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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Point Healthcare & Wellness Centre	375 Cohasset Rd Chico, CA 95926

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F 0565

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to organize and participate in resident/family groups in the facility.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49934

Based on interview and record review the facility failed to ensure resident council grievances were addressed and resolved when confidential interviews indicated ongoing facility issues. This resulted in the residents to express feelings of helplessness and not being wanted.

Findings:

A review of a facility policy titled, Resident Council revised 11/1/2013, indicated the purpose was to promote the exercise of resident rights at the facility. The residents are to have input in the operation of the facility. The resident council provides feedback on procedures that govern the facility. Make recommendations for the improvement of resident services provided by the facility. If the council raises a concern the department responsible for the issue or service is responsible for addressing the concern. The facility's Quality Assessment Assurance Committee review the resident council minutes as part of it's quality review. The Administrator reviews the minutes and any responses from departments and these are presented at the next resident council meeting or sooner if indicated.

During a review of the facility's record titled, Confidential resident meeting minutes, indicated:

a. On 1/18/2024, issues with call light could be answered sooner, Certified Nursing Assistant (CNA) not returning to room after stating will be right back! and never return and CNA still taking a long time to answer call light on am & pm shifts, weekend and Monday were the worst.

b. On 2/29/2024, issues with shower room [ROOM NUMBER] leaking shower heads.

c. On 3/14/2024, issues with Station 2 shower next to room [ROOM NUMBER], leaking while shower in use.

d. On 3/28/2024, issues with meals are coming out cold again, food is not tasting good, leaking in shower Station 1 and residents requested to get new shower heads. Registry CNA being mean, rude, talking down to residents.

e. On 4/11/2024, issues with food has not been good for the past couple of weeks. Not honoring residents' preferences should not be waking residents up for wheelchair cleaning, chair should be returned to residents as soon as possible in case one has to use restroom. CNAs need to clean restroom after resident care.

(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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. On 4/25/2024, issues with how residents get seconds on meals they like, grass needs to be mowed in the courtyard. Screen missing on bathroom [ROOM NUMBER]B. Hard to get CNAs to make residents beds once they got up for the day. g. On 5/9/2024, issues with food is bad. During confidential interviews on 5/22/24 at 9:30 pm, nine of 10 residents confirmed that call lights continue to be a problem. Residents stated direct care staff come in and turn off their call lights and don't come back. Residents explained they wait a long time (one to two hours) and this has been going on forever (a year). Administrator (ADM) talks about that but that is far as it gets. Feel helpless, that we are not wanted; They don't introduce themselves when they come in the room, don't say hello, don't look us in the eye. Residents stated direct care staff wear ear pods in their ears and always are on the phone or talking to their friends while helping us and in the halls (all shifts). Residents stated complaints and grievances are not addressed. Residents stated grooming not being done, especially fingernails. Residents explained not enough activities or staff to coordinate them. Residents stated pain medications take too long to be administered. Residents stated facility temperature issues- are too warm, and room [ROOM NUMBER] was freezing. Eight of 10 residents stated do not like food and it was cold. Residents stated the sliding door was broken in dining room and shower handles finally working right before State arrived, this was going on about year and a half. During a concurrent record review and interview on 5/24/24 at 11:43 am, Activity Director (AD) stated she gives each department head the complaints and suggestions of the resident council meetings to resolve. AD confirmed there have been repeated complaints about long call light response by direct care staff and maintenance issues for the past year. During an interview on 5/24/24 at 1:15 pm, ADM was unaware of the ongoing issues identified by residents during survey and resident council regarding dietary concerns, long waits for call lights to be answered, delivery of care, and building maintenance over the past year. ADM confirmed none of these issues were collected by department staff and brought to the Quality Assurance Perfromance and Improvment (a group of managers who oversee quality care and make plans to improve the quality of care), committee in the last year.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on interviews, medical record review and facility policy and procedure review, the facility failed to ensure two of six resident's responsible parties (Residents 63 and 4) were notified of significant unplanned weight loss. These failures resulted in a delay of communication of Residents 63 and 4's significant weight losses to their responsible parties which had the potential to negatively impact the resident's well-being. Findings: Review of the facility policy and procedure titled, Evaluation of Weight and Nutritional Status revised April 21, 2022, showed, I. Clinical Evaluation B. Any resident that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days, 10% in 180 days, will be evaluated by the IDT- Nutrition and Weight Variance Committee to determine the cause of weight loss/gain and the intervention(s) required. i. Once weight gain or loss as described above is identified, the IDT -Nutrition and Weight Variance Committee will: C. Notify the responsible party. 1. Review of Resident 63's medical record showed, Resident 63 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis (bone infection), acquired absence of right leg below knee (below-knee amputation), and type 2 diabetes mellitus (a disease that causes uncontrolled blood sugar). Review of Resident 63's Weights and Vitals Summary dated 5/23/23 - 5/23/24, showed the following weights: -On 6/1/23, a weight of 192 lbs. -On 9/3/23, a weight of 185 lbs. -On 11/1/23, a weight of 163.4 lbs. -On 12/1/23, a weight of 169.8 lbs. (a 6.4 lbs., 3.8% weight gain from 11/1/23, a 15.2 lbs., 8.2% significant unplanned weight loss from 9/3/23, and 22.2 lbs., 11.6% significant unplanned weight loss from 6/1/23). Review of the MDS (Minimum Data Set) Resident Assessment and Care Screening dated 2/23/24 showed for Section K- Swallowing/Nutritional Status, Height was 73 inches, Weight was 167. Resident 63 had experienced a significant unplanned weight loss of 5% or more in the last month or 10% or more in the last six months. Review of the Weight IDT Meeting dated 12/13/23 written by the Registered Dietitian (RD) showed in part, CBW (current body weight): 169.8 lbs. (12/1), BMI (body mass index- a weight to height ratio) 22.4, Weight Variance: (+) 6.4 lbs. (3.8%) x one month, (-) 15.2 lbs. (8.2%) x three months, (-) 22lbs.)11.6%) x six months. Involuntary weight gain (desirable) related to excess energy intake as evidenced by weight gain x one month. Interventions: 3) MD/RP (doctor and responsible party) notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident 4's medical record showed, Resident 4 was admitted to the facility on [DATE] with diagnoses which included Unspecified convulsions (a medical condition that causes rapid, involuntary muscle contractions and relaxations), aphasia (a language disorder that affects a person's ability to communicate) and major depressive disorder (clinical depression). Review of Resident 4's Weights and Vitals Summary dated 5/23/23-5/23/24 showed, the following weights: -On 6/9/23, a weight of 176.8 lbs. -On 7/5/23, a weight of 169.2 lbs. -On 8/1/23, a weight of 166.4 lbs. -On 10/1/23, a weight of 155.6 lbs. (a 6.5%, 10.8 lb. significant unplanned weight loss from 8/1/23 and 12%, 21.2 lb. significant unplanned weight loss from 6/9/23) -On 11/1/23, a weight of 151.2 lbs. (a 10.6%, 18 lb. significant unplanned weight loss from 7/5/23) -On 12/1/23, a weight of 148.4 lbs. (a 16%, 28.4 lb. significant unplanned weight loss from 6/9/23) -On 1/2/24, a weight of 137.4 lbs. (a 7.4%, 11 lb. significant unplanned weight loss from 12/1/23, a 11.7%, 18.2 lb. significant unplanned weight loss from 10/1/23, and a 18.8% 31.8 lb. significant unplanned weight loss from 7/5/23) -On 2/5/24, a weight of 131.6 lbs. (a 13%, 19.6 lb. significant unplanned weight loss from 11/1/23, and a 21%, 34.8 lb. significant unplanned weight loss from 8/1/23) -On 4/5/24, a weight of 118.6 lbs. (a 13.6%, 18.8 lbs. significant unplanned weight loss from 1/2/24, and a 23.7%, 37 lb. significant unplanned weight loss from 10/1/23) -On 5/1/24, a weight of 120.2 lbs. Review of the MDS Resident Assessment and Care Screening dated 4/6/24, showed for Section K-Swallowing/Nutritional Status, Height was 66 inches, Weight was 119. Resident 4 had experienced a significant unplanned weight loss of 5% or more in the last month or 10% or more in the last six months. Review of the Weight IDT Meeting dated 12/20/23 written by the RD showed in part, CBW: 148.4 lbs. (12/1), BMI 23.9, Weight Variance: stable x one month, (-) 28.4 lbs. (16.1%) x six months. Interventions: 3) MD/RP notified. Review of the Weight IDT Meeting dated 1/10/24 written by the RD showed in part, CBW: 136.6 lbs. (1/8), BMI 22. Weight Variance: (-) 11.8 lbs. (8%) x one month. Interventions: 5) MD/RP notified. Review of the Weight IDT Meeting dated 4/25/24 written by the RD showed in part, CBW: 118.6 lbs. (4/5), BMI 19.1, Weight Variance: (9-) 18 lbs. (13.2%) x three months, (-) 37 lbs. 23.7%) x six months. Interventions: 4) MD/RP notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/22/24 at 2:31 PM, an interview regarding resident weight loss was conducted with Licensed Vocational Nurse (LVN) B. LVN B stated the RD was in charge of resident weight loss. LVN B stated nursing did not notify the resident's Physician or responsible party regarding weight loss. LVN B added the nurse supervisors were in charge of notifying the physician and resident's responsible party regarding weight loss. On 5/23/24 at 8:00 AM, an interview and concurrent review of residents 63 and 4's medical record was conducted with the Director of Nursing (DON). The DON was asked who was responsible to notify the resident's responsible party of significant weight changes. The DON stated the facility residents had not experienced any significant weight loss since she started work at the facility approximately nine weeks ago. The DON then stated she or the nurse supervisor or a floor nurse could notify the resident's responsible party of significant weight changes. The DON confirmed Residents 63 and 4 had experienced significant unplanned weight loss in the past six months. The DON acknowledged the IDT weight meeting note written by the RD stated the resident's responsible party had been notified of the significant weight loss however the DON was not able to confirm nursing had notified Resident 63 and 4's responsible parties of the significant unplanned weight loss. On 5/23/24 at 8:52 AM an interview was conducted with the RD. The RD stated she wrote the IDT (a group of facility managers who discuss resident care and care plans), weight meeting notes. The RD added she wrote that the resident's responsible party was notified in every IDT weight meeting note however, the RD confirmed she nor the IDT notified the resident's responsible party regarding weight changes. The RD stated nursing was responsible to notify the resident's responsible party regarding resident weight loss. The RD added she was not involved in notifying the resident's responsible party regarding weight loss, she just wrote that in the IDT weight meeting notes. On 5/23/24 at 9:02 AM, an interview was conducted with the DON and Nursing Supervisor (NS). The DON and NS were informed when the RD wrote the IDT weight meeting notes she confirmed she nor the IDT notified the resident's responsible party regarding significant weight loss. The DON stated she was not sure how the resident's responsible party was notified of significant weight changes. The NS stated she would find out how a resident's responsible party was notified of significant weight changes. On 5/23/24 at 9:23 AM, an interview was conducted with the NS. The NS stated the previous DON would notify the resident's responsible party of significant weight changes but that she wasn't aware of anyone who did that now. The NS stated the Regional RN will be in the facility later today and she would get clarification from her. On 5/23/24 at 9:34 AM, an interview was conducted Regional RN (RRN). The RRN confirmed it was nursing's responsibility to notify the Physician and resident's responsible party of significant weight changes.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49934 Based on observation, interview, and record review, the facility failed to ensure the facility environment was maintained safe, comfortable and homelike when: 1. Air temperatures were cold throughout the building. 2. The outside resident patio and facility grounds were not maintained. 3. Multiple screens were missing from residents rooms and dining room. This resulted in residents that were cold and had the potential for insects to enter the facility through windows without screens and violated the residents right to have a homelike environment. Findings: A review of a facility policy titled, Resident Rooms and Environment revised 1/1/2012, indicated the purpose was to provide residents with a safe, clean, comfortable and homelike environment. Ensuring comfortable temperatures and cleanliness and order. 1. During confidential interviews on 05/22/24 9:30 am, residents stated the temperature in room [ROOM NUMBER] was freezing. During an facility environmental tour on 5/23/24 at 9 am, with the Maintenance Assistant (MA) he stated he had been there three weeks. Room temperatures were as follows: room [ROOM NUMBER] temperature 65 degrees Fahrenheit (F), room [ROOM NUMBER], 65F, hallway Station 1, 67F, room [ROOM NUMBER], 70F, Rm 26, 67F, and Day room/Dining room [ROOM NUMBER]F, room [ROOM NUMBER], 65F, room [ROOM NUMBER] hallway 67F, room [ROOM NUMBER] 70F, and shower room Station 3, 70F. A review of an undated facility document temperature log indicated Rooms 1-7 on Station 1, had temperatures from 66-68F. 2. During a review of the facility's record titled, Confidential resident meeting minutes, indicated on 4/25/2024, grass needs to be mowed in courtyard. During a concurrent observation and interview on 5/23/24 at 2:30 pm, Maintenance Supervisor (MS) confirmed the grasses were tall behind the facility and in the resident courtyard. MS stated the lawn and landscaping company have not been coming regularly. MS confirmed behind the facility there were multiple bags of leaves and that the gutters were full of debris. MS confirmed facility air temperatures did not meet regulation parameters. 3. During a review of the facility's record titled, Confidential resident meeting minutes, indicated window screen missing on Bathroom [ROOM NUMBER] B. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an facility environmental tour on 5/23/24 at 9 am, MS confirmed the resident's dining room and resident rooms [ROOM NUMBERS] had missing screens on their sliding glass doors.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41567 Based on interview, and record review, the facility failed to ensure required corrective action was followed in the resolution of a grievance for one of 18 sampled residents (Resident 20). This failure had the potential for Resident 20 to feel her grievance was not managed properly, and therefore feel unsupported by the facility. Findings: A review was made of a facility policy titled, Theft and Loss, revised 7/11/17, which indicated that the facility investigates all reports of lost or stolen items and the Administrator (ADMIN) is to notify law enforcement within 36 hours of an incident involving theft of resident property with a value of $100 or more. Resident 20 was admitted to the facility with diagnoses which include heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs for nutrients and oxygen) and atrial fibrillation (the upper chambers of the heart beat fast and irregularly). During a concurrent observation and interview on 5/22/24 2:14 pm, Resident 20 stated approximately a week ago she had left her purse on the bed after withdrawing $300 from her account and demonstrated opening the pocket of the purse where she had tucked the envelope. Resident 20 then went walking in the hallway, and upon her return, found the cash was missing. She stated she informed staff and ADMIN and the Social Services Worker Supervisor (SSW) searched for the money, but it was not found, and she had not heard back from staff about the results of the investigation. During an interview on 5/23/24 10 am, SSW affirmed Resident 20 told her the $300 was missing from her purse, not last week, but the previous month. She stated Resident 20 withdrew $300 from her trust fund account, then on 4/23/24 she reported the missing money to staff; a theft and loss report was completed. SSW and ADMIN looked for the money in the resident's room, including in sheets and hamper, and could not find it. SSW states she spoke with payroll about reimbursing Resident 20 earlier this week. SSW supplied supporting documentation, stating that the form was started by the nurse who took the initial complaint from the resident, then the SSW documented the resolution and resident response, and the last to enter a signature would be the ADMIN when the incident is resolved or complete. A review was made of a document titled, Theft/Loss Report that was dated 4/23/24, for Resident 20, that was initiated by Licensed Vocational Nurse (LVN) A who documented that the resident stated $300 was missing and felt it may have been taken while she was out for a walk. Under Police notified? there is a yes/no option which was unaddressed. Under Resolution in different handwriting, was written facility will reimburse; under resident response to resolution was written resident accepted resolution. These last two entries were undated, and unsigned. The space for ADMIN signature was unaddressed and undated. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review was made of a document titled, Lost and Stolen Property Log, for the month of April 2024 which indicated that Resident 20 reported the loss of money on 4/23/24, that the loss was investigated, that the funds were not recovered, that that there was follow-up with the resident. During an interview and record review on 5/23/24 11 am, ADMIN stated that losses over $100 are reported to the police, and when asked if he had done so he stated he assumed that SSW had done that. Reviewed policy titled, Theft and Loss which directs that it is the ADMIN's role to contact police; he was surprised and stated he had not done that himself. He stated that he signs off the loss/theft form after the investigation and resolution have been completed. He looked in Resident 20's electronic medical record for a social services progress note indicating SSW had contacted police and stated there was no entry. During an interview and record review on 5/23/24 11:25 am, SSW stated she had missed this one and had not contacted the police department about the missing money. Reviewed policy titled, Theft and Loss which directed that it is the ADMIN's role to contact police, and she stated she had always done it, that the Administrator is not aware of reports of loss or theft or grievances until she brings it to his attention. She provided a completed copy of the Theft/Loss Report dated 4/23/24 for Resident 20, now with the ADMIN's signature.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41567 Based on interview, and record review, appropriate procedure was not followed in the execution of an out-of-facility transfer for one of four sampled residents (Resident 84). This failure could have resulted in Resident 84 and the Ombudsman (a resident advocate) not being notified and unaware of the impending transfer. Findings: A review was made of a facility policy titled, Discharge and Transfer of Residents, revised 2/2018, the purpose of which is to ensure that discharge planning is complete and appropriate. The policy directed that prior to discharge social service staff or nursing will provide the resident with a document, Notice of Proposed Transfer and Discharge, and a copy placed in the resident's medical record. Resident 84's admission record was reviewed which indicated she was admitted on [DATE] with diagnoses which included burns to the head, face, neck, right lower leg, and left hand; diabetes mellitus (a chronic condition wherein the body can't move sugar from the bloodstream into its cells for use as fuel); bipolar disorder (a brain disorder that causes changes in a person's mood, energy, and ability to function); and stimulant drug abuse. The admission record also contains the date Resident 84 was discharged , which was 4/4/24 at 11:49 am, with a length of stay of one day, and that she was discharged to an acute care hospital. A review was made of Resident 84's interdisciplinary team (IDT a team of facility managers who oversee the quality of care residents receive), progress note dated 4/4/24 at 1:57 pm, entered into the medical record by the Director of Nurses (DON). The progress note indicated that the IDT determined that resident 84 required a higher level of care and services that were beyond the scope of practice of the facility, and that the facility cannot meet the reverse isolation (a process in which patients vulnerable to infection are protected from others), needs for her level of wound care management. The plan was to return Resident 84 to an acute care setting. During an interview and record review on 5/23/24 at 9:10 AM, the Medical Records Supervisor (MRS) could not explain why there were no transfer records found. During an interview on 5/23/24 at 9:32 am, the Administrator (ADMIN) confirmed he could not provide evidence that Resident 84 was given notice of the transfer or that the Ombudsman had been notified as there were no transfer documents in the medical record.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41567 Based on interview, and record review, appropriate procedure was not followed in the execution of an out-of-facility transfer for one of four residents (Resident 84). This failure could have resulted in Resident 84 not being properly oriented to the purpose for the transfer and being unprepared, which could have resulted in uncertainty and anxiety. Findings: A review was made of a facility policy titled, Discharge and Transfer of Residents, revised 2/2018, the purpose of which is to ensure that discharge planning is complete and appropriate. The policy directed that prior to discharge social service staff or nursing will provide the resident with a document, Notice of Proposed Transfer and Discharge, and a copy placed in the resident's medical record. Resident 84's admission record was reviewed which indicated she was admitted on [DATE] with diagnoses which included burns to the head, face, neck, right lower leg, and left hand; diabetes mellitus (a chronic condition wherein the body can't move sugar from the bloodstream into its cells for use as fuel); bipolar disorder (a brain disorder that causes changes in a person's mood, energy, and ability to function); and stimulant drug abuse. The admission record also contains the date Resident 84 was discharged , which was 4/4/24 at 11:49 am, with a length of stay of one day, and that she was discharged to an acute care hospital. A review was made of Resident 84's interdisciplinary team (IDT) progress note dated 4/4/24 at 1:57 pm, entered into the medical record by the Director of Nurses (DON). The progress note indicated that the IDT determined that resident 84 required a higher level of care and services that were beyond the scope of practice of the facility, and that the facility cannot meet the reverse isolation (a process in which patients vulnerable to infection are protected from others) needs for her level of wound care management. The plan was to return Resident 84 to an acute care setting. During an interview and record review on 5/23/24 9:10 AM, the Medical Records Supervisor (MRS) could not explain why there were no transfer records found. During an interview on 5/23/24 9:32 am, the Administrator (ADMIN) confirmed he could not provide evidence that Resident 84 was oriented and prepared for transfer as there were no transfer documents in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Point Healthcare & Wellness Centre	375 Cohasset Rd Chico, CA 95926

