

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2025
NAME OF PROVIDER OR SUPPLIER  Montclair Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5119 Bandera Street Montclair, CA 91763	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>46917</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident's electronic health records (EHR- medical records kept on a computer system) were kept private and protected from public view for one of nineteen sampled residents (Resident 22) when the Assistant Director of Nursing (ADON) left Resident 22's EHR unattended, visible and viewable to the hallway at the nursing station.</p> <p>This failure had the potential to place Resident 22 at risk for her medical records to be viewed by other residents or healthcare providers who should not have access to Resident 22's medical records.</p> <p>Findings:</p> <p>During an observation on April 3, 2025, at 8:46 AM, there was no nurse at the nursing station. There was one computer facing the hallway, with the EHR open and viewable to the public. The computer screen showed Resident 22's weights. Upon further inspection, the person who accessed Resident 22's EHR was the Assistant Director of Nursing (ADON).</p> <p>During a concurrent observation and interview, on April 3, 2025, at 8:53 AM, in the nursing station, with the ADON, the ADON logged off Resident 22's EHR from the computer. The ADON apologized and stated it should have not been left unattended and visible to the hallway.</p> <p>During a concurrent interview and record review, on April 3, 2025, at 9:09 AM, with the Director of Nursing (DON), the DON reviewed the facility's policy and procedure (P&amp;P) titled, Computer Terminals/Workstations dated revised January 2025, which indicated Computer terminals and workstations will be positioned/shielded to ensure that protected health information (PHI) and facility information is protected from public view or unauthorized access . 3. A user may not leave his/her workstation or terminal unattended unless the terminal screen is cleared, and the user is logged off . The DON stated the P&amp;P was not followed.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055718
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47098</p> <p>Based on interview and record review, the facility failed to ensure the care plan (specific interventions to provide effective and person-centered care to meet the resident's needs) was updated in accordance with the facility's policy and procedure for one of four residents (Resident 41) reviewed for nutrition.</p> <p>This failure had the potential for Resident 41 to be at risk for continued nutritional decline, delayed interventions and unmet care needs related to weight loss and associated medical conditions.</p> <p>Findings:</p> <p>During a review of Resident 41's Admission Record (contains demographic and medical information), it indicated Resident 41 was admitted to the facility on [DATE], with diagnoses of type 2 diabetes (a condition where the body has trouble using sugar properly, causing high blood sugar levels), and hypertension (elevated blood pressure).</p> <p>During a review of Resident 41's Weight Changes Note, dated February 21, 2025, at 3:29 PM, it indicated, Resident noted to have 16 lbs. (pounds) / 13.3% weight loss x 3 months (for 3 months). Significant loss . Nursing reported that the weekly weight today was 106 lbs. (pounds) 2lb gain. She also reported that intakes have improved. At this time would recommend to continue weekly weights and to add fortified diet (practice of deliberately increasing the content of one or more micronutrients in a food or condiment to improve the nutritional quality of the food) to current diet order in order to encourage weight gain .</p> <p>During a review of Resident 41's Physician Orders, dated February 25, 2025, at 7:27 PM, it indicated Fortified Regular [normal, general diet with no food restrictions] NAS [ No added Salt, limits sodium intake] , CCHO [Consistent Carbohydrate, the person gets the same amount of sugar and starchy foods-like bread, rice, fruit] with thin liquids, with meals.</p> <p>During a review of Resident 41's Care Plan for Nutrition, dated April 3, 2025, it indicated, Focus, 10 lbs . while in the hospital. At risk for further signification weight change. There was no documented evidence to indicate the care plan was updated or revised to reflect the interventions placed on February 21, 2025 to address Resident 41's weight loss.</p> <p>During a concurrent interview and record review on April 4, 2025, at 9:57 AM, with the Director of Nursing (DON). The DON reviewed Resident 41's clinical record and stated the care plan for nutrition was not updated even though Resident 41 had a diet order change to address his weight loss. The DON stated the delay may have been due to oversight by the nurse who received the order.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review, on April 4, 2025, at 10:03 AM, with the DON, the facility's undated policy and procedure titled Care Plans, Comprehensive Person-Centered was reviewed. The P&amp;P indicated, .7. The comprehensive, person-centered care plan ., b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being .11. Assessment of resident are ongoing, and care plans are revised as information about the residents are the residents' conditions change.12. The interdisciplinary team reviews and updates the care plan: a. When there has been a significant change in the resident's condition . The DON stated the policy was not followed. The DON further stated the care plan was delayed beyond the expected time frame.