STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055650	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center of Redlands	700 East Highland Avenue Redlands, CA 92374

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41337 Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for two of eleven residents (Residents 40 and 475) reviewed for dining observation when: 1. Licensed Vocational Nurse (LVN 2) was standing over Resident 40 while feeding her lunch on February 18, 2025. 2. Certified Nursing Assistant (CNA 4) pulled Resident 475 while he was on his wheelchair into the dining room, with his feet dragging on the floor, on February 18, 2025. These failures resulted in staff not maintaining and enhancing Residents 40 and 475's individuality and dignity, and had the potential to devalue and dishonor their self-esteem and self-worth. Findings: 1. During an observation on February 18, 2025, at 12:54 PM, in the Memory Care Unit's dining room, LVN 2 was standing over Resident 40 while feeding her lunch. During an interview on February 19, 2025, at 4:45 PM, CNA 5 stated the job expectation when feeding residents was to perform hand hygiene before, sit down beside residents hand hygiene after. During an interview with the Registered Dietician (RD), on February 20, 2025, at 10:58 AM, the RD stated LVN 2 should be at the same level as Resident 40. During a review of the facility's policy and procedure (P&P) titled Assistance with Meals, revised March 2022, it indicated . 3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: A. not standing over residents while assisting them with meals . During a review of the facility's P&P titled Dignity, revised February 2021, it indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . 1. Residents are treated with dignity and respect at all times. (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 - Some	2. During an observation on February 18, 2025, at 1:11 PM, in the hallway, CNA 4 was pulling Resident 475 into the dining room while he was in his wheelchair. Both of his feet was dragging on the floor. During an interview on February 20, 2025, at 4:04 PM, with CNA 6, CNA 6 stated staff were expected to lock wheelchairs first when parked, elevate resident's feet and place on footrest (part of wheelchair where legs are off the floor), and make sure residents are secured before wheeling. During a review of the facility's P&P titled Dignity, revised February 2021, indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . 1. Residents are treated with dignity and respect at all times.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interview, and record review, the facility failed to ensure their policy for assistive device and equipment (tool that helps a person with disability perform daily tasks) was being implemented for one of four residents (Resident 8) reviewed for range of motion (ROM - full movement potential of a joint) when Resident 8's hand splint (device applied to prevent or reduce contractures) was not applied as ordered. This failure had the potential to cause further contractures (when muscles, tendons or skin around a joint become permanently tight and shortened) discomfort and loss functional mobility negatively impacting Resident 8's quality of life and increasing the risk for preventable physical deterioration and pain. Findings: During a review of Resident 8's Admission Record (contains demographic and medical information), it indicated Resident 8 was admitted to the facility on [DATE], with diagnoses of hemiplegia (paralysis or weakness on one side of the body), and hemiparesis (weakness or inability to move on one side of the body) following cerebral infarction (occurs when blood flow to the brain is block) affecting left non-dominant side. During a review of Resident 8's Physician Orders dated May 10, 2024, it indicated, RNA (restorative nurse assistant - person who helps patients regain mobility and independence in nursing home) order: Pt (patient) to have resting hand splint to LUE (left upper extremity) hand in order to decrease risk of contracture 7 (seven) x (times) week. During a review of Resident 8's Care Plan for Risk for decline in ROM, dated November 9, 2020, it indicated, The resident has limited physical mobility r/t (related to) quadriplegia (one affected side with partial or complete paralysis of both arms and hands), Risk for decline in ROM (range of motion - extent to which muscle or joint can be stretched or move without causing pain) or joint mobility of BLE (bilateral lower extremities- legs) .Interventions, RNA to have resting hand splint to LUE (left upper extremity - left hand) in order to decrease risk of contracture. During an observation on February 18, 2025, at 10:04 AM, in Resident 8's room, Resident 8 was lying in bed awake, alert and oriented. His left hand was contracted. A hand splint was found inside the first drawer of his nightstand. During an interview on February 18, 2025, at 10:12 AM, with Resident 8, Resident 8 stated the staff do not ask him if he wants to wear the hand splint. During a virtual interview on February 18, 2025, at 10:16 AM, with Resident 8's mother, in the presence of Resident 8, Resident 8's mother stated that she rarely sees Resident 8 wearing the hand splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on February 18, 2025, at 10:28 AM, with RNA 1, in Resident 8's room, RNA 1 stated Resident 8 was not wearing the hand splint. RNA 1 stated the hand splint should be applied. During a concurrent observation and interview on February 18, 2025, at 10:45 AM, with the Physical Therapist (PT), in Resident 8's room, the PT stated Resident 8's hand splint was not applied and emphasized its importance in preventing further contractures. The PT further stated nursing staff was responsible for ensuring it was applied as ordered. During another observation and concurrent interview, with a Certified Nursing Assistant (CNA 7), on February 19, 2025, at 8:36 AM, in Resident 8's