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49859

Based on interview, and record review, the facility failed to ensure regular (annual, quarterly, or as needed) IDT (an IDT is an interdisciplinary team of health care providers who have knowledge of the resident and his or her needs who is involved in making decisions about the resident's care), assessment for psychotropic medication (mind altering drugs) use and behavioral data for one of five sampled residents, Resident 53.

This failure resulted in Resident 53 having a schizophrenia diagnosis (a mental health disorder that affects the way a person thinks, feels, and behaves and may include hallucinations) added to the medical records, in addition to anoxic brain injury (an injury to the brain due to lack of oxygen).The addition of the schizophrenia diagnosis was not documented by a psychiatric (mental health) physician or primary care physician.

Findings:

A review of Resident 53's records indicated she was admitted on [DATE], with diagnoses which included, Cerebral Infarction (blockage of blood vessels in the brain from a clot), Anoxic Brain Injury (an injury to the brain due to lack of oxygen), and Psychosis (a mental disorder in which there is severe loss of contact with reality).

During a review of Resident 53's May 2024 Medication Administration Record (or MAR), the record indicated an order for Resident 53 to receive Geodon (or Ziprasidone, a mind-altering drug used to control behavior or thought process) for schizophrenia manifested by auditory hallucinations (hearing unreal voices in head).

Further review of Resident 53's electronic medical record, dated May 2024, the record indicated, on 5/22/24, the diagnosis or indication (the reason for use) for Geodon order was changed from schizophrenia to anoxic brain injury (an injury to the brain due to lack of oxygen) for thrashing in bed. The medical record did not show if a psychiatric consultation resulted in the change in diagnosis from schizophrenia to anoxic brain injury.

During an interview with the Director of Nursing (DON), on 5/24/24 at 11:35 AM, the DON stated that only a psychiatric physician can diagnose schizophrenia. The DON also stated that Resident 53 did not have a current mental health consult with a psychiatric physician and the last order for a psychiatric consult was on 10/8/2022. The DON stated that the order for the Geodon (for schizophrenia was signed by the Medical Director and given to the Assistant Director of Nursing (ADON).

During an interview on 5/24/24 at 11:55 AM, with Minimum Data Set nurse (MDSC) (MDS - health care staff that gather and transmit the required resident information to the federal government), the MDSC nurse stated that the facility found the diagnosis of schizophrenia for Resident 53 was a transcription error. The MDSC nurse admitted that this transcription error had been ongoing since at least 6/27/23.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/24 at 1:46 PM with the Medical Director (MD), the MD stated that the facility could not figure out how Resident 53 was diagnosed with schizophrenia and put on Geodon. The Medical Director agreed that a schizophrenia diagnosis must be made by a psychiatric physician. During a concurrent interview and record review, on 5/24/24 at 2:03 PM, with the Social Services Worker (SSW), the SSW reviewed Resident 53's IDT meeting notes regarding psychotropic medication. The last IDT meeting for Resident 53 was held on 10/24/23, more than 6 months ago. The SSW stated that she had been out of the facility from November 2023 to January 2024 and the facility had no psychotropic medication IDT meetings for Resident 53 during that time. During a review of Resident 53's May 2024 Medication Administration Record (MAR) the record indicated that the order for Resident 53 to receive Geodon for Schizophrenia manifested by auditory hallucinations was discontinued on 5/22/24 and an order for Geodon for anoxic brain injury for thrashing in bed was started on 5/22/24. No record is available of a psychiatric consultation to make the change in diagnosis from schizophrenia to anoxic brain injury. During a review of the facility's policy and procedure (P&P) titled, Behavior/Psychoactive Drug Management, dated November 2018, indicated, Upon admission, quarterly, annually, and upon change in condition, the Interdisciplinary Team (IDT) will collect and assess information about the resident including but not limited to . cognitive status and related abilities and medications. The P&P indicated that antipsychotic drugs should not be used for fidgeting.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48129 Based on observation, interview, and record review, the facility failed to provide an ongoing activity program to meet the needs and interests for two of two sampled residents (Residents 47 and 61) to ensure the residents maintained their highest physical, mental, and psychosocial well-being. This deficient practice had the potential not to meet the highest practicable psychosocial well-being of the residents. Findings: A review of Resident 47's Admission Record shows Resident 47 was first admitted to facility on 2/14/22, with medical diagnoses including Displace bimalleolar fracture of left lower leg (a broken left lower leg), Chronic lymphocytic leukemia of B-cell type (a cancer of the blood), and Major depressive disorder, recurrent (Depression). A review of Resident 47's Minimum Data Set (MDS - a standardized comprehensive assessment and care planning tool) dated 4/9/24, shows Resident 47 has a BIMS score of 6 (Brief Interview for Mental Status), which indicates severe cognitive impairment and only sometimes understands, or has trouble expressing their needs and wants. A review of Resident 47's MDS Section F - Preference for Customary Routine and Activity, dated 1/12/24, shows Resident 47 answered that it was Very Important to be able to do their favorite activities. A review of Resident 47's written Activity Assessment, dated 2/21/22, shows Resident 47's Favorite Leisure Preferences as being movies, television, music, and radio. A review of Resident 47's Care Plan, initiated 4/1/24, shows The Resident needs assistance/escort to activity functions. During a concurrent interview and observation with Resident 47 on 5/22/24 at 11:25 AM, Resident 47 was seen laying in bed, wearing a hospital gown, resting quietly. During the interview, Resident 47 stated they like to nap a lot, but would prefer to get out of bed sometimes. Resident 47 was unable to recall the last time they got up out of bed. Resident 47 also stated they like to watch movies or listen to music as an activity, since they are bed-bound, and stated My TV [television] is broken, I think. An observation of Resident's room showed that a TV was mounted to the wall closest to resident, but was not plugged in, and no plug was visibly available in that vicinity. Resident 47 was unable to recall how long the tv had been broken. A review of Resident 61's Admission record, shows Resident 61 was first admitted to facility on 3/2/24, with medical diagnoses including Secondary Malignant Neoplasm of Brain (cancer that has spread to the brain), Dysphagia, unspecified (difficulty swallowing), Malignant Neoplasm of Thyroid Gland (cancer of a gland in the throat), and Legal Blindness. A review of Resident 61's MDS, dated [DATE], shows Resident 61 is cognitively intact, with a BIMS score of 15. A review of a written Activities Assessment, dated 5/16/24, shows Resident 61's favorite activities include movies, music, news and radio. This assessment also notes Resident 61's Blindness. A review of Resident 61's Care Plan, initiated 4/17/24, shows The resident will participate in activities of choice in room activities 2-3 times per week by review date. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation with Resident 61 on 5/21/24 at 8:30 AM, Resident 61 was laying in bed, wearing a hospital gown, and large dark sunglasses. Resident 61 stated they'd like to be able to do more activities, more often. Resident 61 stated they don't get out of bed very often, but would love to have a radio or music in their room. Resident 61 could not recall their last activity session. During an interview with Resident 61 on 5/21/24 at 12:47 PM, Resident 61 stated, They make you cry. I don't have any friends, in regard to their activity preferences and social interaction frequency. Resident 61 stated they do not attend activities, and would like to. Resident 61 stated they would like to listen to music or audio books, due to their blindness, as a preferred activity. During an interview with Activities Director (ACT) on 05/24/24 at 8:20 AM, the ACT stated that some residents will ask to participate in activities, and then refuse at the last minute, and remain in their rooms. ACT also stated that for residents that prefer to remain in their rooms, the Activities Program staff will go to resident rooms and visit with them, play cards, or read them the Daily Chronicle. When asked how ACT communicates Activity preferences and care plans for residents to other staff, such as Certified Nursing Assistants (CNAs), the ACT stated they weren't sure how other staff get that information. The ACT stated, We try to see the residents every day, or every other day. At least see them twice a week. A review of the Policy titled, Activities Program shows The Care Plan should be reviewed with the resident and/or the resident's family to ensure that the resident approves and understands the Plan .As needed, activities are tailored to meet the needs of residents with cognitive impairment or other special needs.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49934 Based on observation, interview, and record review, the facility failed to identify, evaluate, and intervene in a timely manner in order to prevent an avoidable pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence, where bones are close to the surface of the skin), for 1 of 3 residents who were sampled for pressure ulcers (Resident 63). This resulted in Resident 63 developing an infected Stage 4 (full thickness skin loss with damage and exposure of muscle, bone, fat and/or tendon), pressure ulcer on his right heel and subsequent right leg amputation (cut off by surgical operation), below the knee which caused the resident anxiety, depression, and uncontrolled pain. Findings: A review of the facility's policy titled, Skin Integrity Management, revised 10/26/23, indicated that the policy of the facility is to identify, evaluate, and intervene to prevent pressure ulcers and any other skin integrity conditions. The purpose of the policy is to develop a plan of care for residents who are at risk for developing skin integrity conditions and to provide guidelines for the treatment of skin integrity conditions to facilitate healing. A review of the facility's policy titled, Pressure Injury [also means pressure ulcer] Prevention, revised 3/30/23, indicated that a plan of care will be developed for residents who have risk factors, or are at risk for development of a pressure injury. The purpose of the policy is to prevent the development of pressure injury in residents identified at risk. A review of the facility's policy titled, Diabetic Care, revised 1/1/2012, indicated that the policy of the facility is to provide the necessary care and services to permit each diabetic resident to attain or maintain optimal well-being while monitoring their care in accordance with their individualized comprehensive assessment and care plan. The purpose of the policy is to ensure residents with diabetes achieve optimal well-being while recognizing the resident's right to refuse treatment and the impacts of the recognized pathology and the normal aging process. Section VII. A Licensed Nurse will assess and document the resident's skin condition at least weekly. Section VIII. A Licensed Nurse will monitor and report any signs of infection. Section XII. Licensed Nurses will provide diabetes education to residents and family, covering the following topics: H. Maintaining clean feet I. Use of white socks J. Removing shoes and socks at night; and (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	K. Keeping heels off bed A review of Resident 63's Admission Record, dated 4/19/22, indicated diagnoses of type 2 diabetes mellitus (adult onset of high blood sugars), idiopathic peripheral autonomic neuropathy (nerve damage causing numbness or weakness), and dementia (confusion and forgetfulness). A review of Resident 63's Minimum Data Set (MDS- an assessment and care screening tool), dated 7/5/23, indicated a risk for pressure ulcers. The MDS assessment indicated no pressure ulcers, other ulcers, open lesions, infections of the foot, wounds, or skin problems present. A review of Resident 63's Care Plans, initiated on 5/3/22, indicated that he had potential for pressure ulcer development related to incontinence [loss of bowel and bladder control], level of assistance needed for transfers and mobility, and cognitive deficits. On 6/7/2023, it is indicated that he had potential impairment to skin integrity related to dementia and diabetes. A review of the Weekly Skin/Wound Assessments, dated 7/27/23, indicated, Resident's skin is warm and dry. No skin issues or open wounds noted. On 8/8/23, another Weekly Skin/Wound Assessment indicated, No skin issues. During a record review of a Progress Note, dated 8/11/23, the Wound Doctor (WD) assessed Resident 63's right foot. WD found an Unstageable (full-thickness pressure ulcer covered by a scab or yellow-white material on the wound), pressure ulcer to the right heel. A review of the Weekly Skin/Wound Assessments, dated 8/15/23, indicated, No skin issues noted. On 08/22/23, the Weekly Skin/Wound Assessment indicated a pressure ulcer Stage 1 (Intact skin with an area of non-blanchable, (an area of redness that does not disappear under pressure), and was in-house acquired (happened while in the facility). A review of the WD's Progress Notes, dated 9/1/23, indicated Pressure Right Heel and staged at unstageable necrosis (the death of most or all the cells in the tissue due to failure of blood supply). The wound bed was 100 percent Eschar (a dry, dark scab), with a length of 2.5 centimeters (cm- unit of measure), width 3 cm, and depth 0 cm. WD recommended to offload (positioning the body so that pressure does not rest on top of the wound) right heel wound, dietician consult, vitamin C and Zinc Sulfate (vitamins), reposition per facility protocol, and Sponge Boot (a soft boot to relieve pressure) with offloading (to take pressure off of the area), heels. A review of the Order Summary Report of Discontinued and Completed Orders, from 2022 to 2024, indicated there was no pressure relieving interventions for Resident 63 such as floating heels, boots, or repositioning, prior to the development of the pressure ulcer to the right heel. A review of the Order Summary Report of Discontinued and Completed Orders, dated 4/19/22, there are orders for Podiatry (foot doctor) service as clinically indicated, but there are no podiatry consultations or assessments found in Resident 63's record. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0686

Level of Harm - Actual harm

Residents Affected - Few

A review of a Progress Note, dated 9/20/23, indicated that Resident 63's pressure ulcer continued to have a foul odor with redness and swelling at the edges and that there were two types of bacteria in the right heel pressure ulcer wound bed. The Progress Note indicated that one of the bacteria was resistant (the antibiobic will not kill that type bacteria), to the antibiotics that were ordered to treat the infection. On 9/23/23, the Progress Note indicated that the wound had become worse with a strong odor, had an excessive amount of dead tissue, was non-blanchable and the resident complained of pain at his right heel. The WD was notified and requested Resident 63 be sent to the hospital for evaluation.

