's policy titled Ingredient Bins dated 2018, the policy indicated Ingredient bins must be kept clean and covered to prevent food contamination. Scrub the interior and exterior of the bin with detergent solution. Pay special attention to the corners, lids and casters (wheels). A review of the facility's policy titled Labeling and Dating of Foods dated 2020, the policy indicated All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. During a concurrent observation and interview with the Dietary Manager (DM) on 3/18/25 at 11:17 am, the following were observed in the dry food storage room: * One storage bin with a white granulated substance inside a plastic bag within the bin. There was no label to identify the white substance. The DM asked [NAME] D what the substance was, and they identified it as sugar. The DM indicated there should have been a label on the bin and there was not. *Four storage bins: one with sugar, one with chocolate chips, one with flour, and one with rice that had lids with scratches, visible accumulated dust, and brown, white, and black adhesive tape residue. The DM indicated the lids should have been clean and they were not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055612	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Feather River Care Center	1 Gilmore Lane Oroville, CA 95966

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment when: 1a. Certified Nurse Assistant (CNA) I wore the same isolation gown (worn over clothing and used to prevent the spread of infection) while providing care to Resident 24 (who was diagnosed with Clostridium difficile, C-diff, a bacterium that caused diarrhea, was spread from person to person by direct contact, could cause serious illness, hospitalization , or even death) and Resident 23 (who was not diagnosed with C-diff); and 1b. There was no dedicated cleaning equipment for Resident 24's bathroom; and 2. The nurse's station counter was chipped and not able to be disinfected. These failures had the potential to spread infection. Findings: 1a. A review of the facility's undated policy and procedure (P&P) titled, Management of C. Difficile Infection, indicated, the use of isolation gowns would be used as a method to prevent the spread of C-diff. A review of the Admission Record, dated 7/9/24, indicated, Resident 23 was admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease (a disease that affected the lungs and caused breathing problems). A review of the Admission Record, dated, 8/23/21, indicated, Resident 24 was admitted to the facility on [DATE] with the diagnoses of difficulty in walking and need for assistance with personal care. A review of the Client Report, dated 2/23/25, indicated, Resident 24 tested positive for C-Diff. During a concurrent observation and interview on 3/18/25 at 12:33 pm, CNA I was observed putting on an isolation gown at the doorway of room [ROOM NUMBER]. CNA I took Resident 24 his lunch tray and was observed leaning against Resident 24's bed and the isolation gown was touching the bed. CNA I walked to the door, changed her gloves and was provided Resident 23's lunch tray. CNA I was observed leaning against Resident 23's bed wearing the same isolation gown. CNA I confirmed the observation and stated, [Resident 24] has C-diff and Resident 23 did not have C-diff. I leaned against [Resident 23 and 24's] bed, didn't change gowns (in-between resident care), and should have. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 3/20/25 8:26 am, with the Infection Preventionist (IP), the line listing (list of residents with infections) dated March 2025, was reviewed. IP stated, the line listing indicated, [Resident 24] was diagnosed with C-diff and placed on contact isolation and Resident 23 did not have a diagnosis of C-Diff. IP stated, when facility staff provided care to Residents 23 and 24, they were expected to change their isolation gowns in-between resident care. During an interview on 3/21/25 at 10:19 am, Director of Staff Development (DSD) was described the observation made and confirmed, CNA I should have changed the isolation gown in-between care that was provided to Resident 23 and 24 and stated, there was a potential for cross contamination. 1b. A review of the facility's undated policy and procedure (P&P) titled, Management of C. Difficile Infection, indicated, Use disposable equipment whenever possible. During a concurrent observation and interview on 3/19/25 at 2:28 pm, Maintenance Director (MTD) observed Resident 24's bathroom and stated, when a resident was diagnosed with C-diff, a toilet bowl scrubber and plunger would be dedicated to that bathroom only. MTD confirmed there was not a toilet bowl scrubber present in Resident 24's bathroom and stated, there should be. MTD confirmed, the purpose of using a dedicated toilet bowl scrubber was to reduce the potential for spread of infection. During an interview on 3/20/25 at 11:47 am, Housekeeping (HSK) E and H stated, they were unaware C-diff bathrooms required its own toilet bowl scrubber, and confirmed, the toilet bowl scrubber stored on the housekeeping cart was utilized to clean all resident toilets. 