room, Resident 8's hand splint was inside the drawer of the nightstand. CNA 7 acknowledged Resident 8 was not wearing the hand splint and stated when the resident's mother visits, she applies it for him. During a follow up observation on February 20, 2025, at 10:40 AM, inside Resident 8's room, Resident 8 was lying in bed. He was not wearing his hand splint. The hand splint was on top of the nightstand. During an interview on February 21, 2025, at 2:00 PM, with a Licensed Vocational Nurse (LVN 4), LVN 4 stated staff should follow the doctor's order for splint application. During a concurrent interview and record review on February 21, 2025, at 10:45 AM, with the Director of Nursing (DON), the facility's policy and procedure titled Assistive Device and Equipment dated January 2020, was reviewed. The P&P indicated, Policy Statement, our facility maintains and supervises the use of assistive devices and equipment for residents .3. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan .6. c. Device condition - devices and equipment are maintained on scheduled and according to manufacturer's instructions. Defective or worn devices are discarded or repaired. d. Staff practices - staff are required to demonstrate competency on the use of devices and equipment and are available to assist and supervise residents as needed . The DON agreed the facility staff failed to follow the policy.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interview, and record review, the facility failed to ensure one of four residents (Resident 16) reviewed for respiratory received proper respiratory care in accordance with physicians' orders and professional standards of practice. Resident 16's oxygen tubing was found disconnected from the oxygen concentrator (medical device that provides extra oxygen) for approximately 15 minutes on February 18, 2025. This failure had the potential to cause respiratory distress, oxygen deprivation and other health complications due to insufficient oxygen supply, placing Resident 16's health at risk. Findings: During a review of Resident 16's Admission Record (contains demographic and medical information), it indicated Resident 16 was admitted to the facility on [DATE], with diagnoses of chronic obstructive pulmonary disease (a long-term condition that make it hard to breath), dysphagia (difficulty of swallowing) and hypertension (elevated blood pressure). During a review of Resident 16's Physician Orders dated February 19, 2025, it indicated Resident 16 has an order to receive oxygen at 2-5 liter / min (liters per minute) via nasal cannula (plastic clear tube use to delivered oxygen into the body) continuously every shift. During a review of Resident 16's Care Plan for Risk for Respiratory Distress COPD dated December 11, 2024, it indicated Interventions, Monitor and report increases s/s [signs and symptoms] of SOB [shortness of breath or respiratory distress] .Oxygen available .as ordered . During an observation on February 18, 2025, from 12:59 PM through 1:14 PM, Resident 16's oxygen tubing was disconnected from the oxygen concentrator for approximately 15 minutes during lunch time. During an interview on February 18, 2025, at 1:03 PM, with Resident 16, Resident 16 stated I did not feel my oxygen was running. Resident 16 further stated that she was feeling very tired. During a concurrent interview and record review on February 21, 2025, at 1:14 PM, in Resident 16's room, with the Director of Nursing (DON), the DON verified Resident 16's oxygen tubing was disconnected from the oxygen concentrator, and stated Resident 16's oxygen tubing should always be connected to ensure she is receiving the prescribed oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on February 21, 2025, at 10:45 AM, with the DON, the facility's policy and procedure (P&P) titled, Oxygen Administration dated February 2024, was reviewed. The P&P indicated, Assessment, Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restless, confusion); 4. Vital signs; .6. Oxygen saturation, if applicable and ., Steps in the procedure .7. Check the tubing connected to the oxygen .to assure that is free of kinks, 8. Turn on the oxygen, unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. 9. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and / or nasal catheter) . The DON acknowledged the policy was not followed because Resident 16's oxygen tubing was found disconnected which could lead to serious health risk including desaturation (low oxygen levels).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45388 Based on observation, interview, and record review, the facility failed to maintain accurate records of controlled medications (also called narcotics; medications that are controlled by the government because it may be abused or cause addiction) for one of three narcotic medication carts (Unit Station A Cart Number 2). This failure had the potential for a diversion (illegal distribution of controlled drugs for any illicit use) of controlled medications by staff in a highly vulnerable population of 38 residents, who are in Unit Station A. Findings: During a concurrent interview and record review, on February 20, 2025, at 9:20 AM, with the Director of Nursing (DON), the Unit Station A Cart Number 2's Narcotic Count Record (NCR -form used by the facility to verify counting of controlled medications at the change of shift by oncoming and off going licensed nurses), dated February 1, 2025, to February 20, 2025, was reviewed. The NCR indicated the following: a. On February 5, 2025, missing signature from the night shift (11:00 AM - 7:00 PM) off going shift. b. On February 12, 2025, missing signature from the evening shift (3:00 PM - 11:00 PM) oncoming shift. c. On February 12, 2025, missing signature from the night shift (11:00 PM - 7:00 PM) off going shift. d. On February 13, 2025, missing signature from the evening shift (3:00 PM - 11:00 PM) off going shift. e. On February 15, 2025, missing signature from the evening