A review of an Interdisciplinary Team Note (IDT- healthcare team that ensures residents receive quality care and improve how a facility functions), dated 9/27/23, indicated that prior to admit to local hospital, Resident 63's wound at the right heel was not healing and was deteriorating despite treatment interventions.

During an interview on 5/24/24 at 2:14 pm, Certified Nursing Assistant (CNA) D indicated Resident 63 would wear heavy boots in his wheelchair, and frequently self-propelled himself throughout the facility using both heels to maneuver. CNA D explained Resident 63 would dig both heels into his mattress while in bed. CNA D stated Resident 63 was cooperative with care. CNA D described the right heel wound as being deep.

During a concurrent interview and record review on 5/24/24 at 2:30 pm, the Director of Nursing (DON) stated Resident 63 was at high risk for pressure ulcers due to being a diabetic. The DON confirmed there were no podiatry visits found in the record and could not find any preventative measures put in place to prevent pressure ulcer development. The DON also confirmed there were no documented nursing skin checks on Resident 63 and stated he should have had foot, skin, and nails checks due to being a diabetic and having behaviors of digging in his heels when in the wheelchair and bed.

A review of the Discharge Summary from the local hospital, dated 9/27/23, indicated diagnoses of osteomyelitis (bone infection), diabetic ulcer of right heel with fat layer exposed, diabetic ulcer of right heel associated with diabetes mellitus due to underlying condition, unspecified ulcer stage, diabetes mellitus type 2 with neurological manifestations (symptoms caused by the nervous system). The discharge summary indicated that Resident 63 had an Irrigation and Debridement (I&D- procedure where dead tissue is removed from the wound bed), 8 days prior at the facility and was also given oral antibiotics at the facility, but the wound was not healing properly. The WD was concerned and sent Resident 63 to the local hospital for further evaluation. The discharge summary indicated that Resident 63 had a bedside I&D on 9/24/23 at the local hospital, which resulted in revealing bone and the diagnosis of osteomyelitis. Resident 63 also had an ortho-surgery (branch of medicine that focuses on the care of the skeletal system) consult. The discharge summary stated Resident 63 indicated that the pain is not getting better and does want to get admitted to the hospital and get the wound cleaned up. Resident 63 was admitted to the hospital's Emergency Department on 9/23/23, admitted to the local hospital on 9/24/23, had a below the knee amputation (BKA) to his right leg on 9/25/23, and then was discharged back to the facility on [DATE].

During a review of an IDT Note, dated 9/27/23, the experience of a BKA resulted in a decline in mobility, transfers, ADL (activities of daily living) function, and placed Resident 63 at risk for psychosocial distress (unpleasant emotions).