43755 2. A review of the facility's policy titled Routine Cleaning and Disinfection (undated), indicated It is the policy of this facility to ensure the provision of routine cleaning and disinfection (the process of cleaning something, especially with a chemical, in order to destroy bacteria [microorganisms, germs]) in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. During an observation on 3/19/25 at 9:07 am, one of one nursing station was observed. The countertop had many areas of chipped plastic laminate (a countertop covering used to create a durable surface that is moisture resistant and able to be cleaned and disinfected). The 16 feet of countertop edge was missing 13.5 feet of plastic laminate trim which caused porous (something that is full of tiny holes or openings which has a great ability to hold fluid i.e. [for example] sponges, wood, rubber . where microorganisms can grow) wood to be exposed. The top of the counter also had many chips in the plastic laminate. During a concurrent observation and interview with Housekeeper (HSK) on 3/19/25 at 9:15 am, the nursing station countertop was observed. HSK stated I did not know it was that bad, (it is) not able to(be) disinfected. HSK indicated the chipped areas should be fixed. During a concurrent observation and interview with the Infection Preventionist (IP) on 3/19/25 at 9:43 am, the nursing station countertop was observed. IP indicated that the chipped areas of the countertop could not be disinfected, and they should be able to be disinfected.

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F 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation and interview the facility failed to ensure that all their bedrooms accommodated no more than four residents. This had the potential to result in residents not reaching and maintaining their highest practicable level of well-being. Findings: During the initial tour of the facility on 3/18/25 at 10:30 am, room [ROOM NUMBER] had five beds. The residents had a reasonable amount of privacy. The room had adequate storage space, mobility and the provision of care for 5 residents. During an interview with the Administrator on 3/21/25 at 8:36 am, he stated that he would continue the waiver renewal request.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to ensure one out of 13 sampled residents (Resident 4) had access to the resident call system when the call light was not within reach. This failure had the potential to cause a delay in care and could endanger Resident 4's health and safety. Findings: A review of the facility's undated, policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, indicated, call lights would be placed at the bedside so residents could call for assistance. The P&P indicated, Staff will ensure the call light is within reach of resident and secured, as needed. The P&P indicated, residents would be evaluated for needs and preferences .to determine any special accommodations that may be needed in order for the resident to utilize the call system. A review of Resident 4's Admission Record, dated 12/2/23, indicated, admission to the facility on [DATE] with the diagnoses of chronic obstructive pulmonary disease (a disease that affected the lungs causing difficulty with breathing), fracture of lower end of left femur (broken thigh bone), fracture of upper end of right tibia (broken bone of the leg), fracture of upper end left tibia bone, and history of falling. A review of the quarterly Minimum Data Set (MDS, a resident assessment tool), dated 11/29/24, indicated, that Resident 4 was cognitively intact (ability to think, reason and make decisions), with a brief interview for mental status (BIMS) score of 11 out of 15, which indicated good cognition. The MDS indicated, Resident 4 was totally dependent on staff to provide activities of daily living care (showering, rolling or sitting up in bed, and dressing). During a concurrent observation and interview, located in Resident 4's room, on 3/18/25 at 10:50 am, Resident 4 could be heard yelling for help upon entry to the room. Resident 4's call light was observed to be hanging through the lower portion of the bedrail, just below the level of the mattress. Certified Nursing Assistant (CNA) I arrived and stated, [Resident 4] needs the call light clipped to the blanket. She needs to be able to feel it or have it in her visual field to use it. CNA I confirmed, Resident 24 was not able to see or reach her call light. During a concurrent observation, interview, and record review, on 3/21/25 at 10:23 am, Director of Staff Development (DSD) stated, all call light should be within reach of the residents. During an observation in Resident 4's room, the call light cord was observed near the foot of the bed. DSD located the call light cord in between the mattress and foot board, and it hung down to the ground. DSD stated, the call light was not within reach and should be. Director of Nursing (DON) and DSD reviewed Resident 4's undated care plan (a written plan that described resident care needs, preferences, and accommodations that were needed, and how care would be provided), titled Risk for Falls, and both DON and DSD stated, the care plan indicated, Resident 4's call light would be kept within reach.