shift (3:00 PM - 11:00 PM) oncoming shift. f. On February 15, 2025, missing signature from the night shift (11:00 PM - 7:00 PM) off going shift. g. On February 19, 2025, missing signature from the morning shift (7:00 AM - 3:00 PM) oncoming shift. h. On February 19, 2025, missing signature from the evening shift (3:00 PM - 11:00 PM) off going shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON confirmed there were missing signatures for reconciling the narcotic inventory in the NCR. The DON stated oncoming and off going nurses must sign the form to verify they have checked the narcotic medications. During a concurrent interview and record review on February 20, 2025, at 3:55 PM, with the DON, the facility's policy and procedure (P&P) titled, Controlled Substances, dated November 2022, was reviewed. The P&P indicated, .1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up .3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services . The DON stated the policy was not followed and should have been.

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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. 46917 Based on observation, interview, and record review, the facility failed to ensure their policy for self-administration of medications was being implemented for one of four residents (Resident 50) reviewed for environment when Resident 50's self-administered medications were not stored in a safe and secure place. (Three white elongated pills were found in different areas in Resident 50's room.) This failure had the potential to place 72 medically compromised residents at risk for accidental ingestion or exposure to a medication that was not prescribed by the residents' physician. Findings: During a review of Resident 50's Admission Record (contains demographic and medical information), it indicated Resident 50 was admitted to the facility with the diagnoses of multiple sclerosis (chronic autoimmune [the body fights itself] disease that affects the brain and spine), anemia (not having enough healthy red blood cells), and osteomyelitis (bone infection). During a review of Resident 50's Self-Administration of Medications Assessment, dated February 19, 2025, it indicated .6. Resident is a candidate for safe self-administration of medications. During an observation on February 19, 2025, at 11:10 AM, outside Resident 50's room, Resident 50 wheeled himself out of his room. While a Certified Nursing Assistant (CNA 3) carried Resident 50's bedding to a dirty container, one white elongated pill, with no markings, dropped from the bedding and onto the floor. During a concurrent observation and interview on February 19, 2025, at 11:13 AM, inside Resident 50's room, with Registered Nurse (RN 1), RN 1 picked up the white elongated pill and validated that there were no identifying marks on the pill. During a continued observation and concurrent interview on February 19, 2025, at 11:15 AM, with RN 1, there were two additional white elongated pills found inside Resident 50's room. One pill was found under Resident 50's hospital bed, and the other pill was found on the floor next to Resident 50's bedside table. RN 1 stated the pills should not have been on the floor. During a concurrent interview and record review on February 21, 2025, at 2:04 PM, with the Director of Nursing (DON) and the Administrator (Admin), the facility's policy and procedure (P&P) titled, Self-Administration of Medications, revised February 2021, was reviewed. The P&P indicated . 2. The IDT [interdisciplinary team - team of various disciplines such as nurse, doctor, social services, etc.] considers the following factors when determining whether self-administering medications is safe and appropriate for the resident: . f. The resident is able to safely and securely store the medications . 8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart . The DON and the Admin both stated the P&P was not followed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41337 Based on observation, interview, and record review, the facility failed to ensure the diet ordered by the physician was followed for one of eleven residents (Resident 40) reviewed for dining observation when Resident 40 did not receive her physician ordered finger food diet (small, bite-sized foods that can be easily picked up and eaten with the fingers) for lunch on February 18, 2025. (Alternatively, Resident 40 received the regular diet.) This failure had the potential to result in Resident 40 to experience weight loss manifested by Resident 40 not meeting nutritional needs for 1 of 64 medically compromised residents who receive therapeutic food from the kitchen. Findings: During a review of Resident 40's Admission Record (contains demographic and medical information), it indicated Resident 40 was admitted to the facility on [DATE], with the diagnoses of dehydration (loss of fluid in the body), Alzheimer's disease (disease that destroys memory) and schizoaffective disorder (chronic mental health condition that impacts a person's thoughts, feelings, and behavior). During a review of the facility's diet order list, dated February 19, 2025 at 5:33 PM, it indicated Resident 40 had an order from his physician on September 19, 2022, to receive an active fortified/high protein diet, regular texture, thin consistency, finger foods with large portion all meals. The same order was revised on October 26, 2023. During an observation on February 18, 2025, at 12:54 PM, in the Memory Care Unit dining room, Resident 40 was being fed a regular diet. During an interview with the Registered Dietician (RD), on February 20, 2025, at 10:58 AM, the RD stated Resident 40 should be getting finger food diet. During a review of the facility's policy and procedure titled Menus revised October 2017, it indicated Menus are developed and prepared to meet resident choices including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy . 1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences).