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	055656	A. Building B. Wing	05/28/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of a Progress Note, dated 9/29/23, Resident 63 stated a desire for a Hospice evaluation and just wanted to die. Resident 63 wasn't going to take anymore medications or eat, and decided this after they took the right foot off.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 49418 Based on observation, interview, and record review, the facility failed to ensure residents remained free from potential accident hazards when: 1. One Fire Door (FD) A (a door that is fire proof and helps contain smoke), which led to the outside of the facility was damaged and could not be completely closed or locked for the past year and a half. The door led to the facility backyard where there was a steep creek. 2. A staff locker room door (LD) B, that residents had access to, was not kept locked and contained rusty unlocked lockers, stainless steel chemical cleaner, personal protective equipment (eye goggles, face shield and face masks), staff belongings, food items, a broken air conditioner, TV monitors [televisions], cardboard boxes, an industrial-sized container of a chemical rust remover. These failures had the potential to negatively impact the health, safety, and welfare of 82 of 82 residents who currently resided in the facility. This put the residents at risk for serious injury, harm or death by allowing for unannounced, potentially dangerous visitors to enter the facility and for residents to wander out of the facility unsupervised, and to ingest harmful cleaning chemicals. On 5/22/24 at 11:25 am, the Administrator (ADM) was notified that an Immediate Jeopardy (IJ) situation (a situation that requires immediate correction on the facility's part to avoid harm to the residents) was identified and Substandard Quality of Care (SQC, care that is below the standard required), due to the facility's inability to close or lock FD A and LD B, which contained harmful chemicals that the residents had access to. On 5/22/24 at 12 pm, an immediate corrective action plan was requested from the ADM. On 5/22/24 at 4:25 pm, the ADM presented an immediate corrective action plan that was accepted which removed the immediate danger to the residents, by securing FD A and LD B so that they closed and locked. On 5/22/24 at 5:10 pm, the survey team was on-site and verified that the facility's immediate corrective action plan had been implemented and the ADM was informed that the IJ was removed. 3. A toilet that was loose and not secured to the floor, that the facility had knowledge of, was not repaired and contributed to the fall of one resident (Resident 38), when he sat down on the toilet and it moved. This resulted in Resident 38 sustaining a large bruise to his hip and caused him unnecessary pain and anxiety. Findings: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. During review of facility's policy and procedure (P&P) titled, Maintenance Service: Operational Manual - Physical Environment, revised 1/1/12, the P&P indicated its Purpose was to protect the health and safety of residents, visitors, and facility staff. The P&P indicated Maintenance staff will follow established safety regulations to ensure the safety and well-being of all concerned. The P&P indicated the Maintenance Department is responsible for the following: Establishing priorities in providing service repair, Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines, Maintaining the building in good repair and free from hazards, Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order, Maintaining the grounds, sidewalks, parking lots, etc., in good order, Providing routinely scheduled maintenance service to all areas, and Other services that may become necessary or appropriate. During an outside tour of the facility grounds on 5/21/24 at 11:06 am, FD A was observed to be open approximately one-half inch, with a heavy rubber floormat across the threshold under the door. An approximate 1-inch gap was noted between the floor and the bottom of FD A nearest the hinged side. The backyard and area behind the facility contained unmaintained land with weeds and trees leading to a steep embankment which dropped into a (seasonally) dry, rocky creek bed. Observed that LD B was unlocked and there was no locking device on LD B. During concurrent observation of FD A and interview with Maintenance Director (MAINT) on 5/22/24 at 8:55 am, MAINT stated he was aware there was an issue with FD A. MAINT opened FD A and indicated that the door was cracked which caused the heavy door to pull the hinge apart so that FD A was not aligned within the doorframe. MAINT stated it was not possible to fix FD A and that this fire door needed to be replaced. MAINT stated he was waiting for a vendor to give a price quote for a new fire door. MAINT confirmed that LD B was not locked but was equipped with a Wanderguard device (a device worn by residents who tend to wander that triggers the device's alarm). MAINT stated anyone going in or out of LD B wearing a Wanderguard bracelet would set off the alarm; however, an alarm would not sound if a Wanderguard bracelet was not present. Observed that LD B had no lock present. Resident 69 was observed nearing the exit in her wheelchair. Resident 69 stated, I think I'm lost. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. During observation of LD B and the staff locker room on 5/22/24 at 11:12 am, rusty, unlocked lockers were observed to contain stainless steel cleaner, a protective face shield and eye protection, a box of face masks, and other staff belongings to include clothing and food items. A cupboard across from the lockers contained what appeared to be broken equipment to include an air conditioner device, TV monitors, cardboard boxes, and pieces of wood and metal. An industrial-sized container of Diversey Neutralizer (rust remover) was observed in the corner of the locker room. The Diversey Neutralizer's label indicated the undiluted Diversey product could cause, severe skin burns and serious eye damage and would be harmful if swallowed, causing burns/serious damage to mouth, throat and stomach. The label advised avoiding contact of the product with eyes, skin, and clothing and to avoid inhaling product fumes by using face protection. During an interview on 5/22/24 at 9:40 am, Certified Nursing Assistant (CNA) E indicated that FD A, had not been locked for one and a half years since I have been here. CNA E confirmed residents hang out in the hallway next to FD A and could go outside because they can't be seen by staff. During review of record titled, Proposal dated 10/10/23, regarding the replacement of FD A, indicated that an outside vendor (company or business) proposed a bid (potential cost) to furnish, deliver, and install . One (1) new Hollow Metal Door for your existing opening. The record indicated this would include securing new hinges in place, alignment of the door in the opening for proper clearance, lubrication of all moving parts and our Quality Assurance & Safety Check to insure proper operation of the complete door system. A review of an email dated 10/17/23, sent by the ADM to Governing Body (GB) 1, (the GB is a high level of management that makes policies and oversees all of the affairs of the facility and secures funds), included a capital expenditure (means a high cost item that the GB needs to approve), purchase order form for one hollow metal fire door. The capital expense report indicated the current fire door was unable to close and lock due to issues beyond repair. During an interview on 5/22/24 at 4:50 pm, ADM stated he was aware that FD A needed to be replaced a year and a half ago. ADM stated he received an estimate from one vendor and GB 1 requested two estimates, before approving. ADM stated he explained to GB 1 that there was only one available vendor in the area, but the funds were not approved. During an interview on 5/23/24 at 4 pm, GB 2 stated that he had replaced GB 1 about three weeks ago and was unaware of the oustanding facility building projects needing approval. GB 2 stated the capital expense for the broken FD A, should have been approved back when it was identified as an issue. 49934 3. A review of the facility's Fall Management Program policy, revised 3/13/21, indicated the facility will implement a Fall management Program that supports providing an environment free from fall hazards. The purpose of the policy is to provide residents a safe environment that minimizes complications associated with falls. A review of Resident 38's Admission record indicated he was admitted to the facility on [DATE], with diagnoses that included right sided paralysis (unable to move one side of the body after a stroke) and weakness, and was unsteady on his feet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of a Fall Risk Evaluation dated 5/19/24, indicated that Resident 38 was at high risk for falls. A review of Resident 38's Progress Notes dated, 5/20/24, indicated that Resident 38 has had 3 falls. One fall on 3/13/24, 5/11/24, and on 5/19/24. A review of the Minimum Data Sets (MDS- an assessment and care screening tool), dated 5/15/24, indicated that Resident 38 required minimal assistance (only needs a staff member to stand by), with chair to bed transfers, toilet transfers, and walking up to 150 feet. Resident 38 was cognitively intact (ability to make decisions). A review of a Care Plan revised on 5/20/24, indicated Resident 38 was at risk for falls related to balance problems and right sided weakness. Interventions included anticipating needs of resident, call light within reach, and ensure resident was wearing appropriate footwear when ambulating. A review of Progress Notes dated 5/12/24, for a fall that occurred on 5/11/24, indicated Resident 38's fall was due to him losing his footing. There was an evaluation of the environment under contributing factors but had not included the bathroom. A review of a Progress Note written by Licensed Nurse (LN) K dated 5/19/24, indicated that Resident 38 was going to use the restroom and fell to the floor and was found on his right side and there was some bruising to right hip/thigh area. Resident 38 was assisted up to use the bathroom by staff. LN K asked resident if he would like to go the hospital to be evaluated and Resident 38 declined. A review of an Interdisciplinary Team (IDT- healthcare team that ensures residents receive quality care and improve how a facility functions), written on 5/20/24, indicated that medications contributed to Resident 38's fall. There was no record of evaluation of the environment. A review of a Post Fall Evaluation, dated 5/19/24, indicated Resident 38 had a fall due to, Attempting to self-toilet. During an interview and observation with Resident 38 in his room on 5/21/24 at 11:22 am, Resident 38 voluntarily raised his shirt and adjusted the right side of his pants to reveal dark purple discoloration at the right side below the ribs and at the hip. Resident 38 indicated that he fell because his bathroom toilet was very unsteady and not secured to the floor. This was visibly demonstrated when the resident grabbed the front edge of the toilet and spun the toilet from side-to-side. Resident 38 stated, I went to sit down, and the toilet moved. When asked if this was reported to staff, Resident 38 stated that this had been reported, a while ago. Resident 38 stated that he does not use the call light a lot because he wants to get up and do things independently. After the fall, Resident 38 yelled for help, staff came right away, and the nurse did an assessment. A review of a Progress Note by Social Services, dated 05/22/24, indicated that Resident 38 was upset because of the bruising to his right hip and pain and, He feels no one cares. During review of facility records titled, Maintenance Logs, dated 1/1/24 to 5/22/24, the records indicated the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/28/24, Special Issue/Problem: Resident 38's bathroom toilet was loose and leaking. The record did not indicate Date Addressed, Target Date, Date Completed, or Completed By (staff initials). During an interview on 5/21/24 at 11:30 am, Licensed Vocational Nurse (LVN) F and Infection Preventionist (IP), were interviewed regarding Resident 38's fall. LVN F stated that she heard he fell but did not know it involved the toilet. IP stated was not aware that the bruise was from a fall in his bathroom near the toilet. LVN F and IP both confirmed MAINT just went to get parts to fix the toilet and confirmed that Resident 38's toilet had not been repaired up to now.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 48129 Based on observation, interview, and record review the facility failed to: 1. Provide the necessary care and services for dysphagia (difficulty swallowing foods or liquids) and gastrostomy feeding tube (or G-Tube, a medical device inserted into stomach surgically and used to provide liquid nourishment, fluids, and medications by bypassing oral intake) for one of two sampled residents (Resident 61), when Resident 61 was found to be lacking current Speech Therapy orders. This failure had the potential to lead to the Resident not attaining their highest level of practicable nutrition and emotional happiness. 2. Ensure safe assessment and measurement of the residents' gastrostomy feeding tube's gastric residual volume (the fluid left in the stomach after feeding or taking medication, measured to ensure that the stomach is emptying properly) during medication administration and bolus feeding (the administration of a limited volume of fluid formula over brief periods of time) for one out of two sampled residents (Resident 61). This failure had the potential to result in Resident 61 developing reflux, vomiting, or aspiration pneumonia (when fluid gets into the lung and causes infection) when the bolus feeding, or medications are given without proper assessment of residual volume. Findings: A review of Resident 61's Admission record, shows Resident 61 was first admitted to facility on 3/2/2024, with medical diagnoses including Secondary Malignant Neoplasm of Brain (cancer that has spread to the brain), Dysphagia, unspecified (difficulty swallowing), Malignant Neoplasm of Thyroid Gland (cancer of a gland in the throat), and Legal Blindness. During an interview with Resident 61 on 5/21/2024 at 8:30 am, Resident 61 stated they had a feeding tube, and that they'd also like to eat regular food. Resident 61 stated they continued to be hungry at times, despite tube feedings, and wanted to eat their favorite foods again. Resident 61 stated they used to get Speech Therapy when first admitted , but hadn't seen a Speech Therapist for many weeks. Resident 61 stated the speech therapist had left on vacation I think, and has not come back. During an interview with the Director of Rehab (DOR) on 5/24/2024 at 9:20 am, the DOR stated there had been no Speech Therapist at facility for over 1 month. The DOR stated the previous Speech Therapist had left on family leave, and not returned. The DOR stated that the facility and Rehabilitation Dept had not hired or made any efforts to bring in another Speech Therapist. The DOR stated they had asked Social Services for a referral for Outpatient Speech Therapy for Resident 61 a few days ago, and that the outpatient referral was still pending. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Social Services Worker (SSW) ON 5/24/2024 at 9:45 am, SSW confirmed Resident 61 did have outpatient referral for speech therapy. SSW stated their office got the request a few days ago, and that nothing is lined up yet. The SSW stated it typically takes several days or a week to set up. A review of Resident 61's medical records on 05/24/2024 at 11:19 am, shows no current orders for Speech Therapy. A review of Resident 61's medical records titled, Order Review History Report, dated 5/24/2024, shows a range of current, completed, and discontinued orders during a date range of 4/24/2024 to 5/24/2024. This Order Report shows Resident 61's current diet order as Nothing by mouth (NPO) diet and Enteral Feed Order (by stomach tube), six times a day, meaning Resident 61 is not allowed to eat any form of food through their mouth, only by their tube. This order summary also showed the last Speech Therapy order dated 3/4/2024 of ST CLARIFICATION: effective 3/8/2024: 3x/wk/27 days (three times a week for 27 days) . one time only until 4/2/202024. These records show that Resident 61 had not had Speech Therapy available to him since 4/2/2024. 49859 2. During an observation on 5/21/2024 at 4:02 PM, in Resident 61's room, Licensed Vocational Nurse (LVN) NN administered medication and a bolus (feeding given all at once insead of slowly through a pump), feeding through Resident 61's gastrostomy tube and did not check gastric residual volume before administration of the medication and the fluid feeding. During an interview with LVN NN on 5/21/2024 at 4:20 PM, LVN NN stated that she did not check gastric residual volume before administration of the medication and feeding. During an interview on 5/23/2024 at 9:44 AM, with the Assistant Director of Nursing (ADON), the ADON stated that her expectation was for the facility's nurses to check gastric residual volume before administration of medications or feeding to prevent risks associated with aspiration or the stomach's proper functioning. During a review of the facility's policy and procedure (P&P) titled, Feeding Tube - Administration of Medication, dated November 2018, the P&P indicated, that the nurses must check for residual before administration of medications or feedings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49934 Based on observation, interview and record review, the facility failed to implement a plan of care to assess, monitor and modify approaches to pain management for one of three sampled residents (Resident 435). This resulted in Resident 435 to experience unrelieved pain. Findings: A review of the Pain Management policy, revised 05/25/23, indicated the goal for pain management will be resident centered and determined by the resident's acceptable level of pain. It is to help the resident maintain the highest level of well-being and to ensure that pain is assessed and managed. Licensed Nurse documentation should include pain assessments. Pain is managed according to professional standards of practice. A review of Resident 435's record indicated she was admitted to the facility on [DATE], with diagnoses which include blockage (unable to have bowel movements or digest food due to a blockage in the intestines) with surgical repair, gout (arthritis in the feet/toes), depression, and difficulty in walking. A review of the Clinical Admission Assessment, dated 05/02/24, indicated Resident 435 had vocalized generalized pain, with clear speech, and was able to understand and be understood. In the Care Planning section, the pain section was not completed, which included goals and interventions. A review of the, Vitals and Pain Evaluation dated 05/02/24, indicated Resident 435 had vocalized frequent, severe pain and it occasionally made it difficult to sleep at night and limited her participation in therapy, and frequently limited her day-to-day activities. A review of Resident 435's, Physician Order Summary Report indicated an order dated 05/02/24, for Acetaminophen (Tylenol- mild pain reliever), 325 milligrams (mg- unit of measure), give 2 tablets (650 mg) by mouth every 6 hours as needed for Moderate pain (for pain rated 4-7). An order dated 05/06/24, for oxycodone (strong narcotic pain medication), 10 mg, give 10 mg by mouth every 8 hours as needed for pain (for pain rated 5-10). A review of a Care Plan revised on 05/07/24, indicated that nursing staff are to anticipate Resident 435's need for pain relief and respond immediately to any complaint of pain. Nursing is to evaluate the effectiveness of pain interventions and to review for compliance, alleviating of symptoms, dosing schedules and satisfaction with results. A review of the Minimum Data Set (MDS- an assessment and care screening tool), dated 05/09/24 at 10:47 AM, indicated Resident 435 had moderate pain and had pain the previous 5 days, prior to the date of the MDS. The MDS assessment indicated Resident 435 is substantial/maximal (need one to two staff to physically help) assist with bed mobility, transfers, and wheelchair use. The MDS indicated that Resident 435 is cognitively intact. During an observation on 05/21/24 at 08:00 AM, a call light was observed from 08:00 AM to 08:35 AM. Through observation, this call light was not answered for 25 minutes. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/24 at 08:20 AM, Licensed Vocational Nurse (LVN) F stated Resident 435 often turns on the call light due to, anxiety and it does get ignored at times. During an interview on 05/21/24 at 09:11 AM, Resident 435 stated she needed repositioning due to pain. Resident 435 stated she has had to wait up to 2 hours after requesting her pain control medication to receive it, and that this has happened at least twice since her admit. During this interview she had severe pain at her backside, due to a skin issue. Resident 435 stated, They don't turn me. A review of a Medication Administration Record (MAR- a medical chart to keep track of medications given to an individual) dated May 2024, indicated Resident 435 received oxycodone on 05/21/24 at 11:05 PM, after 12 hours of reported pain. The MAR did not indicate any other pain medication was given in that 12-hour period. A review of Resident 435's Shower Sheet dated 05/21/24, indicated tail bone redness. During a concurrent observation and interview on 05/23/24 at 10:26 AM with consent from Resident 435, CNA F while in Resident 435's room, assessed Resident 435's skin, and stated, There is an area of redness surrounded by dry, flakey skin on the tailbone. A review Resident 435's of electronic MAR progress notes for May 2024, LVNs did not document location of pain. A record review of a MAR dated May 2024 indicated that Resident 435 received Tylenol twice since her admit on 05/02/024. The MAR indicated she received oxycodone for 17 days, or for a total of 22 times, and continued to voice complaints of severe pain. During an interview on 05/23/24 at 11:45 AM, CNA F stated Resident 435 complains of whole-body pain when being turned. When CNA F was asked if Resident 435 is cooperative with care, CNA F stated that the resident is. During an interview on 05/23/24 at 11:58 AM, CNA G stated that Resident 435 is cooperative. She complains of pain at her bottom. CNA G states she keeps the resident comfortable to resident's preferences- resident will request to be positioned on a pillow on open area at buttocks. CNA G states, She (Resident 435) doesn't want some CNAs in her room, but she is cooperative with me most of the time. During concurrent interview and record review on 05/24/24 at 2:30 PM, Director of Nursing (DON) confirmed that direct care staff should be answering call lights and repositioning timely and administering medications timely as well to meet her pain needs. DON stated resident may need a routine pain medication at this point since she asks for her medication as needed often. Pain can cause anxiety. DON expects nursing staff to document where the pain is located.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49934 Based on observation, interview, and record review, the facility failed to ensure sufficient staffing to meet the needs of residents for 16 of 18 sampled residents (Resident 435, 55, 7, 33, 27, 20, 44, and nine Residents from a confidential resident meeting) when: 1. Resident 435 was observed waiting for their call lights to be answered for 30 minutes or longer. 2. Five of Eighteen sampled residents (Resident 55, 7, 33, 27, 20) reported waiting over one hour at times for staff assistance. 3. Resident 44 reported that certain Certified Nursing Assistants (CNA's) enter Resident rooms and cancel call lights without assisting Residents. 4. During a confidential resident meeting, nine of ten residents who attended stated call lights were not answered in a timely manner, which resulted in the resident's care needs not being met. These failures resulted in resident's not having their needs met in a timely manner which had the potential to result in physical and psychosocial harm. Findings: 1. During an observation on 5/21/24 at 8:00 am, Resident 435's call light was observed to be on from 8:00 am to 08:35 am, without staff answering it. During an interview on 5/21/24 with Licensed Vocational Nurse (LVN) F, they stated Resident 435 often triggers the call light due to anxiety, and it does get ignored sometimes. 2. During an interview dated 5/21/24 at 8:38 am, Resident 55 stated staff answer in time when he calls for them, but about once a day staff will answer the call light, find out he needs to be changed, and they leave and don't come back, or leave and say they'll be back in 5 minutes, but then don't return for a half hour. During an interview with Resident 7 on 5/21/24 at 8:48 am, Resident 7 stated, The real drawback here is when I need a CNA .I can wait an hour or more, my big thing is when I had a bowel movement and needed to get changed, I was waiting 2 hours. During an interview with Resident 33 on 5/21/24 at 9:31 am, Resident 33 stated they are unhappy at the facility, and feels that staff don't listen to their feelings, and don't respond to call lights. Resident 33 stated they must wait three to four hours with a dirty diaper and stated, It's embarrassing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 27 on 5/21/24 at 10:02 am, Resident 27 stated that yesterday they had waiting for over ninety minutes for help, while sitting on a bedside commode. Resident 27 stated this happened on dayshift, and can happen during the weekend, when the facility does not have adequate staffing. Resident 27 stated they had informed the Director of Staff Development (DSD) about long wait times and stated that the DSD had replied they, did not have enough time to work the magic yet. During an interview with Resident 20 on 5/21/24 at 10:52 am, Resident 20 stated, I waited 2 hours last night for Norco (a pain medication). Resident 20 stated they had started asking at 3:07 am by informing a CNA, but that the nurse did not bring a pain pill until 5 am. This Resident stated long wait times happen more on Night shift and stated, There's always some excuse why they don't answer my call lights right away. 3. During an interview with Resident 44 on 5/22/24 at 9:10 am, Resident 44 stated they can wait over an hour during the night shift for help from staff. Resident 44 stated that CNA C is bad at helping residents, won't follow Resident directions and, does what she wants, and ignores me, period. 4. During confidential interviews on 05/22/24 at 9:30 am, nine of 10 residents confirmed that call lights continue to be a problem. Residents stated direct care staff come in and turn off their call lights and don't come back. Residents explained they wait a long time (one to two hours) and this has been going on forever (a year). Administrator (ADMIN) talks about that but that is far as it gets. These Residents stated they feel helpless, that they are not wanted, and that CNA's don't introduce themselves when they come in the room, don't say hello, don't look us in the eye. Residents stated direct care staff wear ear pods in their ears and always are on the phone or talking to their friends while helping us and in the halls (all shifts). These Residents also stated complaints and grievances are not addressed. During a review of the facility's records titled, Confidential resident meeting minutes, it showed: a. On 1/18/2024, issues with call light could be answered sooner, CNA not returning to room after stating will be right back! and never return and CNA still taking a long time to answer call light on am & pm shifts, weekend and Monday were the worst. b. On 2/29/2024, issues with shower room [ROOM NUMBER] leaking c. On 3/14/2024, issues with Station 2 shower next to room [ROOM NUMBER], leaking while shower in use. d. On 3/28/2024, issues with meals are coming out cold again, food is not tasting, leaking in shower Station 1 and residents requested to get new shower heads. Registry CNA being mean, rude, talking down to residents. e. On 4/11/2024, issues with food has not been good for the past couple of weeks. Not honoring residents' preference should not be waking residents up for wheelchair cleaning, chair should be returned to residents as soon as possible in case one has to use restroom. CNAs need to clean restroom after resident care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/24/24 at 10:34 am, with the DSD she stated that they were aware of complaints against CNA C for not helping Residents. The DSD stated CNA C should have had a written warning for not competently caring for Residents, but that hadn't been done yet. The DSD stated that when staff have complaints against them regarding resident care, administration or DSD will issue a verbal warning, then a written warning, then a second written warning if behavior continues, then are terminated from working at the facility after a third incident. The DSD reported that the facility has terminated one CNA for behavior since February 2024. During this interview the DSD also stated they themselves often work during Night shift and stated, we do not have a problem on night shift for waiting for call lights or toileting times. We should not have a problem. When asked if the facility or DSD perform audits of call light waiting times, the DSD stated, No, there aren't any, and stated the call light system is older so audits must be performed in person via observation.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48129 Based on observation, interview and record review, the facility failed to provide nursing staff with necessary competencies and skill sets to meet the care and services for resident needs for 17 of 18 sampled residents (Resident 435, 55, 7, 33, 27, 20, 44, 58, and nine Residents from a confidential resident meeting) when: 1. Resident 435 was observed waiting for their call lights to be answered for 30 minutes or longer. 2. Five of Eighteen sampled residents (Resident 55, 7, 33, 27, 20) reported waiting over one hour at times for staff assistance. 3. Resident 44 reported that certain Certified Nursing Assistants (CNA's) enter Resident rooms and cancel call lights without assisting Residents. 4. During a confidential resident meeting, nine of ten residents who attended stated call lights that were not answered in a timely manner, which resulted in the resident's care needs not being met. 5. Strong urine odor coming out form Resident 58's room. These failures resulted in resident's not having their needs met in a timely manner which had the potential to result in physical and psychosocial harm. Findings: 1. During an observation on 5/21/24 at 8:00 am, Resident 435's call light was observed to be on from 8:00 am to 08:35 am, without staff answering it. During an interview on 5/21/24 with Licensed Vocational Nurse (LVN) F, they stated Resident 435 often triggers the call light due to anxiety, and it does get ignored sometimes. 2. During an interview dated 5/21/24 at 8:38 am, Resident 55 stated staff answer in time when he calls for them, but about once a day staff will answer the call light, find out he needs to be changed, and they leave and don't come back, or leave and say they'll be back in 5 minutes, but then don't return for a half hour. During an interview with Resident 7 on 5/21/24 at 8:48 am, Resident 7 stated The real drawback here is when I need a CNA .I can wait an hour or more, my big thing is when I had a bowel movement and needed to get changed, I was waiting 2 hours. During an interview with Resident 33 on 5/21/24 at 9:31 am, Resident 33 stated they are unhappy at the facility, and feels that staff don't listen to their feelings, and don't respond to call lights. Resident 33 stated they must wait three to four hours with a dirty diaper and stated, It's embarrassing. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 27 on 5/21/24 at 10:02 am, Resident 27 stated that yesterday they had waiting for over ninety minutes for help, while sitting on a bedside commode. Resident 27 stated this happened on dayshift, and can happen during the weekend, when the facility does not have adequate staffing. Resident 27 stated they had informed the Director of Staff Development (DSD) about long wait times and stated that the DSD had replied they, did not have enough time to work the magic yet. During an interview with Resident 20 on 5/21/24 at 10:52 am, Resident 20 stated I waited 2 hours last night for Norco (a pain medication). Resident 20 stated they had started asking at 3:07 am by informing a CNA, but that the nurse did not bring a pain pill until 5 am. This Resident stated long wait times happen more on Night shift and stated, There's always some excuse why they don't answer my call lights right away. 3. During an interview with Resident 44 on 5/22/24 at 9:10 am, Resident 44 stated they can wait over an hour during the night shift for help from staff. Resident 44 stated that CNA C is bad at helping residents, won't follow Resident directions and does what she wants, and ignores me, period. 4. During a confidential interviews on 05/22/24 at 9:30 am, nine of 10 residents confirmed that call lights continue to be a problem. Residents stated direct care staff come in and turn off their call lights and don't come back. Residents explained they wait a long time (one to two hours) and this has been going on forever (a year). Administrator (ADMIN) talks about that but that is far as it gets. These Residents stated they feel helpless, that they are not wanted, and that CNA's don't introduce themselves when they come in the room, don't say hello, don't look us in the eye. Residents stated direct care staff wear ear pods in their ears and always are on the phone or talking to their friends while helping us and in the halls (all shifts). These Residents also stated complaints and grievances are not addressed. During a review of the facility's records titled, Confidential resident meeting minutes, it showed: a. On 1/18/2024, issues with call light could be answered sooner, CNA not returning to room after stating will be right back and never return and CNA still taking a long time to answer call light on am & pm shifts, weekend and Monday were the worst. b. On 2/29/2024, issues with shower room [ROOM NUMBER] leaking c. On 3/14/2024, issues with Station 2 shower next to room [ROOM NUMBER], leaking while shower in use. d. On 3/28/2024, issues with meals are coming out cold again, food is not tasting, leaking in shower Station 1 and residents requested to get new shower heads. Registry CNA being mean, rude, talking down to residents. e. On 4/11/2024, issues with food has not been good for the past couple of weeks. Not honoring residents' preference should not be waking residents up for wheelchair cleaning, chair should be returned to residents as soon as possible in case one has to use restroom. CNAs need to clean restroom after resident care. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation on 5/23/2024 at 9:57 am, a strong urine odor was observed at the hallway outside Resident 58's room. During an observation on 5/23/2024 at 10:30 am, CNA K was called by LVN A to change the resident [Resident 58]. During an observation and interview on 5/23/2024 at 10:31 am, LVN H and CNA J were observed looking for CNA C at the hallway outside Resident 58's room. LVN H stated CNA C went out for lunch at 9:30 am, she supposed to come back by 10 am to relieve CNA J, so CNA J could take her lunch break. CNA J stated she had been looking all over the station, and checked all residents' room, she could not find CNA C. During an interview on 5/23/2024 at 10:40 am, with CNA K, CNA K acknowledged that she was asked to change Resident 58. CNA K stated that It looked Resident 58 hadn't been changed since last night, she said, Resident 58 smelled really bad, he smelled like urine. There was also stool all over his diaper. CNA K stated that the residents did not like CNA C because of the way she took care of them, CNA C does everything not the right way, just halfway . CNA K stated she had reported CNA C to the DSD. During an interview on 5/24/24 at 10:34 am, with the DSD, the DSD stated that they were aware of complaints against CNA C for not helping Residents. The DSD stated CNA C should have had a written warning for not competently caring for Residents, but that hadn't been done yet. The DSD stated that when staff have complaints against them regarding resident care, administration or DSD will issue a verbal warning, then a written warning, then a second written warning if behavior continues, then are terminated from working at the facility after a third incident. During this interview the DSD also stated they themselves often work during Night shift and stated we do not have a problem on night shift for waiting for call lights or toileting times. We should not have a problem. When asked if the facility or DSD perform audits of call light waiting times, the DSD stated No, there aren't any, and stated the call light system is older, so audits must be performed in person via observation.

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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. 49859 Based on observation, interview, and record review, the facility failed to ensure safe practices in handling and storage of hazardous medications (drugs that pose short- or long-term harm upon exposure to human via skin or inhalation with required special handling by National Institute for Occupational Safety and Health, or NIOSH), when a hazardous liquid medication called Depakote solution (also called Valproic acid in liquid form; used to treat mood swings or seizure disorders) was stored unsafely in medication cart and was handled without use of gloves during medication administration. These failures could contribute to unsafe medication use and exposure of hazardous medication to staff and residents. Findings: During an observation and inspection of the facility's Medication Cart #4 at Station 2, accompanied by Licensed Vocational Nurse (LVN) TT, on 5/21/24 at 3:35 PM, three bottles of liquid Depakote medication (valproic acid) were stored inside the cart. One of the bottles had sticky pink colored spills on the outer surface. The valproic acid liquid bottles were not contained in Ziplock bags to prevent cross-contamination with other medications inside the medication cart. During a medication administration observation, with LVN A on 5/22/24 at 9:24 AM, LVN A with ungloved hands poured Depakote liquid from the bottle into a cup for administration to Resident 2. LVN A then disposed of the cup with the remaining traces of medication into a trash container inside Resident 2's room. A review of Resident 2's electronic medical record titled, Medication Administration Record (MAR), dated May 2024, the MAR included an order for Depakote,VALPROIC ACID SOL (or Depakote Liquid); Give 15mL (mL is milliliter, a measure of volume) by mouth one time a day for Seizures; -NIOSH-Hazardous Med (medication)- DO Not Handle ungloved-Start Date:4/2/24. The safe handling and glove use was a listed part of the order for the Valproic Acid in the MAR and the label on the medication bottle had a warning about pregnancy and safety of medication use. During an interview on 5/23/24 at 9:44 AM, with the Assistant Director of Nursing (ADON), the ADON stated that her expectation of facility nursing staff was that if they find a bottle of hazardous liquid medication in the medication carts that was not in a plastic bag, they were to find a Ziplock bag in the facility and put the hazardous liquid medication into the Ziplock bag. The ADON stated she was unaware of using gloves or double gloving when handling hazardous liquid medications. In an interview with LVN A, on Station 2 hallway, on 5/24/24, at 10:48 AM, LVN A stated she may have missed the MAR note on using gloves when handling the Depakote and did not pay attention as this drug was not a new medication. The facility did not have a policy on handling hazardous medication when requested by the Department. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the drug information for Valproic acid per Lexicomp (a drug information database), indicated to handle the medication as a hazardous drug as follows, Hazardous agent (NIOSH 2016 [group 3]): Use appropriate precautions for receiving, handling, storage, preparation, dispensing, transporting, administration, and disposal. Follow NIOSH and . recommendations and institution-specific policies/procedures for appropriate containment strategy . Review of the Center for Disease Control's National Institute for Occupational Safety and Health (CDC, and NIOSH, a federal agency sets standard of safety in health care) document, titled Managing Hazardous Drug Exposures: Information for Healthcare Settings, dated 4/2023, the document indicated, Many .drugs intended for individual use can be hazardous to healthcare workers with potential occupational exposure to those who handle, prepare, dispense, administer, or dispose of these drugs. Workplace exposure to hazardous drugs can result in negative acute and chronic health effects in healthcare workers including adverse reproductive outcomes. PPE (or Personal Protective Equipment, items like gloves or mask) provides worker protection to reduce exposure to hazardous drugs. Efforts should be made to reduce all worker exposures to hazardous drugs. Occupational exposure to hazardous drugs merits serious consideration, as workers may be exposed daily to multiple hazardous drugs over many years. NIOSH suggests careful precautions and safeguards to protect workers, fetuses, and breastfed infants. Further review of the document indicated to use single gloves for handling intact tablet form and double gloves for handling oral liquid form of the hazardous medications as directed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859 Based on interview and record review, the facility failed to ensure safe monitoring and accurate documentation of psychotropic medications (medication used for mood disorder and mental health) use including diagnosis and use of non-drug interventions (methods used to address other personal, emotional, or physical interventions before giving drugs) in two out of five sampled residents assessed for unnecessary drug use (Resident 61 and Resident 53) when: 1. Nursing interventions for non-drug approaches was not implemented for Resident 61's PRN (as needed) psychotropic medication called lorazepam (or Ativan, a drug used to treat anxiety). 2. Resident 53's medical record listed schizophrenia (a mental health disorder that affects the way a person thinks, feels, and behaves and may include hallucinations) as a diagnosis and indication for the use of Geodon (or Ziprasidone, a mind-altering drug used to control behavior or thought process) since admission when prior history did not confirm the diagnosis and no mental health doctor assessment was documented. These failures could contribute to unsafe medication use and care of the residents with special mental or behavioral health needs. Findings: 1. A review of Resident 61's records indicated she was admitted on [DATE] with diagnoses including, Cancer of the brain, Cancer of the thyroid gland (gland in the neck which regulates hormones in the body), Dysphagia (difficulty swallowing), Legal Blindness, Anxiety Disorder (excessive worry), and Major Depressive Disorder (depressed mood or the loss of interest or pleasure in nearly all activities). During a review of Resident 61's medical record titled, Medication Administration Record (MAR), dated 5/2024, the MAR record indicated, Lorazepam Oral Tablet 0.5 MG (Ativan; MG is milligram, a unit of measure), Give 0.5 MG by mouth every 8 hours as needed for anxiety m/b (manifested by) calling out despite care needs met .Start Date: 5/7/24. Further review of the MAR did not show any non-drug approaches the nursing staff used to meet Resident 61's needs prior to offering Ativan. During a concurrent interview and record review on 5/24/24 at 11:19 AM, with Nursing Supervisor (NS), the NS reviewed Resident 61's medical record and stated that there were no non-drug interventions written in Resident 61's Care Plan (a plan of care in writing by nursing staff) or MAR. The NS acknowledged that the non-drug interventions should have been used and documented prior to PRN (as needed) use of Ativan. The NS confirmed the non-drug interventions for Ativan (or lorazepam) use was not initiated in the electronic medical record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Behavior/Psychoactive Drug Management, dated November 2018, the policy indicated, Non-Pharmacological [Drug] interventions i. Upon identification of factors that may contribute to a resident's mood or behavior symptoms, the Licensed Nurse shall initiate . behavior Log with Non-pharmacological Interventions. ii. The Licensed Nurse will notify and collaborate with the Attending Physician/Prescriber, family, resident, Responsible Party, and/or IDT [Interdisciplinary Team] members regarding the identified contributing factors to the resident's mood/behavior problems and the non-drug interventions taken to address the problems, as well as to evaluate the effectiveness of the non-drug interventions for further recommendations. iii. The Licensed Nurse will document the interventions taken and recommendations in the resident's Care Plan. 2. A review of Resident 53's records indicated she was admitted on [DATE], with diagnoses including Cerebral Infarction (blockage of blood vessels in the brain from a clot), Anoxic Brain Injury (an injury to the brain due to lack of oxygen), and Psychosis (a mental disorder in which there is severe loss of contact with reality). During a review of Resident 53's electronic medical record titled, Medication Administration Record (MAR), dated May 2024, the MAR record indicated an order for Resident 53 to receive Geodon (or Ziprasidone, a mind-altering drug used to control behavior or thought process) for schizophrenia (a mental health disorder that affects the way a person thinks, feels, and behaves and may include hallucinations) manifested by auditory hallucinations (hearing unreal voices in head), Ziprasidone Capsule 60 mg via G-Tube (or Gastrostomy Tube; a surgically inserted tube in the stomach for feeding or taking medicines) two times a day for Schizophrenia m/b (manifested by) auditory hallucination .Start Date 10/4/23. Further review of the electronic medical record for medication history indicated that Resident 53 had been receiving Geodon for schizophrenia since admission in 2022. A review of Resident 53's admission records to the facility, dated 10/4/22, the record did not include Geodon and schizophrenia on the list of transfer medications and diagnosis. Review of Resident 53's medical record titled, History and Physical (or H&P), dated 3/15/22, handwritten by MD, the H&P did not document schizophrenia as an admitting diagnosis. Review of Resident 53's multidisciplinary Care Conference, dated 6/21/23, the document marked as annual review indicated behavior/mood manifestations thrashing while in bed, auditory hallucination and psychoactive medications .Geodon .via G-tube for schizophrenia M/B (manifested by) auditory hallucinations. During a review of Resident 53's electronic MAR, dated May 2024, the record indicated on 5/22/24 the diagnosis or indication (the reason for use) for Geodon order was changed from schizophrenia to anoxic brain injury (an injury to the brain due to lack of oxygen) for thrashing in bed. The medical record did not show if a medical or mental health consultation resulted in the change in diagnosis from schizophrenia to anoxic brain injury. During an interview with the Director of Nursing (DON) on 5/24/24 at 11:35 AM, the DON stated only a psychiatric (mental health) physician can diagnose schizophrenia. The DON also stated that Resident 53 did not have a current mental health consult with a psychiatric physician. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/24 at 11:55 AM, with Minimum Data Set nurse (MDS) C she stated Resident 53's diagnosis of schizophrenia for Geodon was a transcription error. MDS C nurse confirmed that this transcription error had been ongoing since at least 6/27/23. During a telephone interview with the Medical Director (MD) on 5/24/24 at 1:46 PM, the MD stated that the facility could not figure out how the schizophrenia diagnosis was attached to the Geodon use for Resident 53. The MD stated he never used Geodon in his medical practice and this could have come from another provider or facility. The MD confirmed that a diagnosis must be made by a psychiatric physician and cannot be made by a nurse. During a concurrent interview and record review on 5/24/24 at 2:03 PM, with the Social Services Worker (SSW), the SSW reviewed Resident 53's IDT meeting notes regarding psychotropic medication. The SSW stated the last IDT meeting was held on 10/24/23, more than 6 months ago. The SSW stated that she had been out of the facility from November 2023 to January 2024 and the facility had no psychotropic medication IDT meetings for Resident 53 during that time. During a review of the facility's policy and procedure (P&P) titled, Behavior/Psychoactive Drug Management, dated November 2018, the policy indicated It is the policy of this facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of the residents to obtain, or maintain the highest physical, mental, and psychosocial well-being. The policy on assessment section indicated Upon admission, quarterly, annually, and upon change or condition, the Interdisciplinary Team (IDT) will collect and assess information about the resident including but not limited to past life experiences, description of behaviors, preferences such as those for daily routines, presence of pain, medical conditions: cognitive status and related abilities and medications.

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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. 40903 Based on observation, interview, and record review the facility failed to ensure safe medication storage practices when: 1. The respiratory medication called Duoneb inhalation solution (or also known as Ipratropium and Albuterol inhalation solution, two drugs in one, used for better breathing and shortness of breath) stored in facility's Medication Cart #2 at Station 1 and Medication Cart #4 at Station 2, were not dated upon opening and; 2. Medication refrigerator at Station 2's medication room was heavily frosted and insulin (a biological product to treat blood sugar disease) and vaccine (a biological product used to prevent and protect from infections) product were stored in close proximity of the frosted area. These failed practices could result in spoiled, ineffective, and unsafe medication use in the facility. Findings: 1a. During an observation and inspection of station 2's medication cart #4, accompanied by Licensed Vocation Nurse TT (LVN TT), on 5/21/24, at 3:34 PM, multiple containers of respiratory medication known as Duoneb inhalation solution, for 3 different residents, were observed to be open, out of foil wrap with no marking on when it was first opened. LVN TT acknowledged the findings. Review of the manufacturer information, marked on each foil wrap container, indicated Once removed from the foil pouch, the individual vials should be used within one week. LVN TT acknowledged the storage information on the Duoneb product label for a beyond use date(the date after which the product should not be used) of one week after opening. 1b. During an observation and inspection of station 1's medication cart #2, accompanied by Licensed Vocation Nurse NN (LVN NN), on 5/21/24, at 3:52 PM, two containers of respiratory medication called Duoneb for 2 different residents were observed to be open, out of foil wrap with no marking as when it was first opened. The medication cart also contained one opened Duoneb product dated for 4/24 which based on manufacturer instruction exceeded the 7 days beyond use date. LVN NN acknowledged the findings. Review of the manufacturer information for Duoneb inhalation solution, marked on each foil wrap container, indicated Once removed from the foil pouch, the individual vials should be used within one week. LVN NN acknowledged the storage information on the Duoneb product for byond use date of one week after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Assistant Director of Nursing (ADON), on 5/23/24, at 10:34 AM, the ADON stated the nursing staff should follow the manufacturer storage information and mark the date it was first opened on the container. ADON stated pharmacy placed sticker on products that required a Date Open when first opened. Review of the facility's policy, titled Storage of Medications, dated 1/2018, the policy indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations . The policy on Expiration Dating (beyond- Use Dating) section indicated Certain medications or package types, . , once opened, require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency . 2. During an observation and inspection of facility's medication room at Station 2, on 5/21/24 accompanied by LVN TT, the locked refrigerator had extensive frosting covering outside of the freezer area of the refrigerator. Further observation indicated the insulin products, the Emergency Kit (or EKit- a box where spare supplies of Insulin are stored) and a pneumonia vaccine was stored either directly attached to the frosted section or in close proximity of the frosted area. LVN TT acknowledged the findings and stated she was not sure who was responsible for monitoring, de-frosting, and maintenance of the refrigerator. Review of insulin product for brand name Novolin, the outer box label indicated Keep in a cold place and Avoid Freezing. Review of the insulin product for brand name Humalog, the storage information indicated Do not freeze. Do not use HUMALOG if it has been frozen. In an interview with Director of Nursing (DON), in her office, on 5/23/24, at 9:45 AM, the DON stated the facility purchased a new refrigerator immediately and the nursing staff should have been monitoring the refrigerator and should have reported the excess frost to the maintenance staff. DON stated it was overlooked. Review of the facility's policy titled, Storage of Medications, dated 1/2018, the policy indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations .

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 39856 Based on interview and facility document review, the facility failed to ensure federal regulations related to the education qualification requirements of the Certified Dietary Manager (CDM), were followed as outlined in the California Code, Health and Safety Code (HSC 1265.4). This failure had the potential to result in inadequate oversight of the food and nutrition services department associated with meal distribution accuracy, safe food handling and sanitation guidelines. Findings: According to the HSC 1265.4 a CDM, (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. On 5/21/24 at 8:30 AM an observation of the CDM's Credential Verification dated 7/23/23 and concurrent interview was conducted with the CDM. The CDM stated she was a CDM as of 7/23/23. When asked if she had completed six hours of in-service training on California Title 22 dietary service requirements, the CDM stated she was not aware of that requirement and had not completed the required six hours of in-service training on California Title 22 dietary services.)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41567 Based on observation, interview and record review, the facility failed to prepare and serve food that maintained an appetizing flavor, texture, appearance, and at a palatable (pleasant taste) temperature when 10 of 18 sampled residents (Residents 7, 13, and 8 Residents from a confidential resident meeting) when: 1. Resident 13 was served with a puree diet, the taste was so-so, and was cold. 2. Resident 7 stated the food was overcooked and did not have the appearance of what it should be. 3. Confidential resident interviews and resident council meeting minutes review indicated food was served cold. 4. The food on the test tray were mostly bland. These failures resulted in meals to be served cold, unpleasant, and not meet the resident food preference, which had the potential for residents to decrease meal intakes and have weight loss issues. Findings: 1. During a review of Resident 13's clinical record, the record indicated, Resident 13 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (the kidneys can no longer function normally and dialysis is required, a process utilizing medical equipment to filter waste from the bloodstream), and severe protein-calorie malnutrition (nutritional intake fails to meet the body's requirements for nutrients). Resident 13 was her own healthcare decision maker. During an interview on 5/22/24at 2:04 pm, Resident 13 stated that she eats a puree diet and the food tastes so-so, that occasionally foods do not arrive at the temperature they should be. Foods that should be cold, have warmed up, or foods that should arrive warm, have cooled down. 2. During a review of Resident 7's clinical record, the record indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses which included left tibia (the large bone at the front of the lower leg) fracture, hyperparathyroidism (where the parathyroid glands (in the neck, near the thyroid gland) produce too much parathyroid hormone), and difficulty in walking. Resident 39 was her own health care decision maker. During a review of Resident 7's Minimum Data Set (MDS - an assessment and care screening tool), dated 4/2/2024, the MDS indicated that Resident 9 had a brief interview for mental status (BIMS) score of 15, at section C Cognitive Patterns indicating that her cognition was intact. During an interview on 5/21/2024 at 12:30 pm with Resident 7 in Resident 7's room, Resident 7 stated, the breakfast, I don't know if you can call that an omelet, it was something rectangle. It was a small piece . Resident 7 stated that she was weighted 200 lbs. when she was admitted in 2/2024, now she weighted 160 lbs., Resident 7 stated that she believed her weight loss, a lot of that had to do with the stinky food that they had been giving to me . (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/2024 at 10:40 am with Resident 7, Resident 7 stated that she had egg over easy this morning, and she said, the egg was overcooked. Resident 7 stated that she wrote a letter to the Dietary Manager (DM) today, she said that she wrote, It does not do me good even if I got a bigger portion of food, because it does not taste good, mostly all overcooked! 3. During confidential interviews on 5/22/2024 at 9:48 am, eight out of ten residents stated that they did not like the food and the food was always served cold. During a review of the facility's record titled, Confidential resident council meeting minutes, indicated: a. On 3/28/2024, the issue with food was mentioned, meals are coming out cold again, food is not tasting. b. On 4/11/2024, the issue with food was mentioned, food has not been good for the past couple of weeks. Not honoring residents' preference. c. On 5/9/2024, the issue with food was mentioned, food is bad. 4. During a concurrent observation and interview on 5/23/2024 at 1:05 pm with the Regional Certified Dietary Manager (RCDM) and the Registered Dietitian (RD), A test tray of chicken, spinach, rice, corn bread, and cream puff was tested for taste. The chicken had little flavor, rice was sticky and lacked of flavor, corn bread was dry, and cream puff made with whip cream was not sweet, and breading was dry and tasteless. RD confirmed the findings. RCDM stated that there's no pellet (a thermal pellet tray/plate is to keep hot foods at safe temperatures for a certain time) used to keep food hot, and she agreed that a buildings this big could look into a pellet for heating.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49418

Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation requirements were met in accordance with professional standards for food service safety when:

1. Expired food items were present in refrigerator/freezers and dry storage areas;

2. Food was not properly stored, labeled and dated;

3. Kitchen and food service equipment were not in sanitary condition;

4. The kitchen environment was not in sanitary condition;

5. An eyewash station was present in the handwashing station.

These failures created a potential risk for exposure to food- and waterborne illnesses in a medically vulnerable population of 78 residents who received food prepared in the kitchen.