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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. 41337 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen as required by the facility policy when: 1.The floors under equipment had accumulation of food crumbs, trash, and black grime (dirt). The food prep sink drain had residue build-up on the drainpipe and the wall. 2. The dry storage room had food crumbs and trash underneath shelves. The shelves had spill of a powder substance. 3. There were broken tiles, which provided a surface for an accumulation of food crumbs, in the dry storage room and in the main kitchen. 4. Food equipment (food processor, plate warmer, blender, and can opener) were stored with food crumbs and build up. 5. The clean utensil bins had food splash and crumbs. 6. The ice machine had black spots in the ice bin ceiling and yellow discoloration (change of natural color) in the ice chute (the part of the ice machine where ice drops into the ice bin). These failures have the potential to compromise food safety and increase the risk of foodborne illness (caused by the ingestion of contaminated food or bevergaes) for 64 high vulnerable residents who receives food from the the kitchen. Findings: 1. During a concurrent observation and interview with the Dietary Services Supervisor (DSS), on February 18, 2025, at 8:10 AM, in the kitchen, the floors under equipment had accumulation of food crumbs, trash, and black grime (dirt). The food prep sink drain had residue build-up on the drainpipe and the wall adjacent to it. The DSS stated the floors and food prep sink should be kept clean. During an interview with the Registered Dietician (RD), on February 20, 2025, at 10:58 AM, the RD stated her expectation was for the floors to be kept clean. The RD further stated the food prep sink drain should be kept clean and that it needed some kind of splash guard. During a review of the facility's policy and procedure (P&P) titled, Section F: Safety and Sanitation, revised 2017, it indicated Floors are kept clean, dry, and uncluttered . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the U.S. Food and Drug Administration Food Code 2022, 4-602.13, it indicated, (C) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and debris. Annex 3 titled Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils indicates the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. 2. During a concurrent observation and interview with the DSS, on February 18, 2025, at 8:45 AM, in the kitchen, the dry storage room had food crumbs and trash underneath the shelves. The shelves had spill of powder substance. During an interview on February 20, 2025, at 10:58 AM, the RD stated the storage room should be kept clean and free of spills. During a review of the facility's P&P titled, Sanitization, revised November 2022, it indicated All kitchens, kitchen areas, and dining areas are kept clean, free from garbage, debris, and protected from rodents and insects. During a review of the U.S. Food and Drug Administration Food Code 2022, 4-602.13, it indicated, (C) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and debris. Annex 3 titled Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils indicates the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. 3. During a concurrent observation and interview with the DSS, on February 18, 2025, at 8:45 AM, an inspection of the kitchen was conducted. There were broken tiles in the dry storage room and in the main kitchen. During an interview on February 20, 2025, at 10:58 AM, the RD stated there should not be any broken tiles and it should be fixed. During a review of the facility's P&P titled, Section F: Safety and Sanitation, revised 2017, it indicated, Floors are to be kept clean, dry, uncluttered and free of broken tiles or defective boards. During a review of the FDA Federal Food Code, date 2022, 4-202.16, it indicated, Nonfood-Contact Surfaces. shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance. In addition, annex 3 indicated, Hard-to-clean areas could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms. Well-designed equipment enhances the ability to keep nonfood-contact surfaces clean. 4. During a concurrent observation and interview with the DSS, on February 18, 2025, at 8:10 AM, in the kitchen, the food processor and blender had old, crusted food splash in the crevices of the equipment. The plate warmer had food crumbs and splash on the handle. The can opener was sticky and dirty. The DSS stated all equipment should be kept clean. (continued on next page)

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	055650	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center of Redlands	700 East Highland Avenue Redlands, CA 92374