Findings:

1.

During review of facility Policy & Procedure (P&P) titled Food Storage: Operational Manual - Dietary Services, revised [DATE], the P&P indicated food items will be stored, thawed, and prepared in accordance with good sanitary practice, and all items will be correctly labeled and dated.

During concurrent initial kitchen tour and interview with Certified Dietary Manager (CDM) on [DATE] at 8:07 am:

- Observed a blue bag of unlabeled, undated frozen vegetables in the vegetable freezer. CDM stated the blue bag contained green beans that should go in a box and should be labeled and dated. CDM stated she was unsure of the expiration date and discarded the green beans.

- Observed a premade, plastic-wrapped ham sandwich dated [DATE] in the refrigerator. CDM acknowledged it was expired and discarded it.

- Observed a bag of diced ham in a refrigerator dated [DATE]. CDM acknowledged it was expired and discarded it.

- Observed a bag of shredded coconut with handwriting indicating opened [DATE] and use by [DATE]. CDM stated opened dry storage food items were good until six months after date of opening or manufacturer's expiration date. CDM noted the six-month 'use by' date should have been [DATE], acknowledged the product had been open longer than six months, and discarded the coconut.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation of emergency food supply storage in the basement on [DATE] at 4:05 pm, observed a case of pureed green beans which indicated received [DATE], use by [DATE]. During an interview with CDM on [DATE] at 4:23 pm, CDM stated she would discard the expired green beans immediately. During a review of facility P&P titled Food Brought in by Visitors, dated ,d+[DATE], the P&P indicated perishable food requiring refrigeration should be discarded after two hours at bedside, and, if refrigerated, should be labeled, dated, and discarded after 48 hours. During concurrent observation of the resident food refrigerator and interview with Nursing Supervisor (NS) on [DATE] at 9:41 am, NS removed a reused, plastic Parmesan cheese container from the resident refrigerator. The container was labeled with Resident 28's room number, name, dated [DATE] (five days old), and revealed what appeared to be cold ravioli salad with a creamy-appearing dressing. NS stated, I would say this is bad, and discarded it. 2. During concurrent observation of the kitchen and interview with CDM, observed an open, unsealed, unlabeled bag of dry pancake mix stored on a shelf above the pan storage area. CDM acknowledged that the pancake mix should be sealed, labeled, and dated. During review of the 2022 Food Code, United States Food and Drug Administration (USFDA), Section , d+[DATE].11: Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the document indicated: - Equipment food-contact surfaces and utensils shall be clean to sight and touch; - The food-contact surface of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. 3. During concurrent initial kitchen tour and interview with CDM on [DATE] at 8:44 am: - Observed a knife rack containing five knives located next to the facility's internal kitchen door. The knife rack lid was sticky with brown-colored residue. CDM acknowledged the lid was not clean. - Observed an open under-counter storage space used for pots and pans. The storage space had a linoleum-lined base sticky with brown-colored residue and food crumbs/debris. The top frying pans contained food crumbs. Observed two large frying pans and one small frying pan with hard black residue on the inner surface of all three pans. One small frying pan with nonstick coating had areas of nonstick coating that were not intact. CDM acknowledged the storage space was not clean and that frying pans were not cleanable and needed to be replaced. - A musty odor was observed on opening the vegetable steamer. The steamer water contained a brown, soot-like residue. CDM stated the steamer water was drained daily and typically deep cleaned on Mondays (this was Tuesday) but acknowledged the deep clean had not been performed the day prior. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Observed maroon and black bowls being removed from the dishwasher and placed on a metal drying rack. The insides of the maroon bowls appeared worn and rough from cleaning. CDM acknowledged the maroon bowls needed to be replaced and stated, We try to only use the black [newer] bowls. During concurrent observation and interview in the kitchen with CDM and Regional Certified Dietary Manager (RCDM) on [DATE] at 9:07 am, observed the can opener blade was dull and worn with a particle of orange-brown, crusted debris near the blade tip. RCDM acknowledged the blade needed replacing and stated, That looks dirty to me. During concurrent observation and interview in the kitchen with CDM and RCDM on [DATE] at 11:05 am, observed three muffin pans with hard black residue on the top of each pan. CDM stated the batter does not touch the parts with residue. Upon discussion, CDM acknowledged the pans no longer had a cleanable surface and should be replaced. During a review of facility documents titled Dietary Quality Control Review, dated [DATE], [DATE], and [DATE], the records indicated Standards were Not Met for the following: - Kitchen walls, floors, baseboards, and ceilings in good repair and clean ([DATE], [DATE]). - Equipment clean and in working order - Oven/Steamer, top of steamer. ([DATE]). - Equipment clean and in working order - Can opener/knife holder: base of can opener needs cleaning, knife holder dusty ([DATE]). - Equipment clean and in working order - Oven/Steamer: side of oven. Correction: Dietary staff - clean area ([DATE]). - Equipment clean and in working order - Can opener/knife holder: Knife holder dusty. Correction: Dietary staff - clean ([DATE]). - Several items with no label or date - cheese, yogurt. ([DATE]). - Parmesan cheese with no date, bag open to air ([DATE]). - Refrigerated food: Several items with no label or date ([DATE]). - Refrigerated food is securely covered, labeled, and dated when opened with a use by date ([DATE]). During a review of facility documents titled Dietary Quality Control Review, dated [DATE], [DATE], and [DATE], the records indicated Standards were Met for the following: - Kitchen appears generally clean and organized ([DATE], [DATE], and [DATE]). - Dish wash area generally clean and organized ([DATE], [DATE]). - Silverware, cups, glasses, dishes, trays, and lids free of rust, chips, cracks, or excessive wear ([DATE], [DATE], [DATE]). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Cleaning schedule in place and followed ([DATE], [DATE], [DATE]). - Kitchen walls, floors, baseboards, and ceilings in good repair and clean ([DATE]). During a review of facility records titled Dietary Department Cleaning Schedule and Check List, dated , d+[DATE] to [DATE], the records indicate the last documented weekly cleaning of vegetable steamer occurred [DATE]. 4. During review of the 2022 Food Code, USFDA, Section ,d+[DATE].11: Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the document indicated nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. During review of facility policy and procedure (P&P) titled Cleaning Schedule: Operational Manual - Dietary Services, revised [DATE], the P&P indicated dietary staff will maintain a sanitary environment in the dietary department by complying with the routine cleaning schedule developed by the CDM. The CDM will monitor the cleaning schedule to ensure compliance. During concurrent initial kitchen tour and interview with CDM on [DATE] at 8:44 am: - Observed a brown, sticky film and food debris present on the floor underneath the oven and in a small space between the oven and the wall. CDM stated kitchen floors are swept and mopped nightly and deep cleaned once a week but acknowledged the floor was not clean. - Observed two oven racks with hard black residue and food debris that had been placed on the floor between the oven and the pan storage area. CDM stated the oven racks may have been removed from the oven when it was last cleaned. - Crusty, dried food debris was observed on the sides of the oven and pan storage area. - Observed a sticky black residue on a metal shelf above the stovetop. CDM acknowledged the shelf was not clean. During observation and interview in the kitchen with CDM, RCDM, and Dietary Aide (DA A) on [DATE] at 9:17 am, observed a white wall behind the dishwashing sink with black slimy residue where water splashed from a handheld dish sprayer. DA A stated kitchen staff were responsible for cleaning the walls next to the dishwasher. During an interview in the kitchen with CDM on [DATE] at 8:30 am, CDM stated walls and doors were on the schedule to be cleaned weekly. CDM stated bleach takes the paint off, and kitchen staff use regular soap. CDM stated the black slimy residue was difficult to scrub off, and she has painted over the black residue every month or two with anti-mildew paint. During observation and interview in the kitchen with CDM, RCDM, and Dietary Aide (DA A) on [DATE] at 9:17 am, observed seven gray and three white dishwasher racks with hardened black residue on the outsides of all racks. CDM stated it was not okay for black residue to be present and would request to order new racks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Registered Dietitian (RD) on [DATE] at 9:57 am, RD was asked if there were any concerns with the cleanliness of the kitchen. RD stated, There's always room for improvement, but it's better than it was. I can't give a specific timeframe, maybe in the last six to 12 months. The cleaning logs are better. RD stated she was aware frying pans needed to be replaced and stated the CDM was in the process of reordering. RD stated kitchen floors were something I would look at on monthly kitchen audits. RD stated she had noticed the wall by the dishwashing station, adding, Part of the problem is it's really old and could use some upgrades. 5. During review of the 2022 Food Code, USFDA, Section ,d+[DATE].11: Using a Handwashing Sink, the record indicated handwashing sink may not be used for purposes other than handwashing. During a review of facility documents titled Dietary Quality Control Review, dated [DATE], the records indicated standards were Met for the Proper handwashing procedure is in place and can be demonstrated by staff. During concurrent kitchen observation and interview with CDM and RCDM on [DATE] at 9:07 am, CDM was observed to wash her hands using the eyewash faucet located in the kitchen handwashing sink. CDM acknowledged she should have used the warm-water handwashing faucet, not the eyewash faucet. During an interview with RCDM on [DATE] at 10:47 am, RCDM stated it was typical in a limited space for an eyewash station to be present in the handwashing sink.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 49418 Based on observation, interview, and record review, the facility failed to ensure refuse (garbage) was stored in a sanitary manner when: 1. the lids to two of three outdoor refuse dumpsters did not close tightly, and 2. the area surrounding the dumpsters was not maintained in a sanitary manner to prevent pest/rodent infestation. These failures had the potential to attract pests and rodents that carry diseases. Findings: During review of the 2022 Food Code, United States (U.S.) Food and Drug Administration (FDA), Section 5-501.13: Receptacles, the document indicated receptacles and waste handling units for refuse, recyclables, and returnables and for use with materials containing food residue shall be durable, cleanable, insect- and rodent-resistant, leakproof, and nonabsorbent. During review of the 2022 Food Code, USFDA, Section 5-501.110: Storing Refuse, Recyclables, and Returnables, the document indicated refuse, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. During review of the 2022 Food Code, USFDA, Section 5-501.112: Outside Storage Prohibitions, the document indicated cardboard or other packaging material that does not contain food residues and that is awaiting regularly scheduled delivery to a recycling or disposal site may be stored outside without being in a covered receptacle if it is stored so that it does not create a rodent problem. During review of the 2022 Food Code, USFDA, Section 5-501.113: Covering Receptacles, the document indicated receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered with tight-fitting lids or doors if kept outside. During review of the 2022 Food Code, USFDA, Section 5-502.11: Removal Frequency, the document indicated refuse, recyclables, and returnables shall be removed from the premises at a frequency that will minimize the development of objectionable odor and other conditions that attract or harbor insects and rodents. During a review of facility policy and procedure (P&P) titled Waste Management, dated 4/21/22, the P&P indicated its purpose was to reduce risk of contamination from regulated waste and maintain appropriate handling and disposable [sic] of all waste. During a review of facility documents titled Dietary Quality Control Review, dated 1/26/24 and 2/29/24, the records indicated Standards were Not Met for the following: 1/26/24: Dumpster open; trash littered on the ground around dumpsters. Correction: All staff close lids, pick up trash. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/29/24: Dumpster open and with trash and debris on ground outside. Correction: All staff keep lids closed and trash off the ground. During a review of facility documents titled Dietary Quality Control Review, dated 4/30/24, the records indicated standards were Met for garbage dumpsters closed, not overflowing, with clean area around them. During an observational tour of the facility grounds on 5/21/24 at 11:05 am, three dumpsters (two for garbage, one for cardboard only) were present at the rear of the facility, behind which were weeds, trees, and a dry creek bed. The plastic dumpster lids were split in two by the manufacturer. A large orange traffic cone was observed propping open one side of the first garbage dumpster lid, and the second lid revealed multiple one-half to 1-inch gaps between lid and base. Both sides of the second garbage dumpster lids revealed multiple one-half to 1-inch gaps between lid and base. The area surrounding the dumpsters was not well maintained and contained two stacks of 10-12 (total) wooden pallets in an area containing overgrown weeds and a dead tree branch. During concurrent observation of the dumpster area and interview with Maintenance Director (MAINT) on 5/21/24 at 11:35 am, MAINT stated plastic dumpster lids should seal to the metal base and that the dumpsters are usually closed. MAINT stated propping open dumpster lids is not okay and acknowledged there should also not be gaps between the dumpster lids and bases. MAINT stated it had been his practice to call the local trash company to replace dumpsters in disrepair. MAINT stated the wooden pallets near the dumpsters were from old deliveries/shipments to the facility. MAINT stated pallets were typically picked up every week or two by a gentleman who sold them. MAINT stated he would break down pallets and get rid of the pieces if they were not picked up and started to rot.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview, and record review, the facility's Administrator (ADM) failed to ensure effective oversight and necessary resources to ensure resident care services were met to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident when: 1. The ADM failed to ensure the resident environment was safe, clean, and free from accident hazards. This resulted in an immediate jeopardy for failure to provide a system to ensure the safety of the resident and prevent the outsiders from entering the facility. These failures had the potential to put all the residents at risk for accident and hazards. Refer to F 689. 2. The ADM failed to ensure that the facility have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services. Refer to F 725, and F 726. 3. Dietary services did not follow national standards and guidelines for kitchen cleanliness, and the safety of the food storage. These failures had the potential for the spread of infection, and foodborne illness to occur in residents. Refer to F 812, 4. Dietary services did not meet the nutritional and palatability needs of residents. These failures created the potential for residents to receive food that did not comply with the physician ordered diet, did not meet resident nutritional needs, and had the potential to compromise residents' medical status, nutritional status, and quality of life. Refer to F 804. 5. Pharmacy services related to administration, storage, assessment, psychotropic medication intervention did not meet standards. Refer to F 641, F 755, F 758, F 761, and F 880. 6. Activities services did not meet the need and the preference of the residents. Refer to F 679. 7. Oversight of the administrative departmental managers to ensure they were resolving resident identified concerns with the facility. Refer to F 565, F 585. Findings: During a review of the facility undated document titled, Administrator Job Description, indicated: A. The administrator (ADM) reports to Governing Body & President of Operation. B. The ADM's principal responsibilities and duties are: - Serves as liaison between Governing Body and Facility Personnel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER: Riverside Point Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE: 375 Cohasset Rd, Chico, CA 95926	

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Implementing performance improvement initiatives to ensure that residents are continuously improving. - Directing and monitoring compliance with federal and state regulations and laws. - Coordinating compliance with established policies and procedures. - Allocating resources to effectively carry out facility programs. - Recruiting, hiring, and training competent and committed staff. - Fostering cooperative rapport with and between departments fostering the importance of each staff member's contributions to the facility. - Positioning the facility to operate in a successful manner. 1. One fire door (a door that is fireproof and helps contain smoke), which led to the outside of the facility was damaged and could not be completely closed or locked in the past year and a half. The door led to the facility backyard where there was a steep creek. A staff locker room that residents had access to which was not kept locked, contained rusty unlocked lockers, stainless steel chemical cleaner, personal protective equipment (eye goggles, face shield and face masks), staff belongings, food items, a broken air conditioner, TV monitors, cardboard boxes, an industrial-sized container of a chemical rust remover. A review of an email dated [DATE], sent by the ADM to Governing Body (GB) 1, (the GB is a high level of management that makes policies and oversees all of the affairs of the facility and secures funds), included a capital expenditure (means a high-cost item that the GB needs to approve), purchase order form for one hollow metal fire door. The capital expense report indicated the current fire door was unable to close and lock due to issues beyond repair. During an interview on [DATE] at 4:50 pm, ADM stated he was aware that the fire door needed replaced a year and a half ago. ADM stated he received an estimate from one vendor and GB 1 requested two estimates before approving. ADM stated he explained to GB 1 that there was only one available vendor in the area, but the funds were not approved. During an interview on [DATE] at 4 pm, GB 2 stated that he had replaced GB 1 about three weeks ago and was unaware of the outstanding facility building projects needing approval. GB 2 stated the capital expense for the broken fire door should have been approved back when it was identified as an issue. 2. a. Confidential resident interviews and meeting minutes review indicated call lights were not answered timely. The average waiting time was over one hour. b. Resident 44 stated that certain Certified Nursing Assistants (CNAs) would enter the room and cancel call lights without providing any assistance. c. Resident 435 was observed waiting for the call light to be answered for 35 mints. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During confidential interviews on [DATE] 9:30 am, nine of 10 residents confirmed that call lights continue to be a problem. Residents stated direct care staff come in and turn off their call lights and don't come back. Residents explained they wait a long time (one to two hours), and this has been going on forever (a year). Administrator (ADMIN) talks about that but that is far as it gets. Feel helpless, that we are not wanted; They don't introduce themselves when they come in the room, don't say hello, don't look us in the eye. Residents stated direct care staff wear ear pods in their ears and always are on the phone or talking to their friends while helping us and in the halls (all shifts). Residents stated complaints and grievances are not addressed. Residents stated grooming not being done: especially fingernails. Residents explained not enough activities and staff to coordinate them. Residents stated pain medications take too long to be administered. Residents stated facility temperature issues- are too warm, and room [ROOM NUMBER] was freezing. Eight of 10 residents stated do not like food and food was cold. Residents stated sliding door broken in dining room, and shower handles finally working right before State arrived, this was going on about year and a half. During an interview on [DATE] at 10:34 am with Director of Staff Development (DSD), the DSD stated that they were aware of complaints against CNA C for not helping Residents. The DSD stated CNA C should have had a written warning for not competently caring for Residents, but that hadn't been done yet. The DSD stated that when staff have complaints against them regarding resident care, administration or DSD will issue a verbal warning, then a written warning, then a second written warning if behavior continues, then are terminated from working at the facility after a third incident. The DSD reported that the facility has had 1 termination for CNA behavior since February 2024. During this interview the DSD also stated they themselves often work during Night shift and stated we do not have a problem on night shift for waiting for call lights or toileting times. We should not have a problem. When asked if the facility or DSD perform audits of call light waiting times, the DSD stated No, there aren't any, and stated the call light system is older, so audits must be performed in person via observation. 3. a. Expired food items were present in refrigerator/freezers and dry storage areas. b. Food was not properly stored, labeled, and dated. c. Kitchen and food service equipment were not in sanitary condition. d. The kitchen environment was not in sanitary condition. e. An eyewash station was present in the handwashing station. 4. a. Resident 13 was served with a puree diet, the taste was so-so, and was cold. b. Resident 7 stated the food was overcooked and did not have the appearance of what it should be. c. Confidential resident interviews and meeting minutes review indicated food was served cold. d. The food on the test tray were mostly bland. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. a. Resident 53 was diagnosed with schizophrenia (a mental health disorder that affects the way a person thinks, feels, and behaves and may include hallucinations) without a proper Interdisciplinary Team (IDT - an interdisciplinary team of health care providers who have knowledge of the resident and his or her needs who is involved in making decisions about the resident's care) assessment for psychotropic medication (mind altering drug) use and behavioral data. b. A hazardous liquid medication called Depakote solution (also called Valproic acid in liquid form; used to treat mood swings or seizure disorders) was stored unsafely in medication cart and was handled without use of gloves during medication administration. c. The use of the psychotropic medications (medication used for mood disorder and mental health) for Resident 53, and 61 was not properly monitored and documented correctly. d. medications were not storage properly. e. Glucometer (a shared device, measured blood sugar level) and Blood Pressure (or BP; measure the pressure inside blood arteries) were not cleaned and sanitized between residents' care (Resident 9, 13, 38, 54, and 286). 6. Activities department failed to provide an ongoing activity program to meet the needs and interests for Residents 47 and 61. 7. Resident Council grievances were not addressed and resolved timely when confidential interviews indicated ongoing facility issues were not resolved. A review of a facility policy titled Resident Council, revised [DATE], indicated the purpose was to promote the exercise of resident rights at the facility. The residents are to have input in the operation of the facility. The resident council provides feedback on procedures that govern the facility. Make recommendations for the improvement of resident services provided by the facility. If the council raises a concern the department responsible for the issue or service is responsible for addressing the concern. The facility's Quality Assessment Assurance Committee review the resident council minutes as part of its quality review. The Administrator reviews the minutes and any responses from departments, and these are presented at the next resident council meeting or sooner if indicated. During confidential interviews on [DATE] 9:30 pm, nine of 10 residents confirmed that call lights continue to be a problem. Residents stated direct care staff come in and turn off their call lights and don't come back. Residents explained they wait a long time (one to two hours), and this has been going on forever (a year). Administrator (ADM) talks about that but that is far as it gets. Feel helpless, that we are not wanted; They don't introduce themselves when they come in the room, don't say hello, don't look us in the eye. Residents stated direct care staff wear ear pods in their ears and always are on the phone or talking to their friends while helping us and in the halls (all shifts). Residents stated complaints and grievances are not addressed. Residents stated grooming not being done: especially fingernails. Residents explained not enough activities and staff to coordinate them. Residents stated pain medications take too long to be administered. Residents stated facility temperature issues- are too warm, and room [ROOM NUMBER] was freezing. Eight of 10 residents stated do not like food and it was cold. Residents stated sliding door broken in dining room. and shower handles finally working right before State arrived, this was going on about year and a half. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent record review and interview on [DATE] at 11:43 am, Activity Director (AD) stated she gives each department head the complaints and suggestions of the resident council meetings to resolve. AD confirmed there have been repeated complaints about long call light response by direct care staff and maintenance issues for the past year. During an interview on [DATE] at 1:15 pm, ADM was unaware of the ongoing issues identified by residents during survey and resident council. about dietary, long call lights, delivery of care, and building maintenance over the past year. ADM confirmed none of these issues were collected by department staff and brought to the Quality Assurance Performance and Improvement committee in the last year.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 43739 Based on interview and record review, the facility's Governing Body (GB), legally responsible for establishing and implementing facility policies, failed to effectively manage the facility when: 1. The GB did not ensure the administrator (ADM) had capital expense approval to ensure of the safety of the residents. Refer to F 689. 2. The GB did not ensure sufficient and competent staffing was present to meet the needs of all residents. Refer to F 725, F 726. 3. The GB did not ensure adequate oversight and monitoring of the dietary department. Refer to F 812. 4. The GB failed to ensure and effective Quality Assessment and Assurance Program to identify, implement corrective actions and evaluate their effectiveness. These failures led to an Immediate Jeopardy (IJ) being declared on 5/22/2024 at 11:25 am, at F 689. On 5/22/2024, at 11:25 am, an Immediate Jeopardy (IJ) was declared, when one of the seven facility doors leading to the outside was damaged and could not be completely closed and remaining partially open and unlocked. The facility failed to ensure the residents' safety and prevent the outsiders from entering the facility for one and half years. On 5/22/2024, at 4:25 pm, an immediate corrective action plan to address unsafe, insecure entrance/exit door was provided by the facility's Administrator. On 5/22/2024, at 5:10 pm, the IJ was removed based on onsite verification that IJ removal plan was implemented to ensure residents were free from accidents and hazards. Findings: Findings: During a review of the facility's policy titled, Governing Body, revised 5/23/2019, indicated: a. The Governing Body is to ensure the proper oversight of the Facility. b. The Governing Body has full legal authority and responsibility for the management and operation of the Facility. c. The Governing Body appoints a qualified Administrator, who is a licensed by the State of California, responsible for the management of the Facility and accountable to the Governing Body. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d. The Governing Body is responsible and accountable for the Quality Assurance and Performance Improvement (QAPI) program. This includes: - Ensuring ongoing QAPI program is defined, maintained, and implemented. - The QAPI program is sustained during transitions in leadership and staffing. - Adequately resources including staff time, equipment, and training as needed. - Identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data and resident and staff input. - Corrective action addresses gaps in the system and are evaluated for effectiveness. - Clear expectations are set around safety, quality, rights, choice, and respect. e. Establishes and implements a system whereby resident and staff grievances and/or recommendations, including those relating to resident rights, are identified within the Facility. - The system includes a feedback mechanism through management to the Governing Body, indicating what action was taken and whether or not an amicable solution was reached. 1. One fire door (a door that is fire proof and helps contain smoke), which led to the outside of the facility was damaged and could not be completely closed or locked for the past year and a half. The door led to the facility backyard where there was a steep creek. A staff locker room that residents had access to which was not kept locked, contained rusty unlocked lockers, stainless steel chemical cleaner, personal protective equipment (eye goggles, face shield and face masks), staff belongings, food items, a broken air conditioner, TV monitors, cardboard boxes, an industrial-sized container of a chemical rust remover. A review of an email dated 10/17/23, sent by the ADM to Governing Body (GB) 1, (the GB is a high level of management that makes policies and oversees all of the affairs of the facility and secures funds), included a capital expenditure (means a high cost item that the GB needs to approve), purchase order form for one hollow metal fire door. The capital expense report indicated the current fire door was unable to close and lock due to issues beyond repair. During an interview on 5/22/24 at 4:50 pm, ADM stated he was aware that the fire door needed replaced a year and a half ago. ADM stated he received an estimate from one vendor and GB 1 requested two estimates before approving. ADM stated he explained to GB 1 that there was only one available vendor in the area, but the funds were not approved. During an interview on 5/23/24 at 4 pm, GB 2 stated that he had replaced GB 1 about three weeks ago and was unaware of the outstanding facility building projects needing approval. GB 2 stated the capital expense for the broken fire door should have been approved back when it was identified as an issue. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. a. Resident 435 was observed waiting for their call lights to be answered for 30 minutes or longer. b. Five of Eighteen sampled residents (Resident 55, 7, 33, 27, 20) reported waiting over one hours at times for staff assistance. c. Resident 44 reported that certain Certified Nursing Assistants (CNA's) enter Resident rooms and cancel call lights without assisting Residents. d. During a confidential resident meeting, nine of ten residents who attended stated call lights that were not answered in a timely manner, which resulted in the resident's care needs not being met. e. Strong urine odor coming out form Resident 58's room. 3. a. Dietary services did not follow national standards and guidelines for kitchen cleanliness, and the safety of the food storage. b. Dietary services did not meet the nutritional and palatability needs of residents. 4. During an interview on 5/24/24 at 1:15 pm with the ADM, ADM was unaware of the ongoing issues identified by residents during survey and resident council. about dietary, long call lights, delivery of care, and building maintenance over the past year. ADM confirmed none of these issues were collected by department staff and brought to the Quality Assurance Performance and Improvement committee in the last year.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 43739 Based on interview and record review, the facility failed to have an effective Quality Assurance Performance Improvement (QAPI) committee when they did not identify nor correct facility issues to ensure care and services met residents needs when: 1. The facility had two unlockable doors, one -as a fire door with a broken hinge, leading to the facility's backside parking lot that nears a creek and a busy road. The facility's QAPI Program failed to monitor and take action to improve known defects in the facility's process for obtaining the vender's quote for the cost of the fire door and the capital expense approval. This resulted in an immediate jeopardy for failure to provide a system to ensure the safety of the resident and prevent the outsiders from entering the facility. Refer to F 689. 2. Dietary services did not follow national standards and guidelines for kitchen cleanliness, and the safety of the food storage. These failures had the potential for the spread of infection, and foodborne illness to occur in residents. Refer to F 812. 3. Dietary services did not meet the nutritional and palatability needs of residents. These failures created the potential for residents to receive food that did not comply with the physician ordered diet, did not meet resident nutritional needs, and had the potential to compromise residents' medical status, nutritional status, and quality of life. Refer to F 804. 4. Pharmacy services related to the QAPI committee, when the consulting pharmacist who oversees administration, storage, assessment, psychotropic medication intervention was not included in the QAPI committee. 5. Resident council ongoing complaints were not addressed by administration and therefore left unresolved. These ongoing failures had the potential for residents needs to go unmet and to jeopardize resident safety. Findings: During a review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Program, revised 9/19/2019, indicated: The purpose of the QAPI program is to describe a process that identifies opportunities for improvement and leads to achievement in clinical and operational outcomes. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility implements and maintains an ongoing, facility-wide QAPI Program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality of care and resolve identified problems. The Goals of the QAPI program are to provide a structure and process to correct identified opportunities for improvement and establish benchmarks to measure outcomes, and to establish a system and process to maintain documentation relative to the QAPI program, as a basis for demonstrating that there is an effective ongoing program. The Governing Body of the facility shall be responsible to oversee the QAPI program. The Administrator is responsible for ensuring that the facility's QAPI complies with local, state and federal regulatory agency requirements. The Quality Assessment and Assurance (QAA) Committee ensures QAPI principles are utilized in the implementation of all quality improvement activities. The Administrator will appointment a QAPI Coordinator who will help other committees, individuals, departments and /or services develop quality indicators, monitoring tools, criteria and assessment methodologies and identify and evaluate concerns impacting resident care and safety. Each department or service reviews its approaches to monitoring performance and outcomes and provides a summary of its findings to the QAPI committee annually and as needed. The QAPI committee evaluates these various reports to help define issues, plan and implement actions and ensure monitoring and follow-up. 1. There were no QAPI records provided that included information about the damaged, unsecure fire door. On 5/22/2024, at 11:25 am, an Immediate Jeopardy (IJ) was declared, when one of the seven facility doors leading to the outside was damaged and could not be completely closed and remaining partially open and unlocked. The facility failed to ensure the residents' safety and prevent the outsiders from entering the facility for one and half years. On 5/22/2024, at 4:25 pm, an immediate corrective action plan to address unsafe, insecure entrance/exit door was provided by the facility's Administrator. A review of an email dated 10/17/23, sent by the ADM to Governing Body (GB) 1, (the GB is a high level of management that makes policies and oversees all of the affairs of the facility and secures funds), included a capital expenditure (means a high cost item that the GB needs to approve), purchase order form for one hollow metal fire door. The capital expense report indicated the current fire door was unable to close and lock due to issues beyond repair. During an interview on 5/22/24 at 4:50 pm, ADM stated he was aware that the fire door needed replaced a year and a half ago. ADM stated he received an estimate from one vendor and GB 1 requested two estimates before approving. ADM stated he explained to GB 1 that there was only one available vendor in the area, but the funds were not approved. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/23/24 at 4 pm, GB 2 stated that he had replaced GB 1 about three weeks ago and was unaware of the outstanding facility building projects needing approval. GB 2 stated the capital expense for the broken fire door should have been approved back when it was identified as an issue. 2. During an interview with the Registered Dietitian (RD) on 5/22/2024 at 9:57 am, RD was asked if there were any concerns with the cleanliness of the kitchen. RD stated, There's always room for improvement, but it's better than it was. I can't give a specific timeframe, maybe in the last six to 12 months. The cleaning logs are better. RD stated she was aware frying pans needed to be replaced and stated the CDM was in the process of reordering. RD stated kitchen floors were something I would look at on monthly kitchen audits. RD stated she had noticed the wall by the dishwashing station, adding, Part of the problem is it's really old and could use some upgrades. During a concurrent interview and record review on 5/242/2024 at 1:10 pm with the ADM, the kitchen cleaning log was reviewed. The ADM stated each department did their own audit and if there's an issue, the head of the department would discuss the issue in the QAPI meeting. The ADM admitted that the kitchen cleaning issues had never brought to him and was never discussed in QAPI meeting. 3. During an interview on 5/24/2024 at 1:10 pm with the ADM, the ADM was unaware of the ongoing dietary concerns, ADM confirmed none of these issues were collected by department staff and brought to the Quality Assurance Performance and Improvement committee in the last year. 4. During a review of the facility's document titled, QAPI Plan, indicated the Framework for QAPI included All department managers, the administrator, the director of nursing, infection control preventionist, medical director, consulting pharmacist, resident and/or family representatives (if appropriate), and additional general staff will provide QAPI leadership by serving on the QAA committee . During a concurrent interview and record review on 5/24/2024 at 1:10 pm with the ADM, the QAPI meeting minutes were reviewed, there were no signature from the pharmacy department to be located, the ADM stated the pharmacy was not part of the QAPI, the ADM said, I haven't had the ability to have him on there yet. 5. During an interview on 5/24/2024 at 1:15 pm, ADM was unaware of the ongoing issues identified by residents during survey and resident council regarding dietary concerns, long waits for call lights to be answered, delivery of care, and building maintenance over the past year. ADM confirmed none of these issues were collected by department staff and brought to the Quality Assurance Performance and Improvement committee in the last year.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41567 Based on observation, interview, and record review, the facility failed to sustain a safe and sanitary environment for 82 out of 82 residents when: 1. During an inspection of the water-borne pathogen prevention program, the Maintenance Supervisor (MAINT) was unable to consistently provide proof that water temperatures were being monitored, and, 2. Personal protective equipment (PPE) consisting of a box of surgical masks, eye goggles and a face shield designed to be used during direct patient care were found in rusted employee lockers, and PPE and medical supplies were found to be stored in a basement around an active water leak directly below the dishwasher upstairs, and, 3. Nurses were observed to apply disinfecting agents (solutions designed to kill disease-causing pathogens) for inadequate lengths of time on shared medical equipment. These failures had the potential for contamination (the transfer of harmful pathogens from one source to another) and posed a threat to the physical well-being of residents, staff, and visitors. Findings: 1. A review was made of a facility policy titled, Infection Control Committee, Composition and Duties, revised 5/20/21, which indicated that the Infection Control Committee (ICC) provides oversight of all infection control practices in the delivery of resident care, including help monitoring the infection prevention and control processes for the facility's ventilation and water systems. A review was made of a facility policy titled, IPC412 Water Management, revised 5/25/23, which indicated that the facility will develop and utilize water management strategies to reduce the risk of growth and spread of Legionella (a type of pathogen that can cause a severe form of lung inflammation and infection called Legionnaires' Disease) and other opportunistic water-borne pathogens in facility water systems. A review was made of a facility policy titled, Water Temperatures, revised 1/1/12, which indicated that the maintenance department will check tap water temperatures and record the results in a safety log. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Riverside Point Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 375 Cohasset Rd Chico, CA 95926	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an inspection of the water-borne pathogen prevention program that took place on 5/24/24, 8:15 am, a concurrent interview and record review was done with MAINT who indicated there were two methods used to document water temperature checks, one computerized and the other manual. On a laptop he pulled up the data-entry page in which he documented water temperatures. There were completed tasks titled, Water Systems: Testing and Monitoring of Water Management Plan for Legionella. The description of the completion of these tasks was limited to indicating the task was done, the date done, and by whom. MAINT was not able to produce the data entered and could not provide the actual temperatures or the locations checked. MAINT was asked for the manual maintenance log. Unable to immediately locate the log, he followed up with a single document consisting of resident room numbers with hand-written hot and cold-water temperatures. A review of the document was made; the document had no year, no month, nor day of the month written on it. During a concurrent interview and record review conducted 5/24/24, 9:55 am, the Infection Preventionist (IP) confirmed the finding, stating there was no validating that water temperatures were being done timely. 2. A review was made of a facility policy titled, Infection Control Committee, Composition and Duties, revised 5/20/21, which indicated that the ICC provides oversight of all infection control practices in the delivery of resident care, including help monitoring and assessing facility-wide environmental infection control practices, and provides guidance for maintaining the facility in a sanitary condition. During an observation made on 5/22/24 11:12 am, in conjunction with Health Facility Evaluator Nurse 49418, of the unsecured back entry to the facility, it was noted that employee lockers were in poor condition, rusted and dirty appearing. Two unlocked, unlabeled locker cabinets were opened, and the following PPE was found: an opened box of disposable surgical masks (locker 1) and a face shield and eye goggles (locker 4). Photographs were taken. During a concurrent interview and record review conducted 5/24/24, 9:55 am, the IP reviewed the photographs of the PPE in the locker cabinets and stated, it's not a storage space for our PPE, it's rusted and not a clean area. During a concurrent interview and record review conducted 5/24/24, 9:35 am, the Director of Nurses reviewed the photographs of the PPE in the locker cabinets and stated, she was not aware staff were storing these items and it was not acceptable. 40903 3. a. During a medication administration observation, with Licensed Vocational Nurse XX (LVN XX) in the facility's station 1, on 5/21/24, at 11:43 AM, LVN XX gathered the blood sugar measurement supplies including a glucometer (a device that measured blood sugar), a test strip (used to soaked with blood to measure blood sugar) inserted into glucometer, one lancet (single use small sharp needle-like device used to poke the finger to get drops of blood for sugar measurement), and alcohol pads (small sanitizing pad) into the Resident 38's room. LVN XX measured the blood sugar and then existed the room to address low blood sugar by providing orange juice and snack to help raise the blood sugar. LVN XX placed a tissue on top of the medication cart, then used sanitizing wipe once to quickly (less than 10 seconds) wipe the outer surface of glucometer and let it air dry on top of the cart. (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 medication administration observation, with LVN XX, in the facility's station 1, on 5/21/24, 12:02 PM, LVN XX used the same glucometer with test strip, lancet and alcohol pad into the Resident 54's room. LVN XX placed the glucometer on top of the bed side table, then poke the right index finger with lancet to get blood and soak the test strip attached to the glucometer. After blood sugar measured, LVN XX washer her hand and exited the room. LVN XX wiped the outer surface of glucometer with sanitizing wipe once for less than 20 seconds and placed it on tissue to air dry. In an interview with Infection Prevention (IP) nurse, on 5/23/24, at 10:06 AM, the IP stated the shared glucometer should be cleaned with facility's approved sanitizer wipes. The IP stated the nurse should wipe to sanitize the outer surface of glucometer and follow the contact time on the container of the sanitizing wipe. The IP stated no cleaning step needed unless the surface contaminant seen by the eyes. The IP stated the one step process of sanitizing with use of approved wipes was acceptable to her. The IP stated she did not time the nurses on how long they cleaned the surfaces of the glucometer. Review of CDC (Center for Disease Control, nation's leading science-based, data-driven, service organization that protects the public's health) guideline titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration last accessed via https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html#anchor_1556215485 ,on 5/28/24, the guideline indicated If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared. Review of the facility's glucometer manufacturer, called Arkray Technical Brief, with revision date of 10/23, the document under Cleaning and Disinfecting indicated The cleaning procedure is needed to clean dirt, blood, and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfecting procedure is needed to prevent transmission of bloodborne pathogens. The Document under Cleaning and Disinfecting FAQ (Frequently Asked Questions) indicated Can cleaning and disinfecting be accomplished with one wipe? No, Each time the cleaning and disinfecting procedure is performed two wipes are needed. One wipe to clean the meter and a second wipe to disinfect the meter. 3. b. During a medication administration observation, with Licensed Vocational Nurse A (LVN A), on 5/22/24, at 8:32 AM, LVN A took the BP device into the Resident 13's room, measured the BP thru the left arm then existed the room. LVN A used one sanitizing wipe in the cart, with bare hands, to clean the outer surface of the BP cuff very quickly, LVN A did not cover all the areas touched the resident's skin. During a medication administration observation, with LVN A, on 5/22/24, at 8:49 AM, LVN A used the same BP device to measure the blood pressure of Resident 9. LVN A when exited the room with bare hand used one sanitizing wipe and lightly wiped the BP device. In an interview with LVN A on 5/23/24, at 10 AM, LVN A stated she could have done a better job on cleaning the BP devices in-between resident care. LVN A stated she wanted to make sure the BP were in a stable range right before BP medications were due to be administered despite having a measured BP level by CNA's (Certified Nursing Assistants) from earlier that day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Point Healthcare & Wellness Centre	375 Cohasset Rd Chico, CA 95926