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on February 20, 2025, at 10:58 AM, the RD stated she started working for the facility a month ago and the DSS started a couple weeks ago. The RD further stated the kitchen was in a terrible condition and the kitchen staff had no supervisor when she started. The RD stated she made a lot of changes and improvements, however, she expects the equipment to be kept clean and staff need a strict cleaning schedule. During a review of the facility's P&P titled, Section F: Safety and Sanitation, revised 2017, it indicated, Food & Nutrition Services employees will practice safe handling practices for themselves and the equipment by . 11. Wash can opener daily. During a review of the facility's P&P titled, Sanitation, dated November 2022, it indicated, The food service area is maintained in a clean and sanitary manner - 2. All utensils, counters, shelves and equipment are kept clean . 3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions . 5. During a concurrent observation and interview with the DSS, on February 18, 2025, at 8:24 AM, in the kitchen, the clean utensil bins (3 metals and 1 plastic bins with lids) had food splash and crumbs inside. The DSS stated it should be kept clean. During an interview on February 20, 2025, at 10:58 AM, the RD stated utensils should be kept clean and run in the dish washer after every meal. During a review of the facility's P&P titled, Sanitation dated November 2022, it indicated, The food service area is maintained in a clean and sanitary manner - 2. All utensils, counters, shelves and equipment are kept clean . 3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions . 6. During a concurrent observation and interview with the Maintenance Supervisor (MS), on February 18, 2025, at 10:02 AM, the ice machine was inspected. The ice machine had a black build-up in the bin of the ice machine ceiling. The black spots were wipeable with a paper and there was yellow discoloration in the ice chute. The MS stated he oversees cleaning the ice machine monthly however the facility has a contracted company, who cleaned it for the month of February 2025. The MS stated he expects the ice machine to be clean. During an interview on February 20, 2025, at 10:58 AM, the RD stated the ice machine should always be kept clean. During a review of the facility's P&P titled, Sanitation, dated November 2022, it indicated, Ice machines and ice storage containers are drained, cleaned and sanitized per manufacturer's instructions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46917 Based on observation, interview, and record review, the facility failed to ensure proper and safe infection control practices were followed when: 1. Resident 10's oxygen nasal cannula tubing (device used to deliver oxygen into the nose via a tube) was found unlabeled and undated. 2. Resident 16's oxygen nasal cannula tubing was found unlabeled and undated. 3. A warm coffee cup was found on top of an intravenous (IV) medication cart (cart used for storage of intravenous medication solutions). These failures had the potential to result in cross-contamination (the transfer of harmful bacteria) causing a preventable infection to 72 highly vulnerable residents whose health conditions are already compromised. Findings: 1. During a review of Resident 10's Admission Record (contains medical and demographic information), it indicated Resident 10 was admitted to the facility with the diagnoses which included acute respiratory failure with hypoxia (lungs are unable to exchange oxygen leading to low levels of oxygen in blood), malignant neoplasm of cerebellum (cancer in part of brain that controls balance and movement) and encounter for palliative care (specialized care focusing on comfort). During a review of Resident 10's Physician Order dated February 4, 2025, it indicated Resident 10 had order to Change oxygen nasal cannula q [every] wk [week] on Sunday and PRN [as needed] (w/ [with] name & date label) every shift. During an observation on February 18, 2025, at 9:45 AM, in Resident 10's room, Resident 10 was lying in bed, sleeping. There was an oxygen nasal cannula tubing wrapped around the bedrail attached to an oxygen concentrator (device that provides supplemental oxygen). During a concurrent observation and interview on February 18, 2025, at 9:53 AM, with a Registered Nurse (RN 1), in Resident 10's room, RN 1 inspected the oxygen nasal cannula tubing. RN 1 stated the oxygen nasal cannula tubing was not labeled and should have been labeled and dated. During a concurrent interview and record review on February 21, 2025, at 2:01 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection dated revised November 2011 was reviewed. The P&P indicated, . 7. Change the oxygen cannulae (cannula-name for tubing) and tubing every seven (7) days, or as needed. 8. Keep the oxygen cannulae and tubing used PRN (as needed) in a plastic bag when not in use. The DON stated the P&P was not followed. 47098 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident's 16's Admission Record, it indicated Resident 16 was admitted to the facility on [DATE], with diagnoses of chronic obstructive pulmonary disease (a long-term condition that make it hard to breath), dysphagia (difficulty of swallowing) and hypertension (elevated blood pressure). During a review of Resident 16's Physician Orders dated February 18, 2025, at 1:32 PM, it indicated Resident 16 had an order to Change Oxygen Nasal Cannula Q, Wk on SUNDAYS and PRN (w/name & date label). During an observation on February 18, 2025, at 8:58 AM, in Resident 16's room, Resident 16 was lying down on bed. Resident 16 had an oxygen tubing connected to an oxygen concentrator at 4 liters (unit of measurement) via nasal cannula. During a concurrent observation and interview on February 18, 2025, at 9:04 AM, in Resident 16's room, with a License Vocational Nurse (LVN 3), LVN 3 inspected Resident 16's oxygen nasal tubing and confirmed it was unlabeled. LVN 3 stated for infection control purposes, the oxygen tubing should always be labeled to ensure proper tracking of when to replace it. During a concurrent interview and record review on February 21, 2025, at 10:22 AM, with the DON, the DON reviewed the facility's P&P titled Departmental (Respiratory therapy) -Prevention of Infection dated November 2011, which included, Infection Control Considerations Related to Oxygen Administration . 