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with Infection Prevention (IP) nurse, on 5/23/24, at 10:06 AM, the IP stated the BP cuff should be cleaned with facility's approved sanitizer wipes. The IP stated the nurse should wipe and cover all areas of the BP cuff and follow the contact time on the container of the sanitizing wipe.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49934 Based on observation, interview and record review the facility failed to ensure facility equipment was functioning when: 1. Air conditioner (AC) units to cool Rooms 11-18 were not working properly and needed replacement. 2. Toilet in room [ROOM NUMBER] was not secured to the floor. 3. Shower heads in shower rooms were leaking with low water pressure. 4. Sliding glass door track bent in dining room. 5. The door at the facility entrance would not close. 6. Leaking back flow pipe left corner of the building. 7. Floor of dietary department is leaking and flooding into basement These failures resulted in an uncomfortable warm temperatures, a fall with injury, and put all residents at risk for accidents and hazards. Findings: During a review of facility policy and procedure (P&P) titled Maintenance Service: Operational Manual - Physical Environment, dated 1/1/12, the P&P indicated the Maintenance Department maintains all areas of the building, grounds, and equipment to protect the health and safety of residents, visitors, and Facility Staff. 1. During confidential interviews on 05/22/24 9:30 pm, residents stated the facility temperature issues can be too warm. A review of a project proposal from a local air conditioning company dated August 2023, indicated the facility needed to replace two AC units. A review of an email dated 8/1/23 at 1:45 pm, the Administrator (ADM) sent a quote and asked the Governing Body (GB 1) to sign so they could move forward with the replacement. 2. During review of facility records titled, Maintenance Logs, dated 1/1/24 to 5/22/24, the records indicated the following: - On 4/28/24, Special Issue/Problem: Resident 38's bathroom in room [ROOM NUMBER] toilet was loose and leaking. The record did not indicate Date Addressed, Target Date, Date Completed, or Completed By (staff initials). (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 5/20/24, Special Issue/Problem: room [ROOM NUMBER] and 13 toilet lid is broke, needs new one and comes off. The record did not indicate Date Addressed, Target Date, Date Completed, or Completed By (staff initials). During an interview with Resident 38 in room [ROOM NUMBER] on 05/21/24 at 11:22 AM, Resident 38 voluntarily raised his shirt and adjusted the right side of his pants to reveal dark purple discoloration at the right side below the ribs and at the hip, due to a fall related to the toilet being very movable. This was visibly demonstrated when the resident grabbed the front edge of the toilet and spun the toilet from side-to-side. Resident 38 stated, I went to sit down, and the toilet moved. Resident 38 stated that the toilet has had movement since the first day in his room and the toilet has only become looser over time. When asked if this was reported to staff, he stated that it had been reported, a while ago. Resident 38 stated that he does not use the call light a lot because he wants to get up and do things independently. After the fall, Resident 38 yelled for help, staff came right away, and the nurse did an assessment. During an interview on 5/21/24 at 11:30 am, Licensed Vocational Nurse F and Infection Preventionist both confirmed Maintenance Supervisor (MAINT) just went to get parts to fix the toilet and confirmed that Resident 38's toilet had not been repaired up to now. 3. During a review of the facility's record titled, Confidential resident meeting minutes, indicated: a. On 2/29/2024, issues with Shower room [ROOM NUMBER] leaking b. On 3/14/2024, issues with Station 2 shower next to room [ROOM NUMBER], leaking while shower in use. c. On 3/28/2024, leaking in shower Station 1 and residents requested to get new shower heads. A review of a Maintenance Special Issue log dated 4/10/24, indicated shower heads need to be replace. There were no dates entered in the date addressed, target date, completion date and who completed the repair. During confidential interviews on 5/22/24 9:30 pm, shower handles finally working right before State arrived and this was going on about year and a half. 4. During confidential interviews on 5/22/24 9:30 pm, residents stated sliding door broken in dining room. During review of record titled, Proposal dated 10/10/23, regarding the sliding glass door replacement, which included removing the glass sliding door and match up/replace rollers same day. A review of an email dated 10/17/23, sent by the ADM to Governing Body (GB) 1, (the GB is a high level of management that makes policies and oversees all of the affairs of the facility and secures funds), included a capital expenditure (means a high cost item that the GB needs to approve), purchase order form for a sliding glass dining room door. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an environmental tour on 5/23/24 at 2:30 pm, MAINT confirmed showers heads were leaking in all shower rooms and were recently replaced. MAINT confirmed the Day Dining room's middle sliding glass door had a bent track. ADM sent a capital expense request for a new last October 2023. MAINT confirmed hot in the summer months in Rooms 11-18 last August 2023. MAINT stated AC units not working and had no temperature logs for that time period. MAINT stated a capital expense was done for a two new units and sliding glass door was not approved by GB 1 as of today. MAINT explained he was only one person and could not get to all the work that needed to be done and not having timely approval of capital expenses for larger projects also a barrier. 49418 5. During initial facility observational tour on 5/21/2024 at 7:37 am, the front door to the facility was observed to be fully open. During observation of the facility lobby on 5/21/24 at 10:40 am, the front door to the facility was again noted to be fully open. Insects were observed flying into the building. After pulling the door closed, the door slowly swung open approximately 2 feet and stayed open. During concurrent observation and interview with Receptionist (REC) at front desk on 5/22/24 at 9:20 am, REC stated the front door was broken. REC stated she worked Friday (five days prior), and the door was not broken at that time. REC stated she informed the Maintenance Supervisor (MAINT) who told her the door's automatic open/close system was not working. REC stated MAINT was working on fixing it. REC stated ADM informed her facility doors were locked from 8 pm to 8 am. REC stated a weekend receptionist works 8:30 am to 5:30 pm. REC stated a bell in the lobby is available for visitors to announce their presence from the time weekend receptionist leaves at 5:30 pm until the doors are locked at 8 pm (two and a half hours). REC stated we redirect unauthorized visitors who arrive in the lobby. 6. During observation of the facility grounds on 5/21/24 at 11:05 am, observed a metal pipe draped with a green plastic cover; the pipe extended from the left front corner of the building into the ground. On lifting the green cover, a steady stream of water was observed dripping from the pipe to the ground which created a puddle approximately 3 feet by 2 feet. During a review of facility document titled [Company Name] Invoice 14813, dated 11/29/23, the document indicated backflow repair labor was performed with total repair kit on 11/20/23. During concurrent observation and interview with MAINT on 5/21/24 at 11:56 am, MAINT stated the pipe was for backflow from the kitchen. MAINT stated the pipe was maintained by a local company that usually came out quarterly, but they haven't been out yet this year. MAINT stated the backflow pipe was for changes in water pressure in the kitchen. MAINT acknowledged that the pipe should not be dripping. MAINT stated fixing the line required turning off the water and checking the seals. 7. During review of facility document titled Capital Expenditure Purchase Order Form, Appendix A, dated 6/26/23, the document indicated an emergency request for replacement of floor tile under sink and dishwasher. The document indicated, Floor of dietary department is leaking and flooding into basement where emergency food and nursing supplies are stored. The documented indicated a signature by [NAME] President of Operations (undated). (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of facility email from Property Manager (PM) to MAINT on 6/26/23 at 1:38 pm, the document indicated PM recommended to move forward these repairs before it gets worse. During concurrent observation and interview with MAINT on 5/21/24 at 11:56 am, MAINT stated internal kitchen lines are jetted clean every other month for grease removal. MAINT stated there is a small leak in one area of the basement when this is performed. MAINT stated a local company was supposed to come out to perform line jetting last week but were unable to get their equipment through the parking lot; MAINT stated he thought they were rescheduled to revisit this week. During concurrent observation of the basement and interview with Infection Preventionist (IP) and MAINT on 5/21/24 at 4:05 pm, the following was observed: - Dirt and debris were noted on stairs down to the basement. The stairwell area had a musty odor. - A large hole (approximately 2 feet by 3 feet) was observed to the left wall at the bottom steps. MAINT stated a heavy box had been dropped which fell down the stairs, hit the left wall, and caused the hole. - Two doors were present to the right and left at the bottom of the stairs. On entry through the right door, two puddles approximately 2 feet by 2 feet were observed on the painted concrete floor. Above the puddles were pipes extending from a hole in the ceiling where several ceiling tiles had been removed. MAINT stated the pipes above the puddles were from the kitchen dishwasher. -Metal shelving along walls around the water leak contained cardboard boxes of nursing supplies: gauze pads for wounds, syringes, and personal protective equipment like paper face masks and shoe covers. IP stated, I don't feel good about it when asked how she felt about water dripping near the supplies. IP stated she had discussed the subject with the Administrator (ADM) several times. IP stated there had been a large leak in the same area last year, at which time she had removed all stock and reordered everything. IP stated she had observed the pipes leaking again for the last two months. IP stated, It was a little drip, but it's getting worse. IP stated she has been checking downstairs daily to make sure nursing supplies were not getting wet. - MAINT stated the basement had been remodeled by himself and ADM last year. MAINT stated the room had been repainted, the floor rebuffed, and the leak fixed. MAINT stated this leak was new in the past week or two.