7. Change the oxygen cannulae and tubing every (7) days, or as needed. The DON acknowledged the policy and stated his expectation was that nurse date the tubing. 45388 3. During a concurrent observation and interview on February 18, 2025, at 3:40 PM, with a Certified Nursing Assistant (CNA 1), across from the Nurse's Station in Unit A, a warm coffee cup was on top of an intravenous (IV) medication cart. CNA 1 acknowledged the finding, and stated there should be no coffee cups on top of medication carts. During a concurrent interview and record review on February 19, 2025, at 1:23 PM, with the DON, the DON reviewed the facility's P&P titled, Medication Labeling and Storage, dated February 2023, which indicated, . The nursing staff is responsible for maintain medication storage and preparation areas in a clean, safe, and sanitary manner . The DON stated the policy was not followed and should have been for infection control reasons.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 41337 Based on observation, interview, and record review, the facility failed to maintain equipment in safe operating condition when: 1. One of three refrigerators in the kitchen had missing side screws on the front grill leading to a detachment (falling off). 2. Resident Refrigerator had condensation (excessive moisture or water) on the back wall. 3. The electrical panel in the memory care unit (units designed to prevent wandering and specialized care for people with memory loss) was found open and unlocked These failures had the potential to place the health and safety of 72 of 72 medically compromised residents at risk. It had the potential to cause food to not be cooled properly, compromising 64 residents who could receive food from these refrigerators. And it also had the potential to place 34 medically compromised memory care residents at risk for accidental electrical shock. Findings: 1. During a concurrent observation and interview on February 18, 2025, at 8:10 AM, with the Dietary Services Supervisor (DSS), Refrigerator # 1, which was near the main entrance to the kitchen, was inspected. It had missing side screws on the front grill and as a result it was hanging. The DSS stated it should not be hanging. During an interview on February 20, 2025, at 10:58 AM with the Registered Dietitian (RD), the RD stated her expectation was the equipment should be clean, intact, and working properly. During a review of the facility's policy and procedure (P&P) titled Maintenance Service revised December 2024, indicates 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . 2. Functions of maintenance personnel include but are not limited to: f. establishing priorities in providing repair service. 2. During a concurrent observation and interview on February 18, 2025, at 10:15 AM, with the Maintenance Supervisor (MS), the Resident Refrigerator was inspected. It had some condensation on the back wall. During an interview on February 20, 2025, at 10:58 AM, with the RD, she stated her expectation was that the refrigerator should be working well and should have no condensation. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the U.S. Food and Drug Administration Food Code 2022, 4-501,11, Annex 3 titled Maintenance and Operation: Equipment, Good Repair, and Proper Adjustment, it indicated Proper maintenance of equipment to manufacturer specifications helps ensure that will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the code that place the health of the consumer at risk. For example, refrigeration units in disrepair may no longer be capable of properly cooling or holding time/temperature control for safety foods at safe temperatures. 46917 3. During an observation on February 18, 2025, at 11:05 AM, in front of the Nurse's Station B, there was a large television hanging on the wall with two benches for seating. On the same wall, there was an electrical panel. The door of the electrical panel was ajar. It was unlocked, and can easily be opened to access electrical wires on the inside at level with the bench on the right side. During a concurrent observation and interview on February 18, 2025, at 11:09 AM, with the Maintenance Supervisor (MS), in front of Nurse's Station B, the MS inspected the electrical panel. The MS validated the electrical panel was open and unlocked and stated it should be locked. During a concurrent interview and record review on February 20, 2025, at 8:07 AM, with the Administrator (Admin), the facility's policy and procedure (P&P) titled, Electrical Safety for Residents revised January 2011 was reviewed. The P&P indicated, The residents will be protected from injury associated with the use of electrical devices, including electrocution, burns and fire . 2. Inspect . electrical devices as part of routine fire safety and maintenance inspections. The Admin stated if the MS acknowledged that it was not followed then it was not followed.

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F 0912 Level of Harm - Potential for minimal 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** 46917 Based on observation, interview, and record review, the facility failed to ensure four rooms (Rooms 119, 122, 124, and 125) measured at least 80 square feet per resident. This failure had the potential for the residents housed in Rooms 119, 122, 124, and 125 to not have the ability to move about freely if the square footage limited their personal space. Findings: During a concurrent interview and record review, with the Administrator (Admin) on February 18, 2025, at 8:40 AM, the Admin reviewed the Entrance Conference Checklist and stated the facility had room waivers for Rooms 119, 122, 124, and 125 for less than 80 square feet. During an environmental tour with the Maintenance Supervisor (MS) and the Admin, on February 20, 2025, at 3:48 PM, Rooms 119, 122, 124, and 125 were inspected and the residents' rooms and their measurements of livable space were noted as follows: 1. room [ROOM NUMBER] (two beds) measured: 143.64 sq. ft. [square feet] (71.8 sq. ft. per resident) 2. room [ROOM NUMBER] (two beds) measured: 149.16 sq. ft. [square feet] (74.58 sq. ft. per resident) 3. room [ROOM NUMBER] (two beds) measured: 147.63 sq. ft. [square feet] (73.81 sq. ft. per resident) 4. room [ROOM NUMBER] (two beds) measured: 150.48 sq. ft. [square feet] (75.24 sq. ft. per resident) During a follow up interview with the Admin, on February 21, 2025, at 1:50 PM, the Admin confirmed the measurements of the four resident rooms and room [ROOM NUMBER], 122, 124, and 125 did not meet the 80 square feet per resident. The rooms were not crowded and did not impose any safety hazards to the residents. There were no complaints of space or room issues from the residents occupying these rooms. The survey team recommends the approval of the room waiver request for the rooms listed in this deficiency.

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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** 47098 Based on observation, interview, and record review, the facility failed to ensure one of five residents (Resident 28) reviewed for environment was provided with adequate access to their call light system when Resident 28's call light was not accessible. This failure had the potential to place Resident 28's health and safety at risk because it could lead to delayed care and increased risk of harm in an emergency. Findings: During a review of Resident's 28's Admission Record (contains demographic and medical information) indicated Resident 28 was admitted to the facility on [DATE], with diagnoses of hemiplegia (paralysis on one side of the body), and hemiparesis (weakness on one side of the body) following cerebral infarction affecting right dominant side, dysphagia (difficulty of swallowing) and hypertension (elevated blood pressure). During a review of Resident's 28's Care Plan for Risk for Fall/Injury, dated January 31, 2025, it indicated, Interventions .Call light within reach . During an observation on February 18, 2025, at 11:43 AM, in Resident 28's room, the call light was found inside the first drawer of the bedside nights stand. The call light was not within Resident 28's reach. During a concurrent observation and interview on February 18, 2025, at 11:49 AM, with a Certified Nursing Assistance (CNA 2), inside Resident 28's room, CNA 2 confirmed the call light was inside the drawer and acknowledged it was not within Resident 28's reach. During a concurrent interview and record review on February 21, 2025, at 10:47 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Call light dated January 2024, was reviewed. The P&P indicated, 6. Upon admission and as needed, resident call light shall be within reach. The DON agreed the staff did not follow the policy.