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51815</p> <p>Based on interview and record review, the facility failed to ensure their catheter (tube that is inserted into your bladder, allowing your urine to drain freely) care policy and procedure was implemented for one of two residents (Resident 11) reviewed for catheter.</p> <p>This failure had the potential to place Resident 11 at risk for developing urinary infection (when bacteria enters and infects the urinary tract).</p> <p>Findings:</p> <p>During a review of Resident 11's face sheet (contains demographic and medical information), it indicated Resident 11 was admitted to the facility on [DATE], with diagnoses of hydroureter (a muscular tube that transports urine from the kidneys to the bladder, gets bigger than normal due to a backup of urine) caused by any blockage that prevents urine from draining into the bladder, chronic kidney disease (a long-term condition where the kidneys do not work as well as they should) and obstructive, and reflux uropathy (flow of urine is blocked).</p> <p>During a review of Resident 11's physician's order, dated February 14, 2023, it indicated Suprapubic [above the pubic bone] catheter care; wash with water and soap every shift [a set amount of time an employee to work Morning, Evening and Night] and PRN [as necessary].</p> <p>During a concurrent interview and record review, on April 3, 2025, at 4:44 PM, with the Director of Nursing (DON), the DON reviewed Resident 11's Treatment Administration Record (TAR) for the month of March 2025. The TAR indicated catheter care were not recorded for the following dates:</p> <ul style="list-style-type: none"> <li>a. March 2, 2025, evening shift</li> <li>b. March 3, 2025, day shift</li> <li>c. March 5, 2025, day shift</li> <li>d. March 6, 2025, day shift</li> <li>e. March 8, 2025, evening shift</li> <li>f. March 9, 2025, evening shift</li> <li>g. March 10, 2025, day shift</li> <li>h. March 12, 2025, day shift</li> <li>i. March 20, 2025, day shift</li> <li>j. March 22, 2025, evening shift</li> </ul> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>k. March 31, 2025, evening shift</p> <p>The DON acknowledged the finding and stated staff should complete the catheter care every shift and document it right after if it was done.</p> <p>During a follow up interview and concurrent record review, on April 3, 2025, at 4:45 PM, with the DON, the DON reviewed the facility's undated policy and procedure (P&amp;P) titled, Catheter Care which indicated It is the policy of the facility to improve hygiene and reduce infection by ensuring that catheter care is done every shift to residents who are using foley catheter. The DON stated the policy was not followed.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51269</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure physician ordered therapeutic diets (special meal plans, made for people with health problems) were provided to three of 11 residents (Residents 34, 48, and 41) reviewed for dining observation when:</p> <ol style="list-style-type: none"> <li>Residents 34 and 48 did not receive their physician ordered cardiac diet (low sodium, low fat diet).</li> <li>Resident 41 did not receive the prescribed therapeutic diet for lunch on April 1, 2025.</li> </ol> <p>These failures had the potential to cause nutritional decline and unmet care needs for Residents 41, 34 and 48.</p> <p>Finding:</p> <ol style="list-style-type: none"> <li>During a review of a facility document titled Order Listing Report [contains the resident's diet], it indicated Residents 34 and 48 had therapeutic diets of .Regular Cardiac (Low fat, Low sodium), CCHO (Consistent Carbohydrate) NAS (No added Salt) with meals.</li> </ol> <p>During an interview on April 2, 2025, at 8:40 AM, with the Dietary Services Supervisor (DSS), the DSS stated they do not provide the cardiac diet at the facility. The DSS further stated for residents who have cardiac diet orders (Residents 34 and 48), they provide the NAS (No Added Salt) diet.</p> <p>During an interview on April 3, 2025, at 10:41 AM, with the RD, the RD stated the facility missed these residents [Residents 34 and 48] were on the cardiac diet. The RD further stated the diets of these residents should have been changed to a diet the facility can provide. The RD stated that the DSS should have made sure that the order on PCC (electronic health record) was correct.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled Food Preparation, it indicated, Food shall be prepared by methods that conserve nutritive value, flavor, and appearance . The facility will use approved recipes, standardized to meet the resident census .</p> <p>47098</p> <ol style="list-style-type: none"> <li>During a review of Resident 41's Admission Record (contains demographic and medical information), it indicated Resident 41 was admitted to the facility on [DATE], with diagnoses of type 2 diabetes (a condition where the body has trouble using sugar properly, causing high blood sugar levels), and hypertension (elevated blood pressure).</li> </ol> <p>During a review of Resident 41's physician order, dated February 25, 2025, it indicated Fortified Regular [normal, general diet with no food restrictions] NAS [ No added Salt, limits sodium intake] , CCHO [Consistent Carbohydrate, the person gets the same amount of sugar and starchy foods-like bread, rice, fruit] with thin liquids.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview, on April 1, 2025, at 12:30 PM, with the Treatment Nurse (TN), in the dining room, Resident 41's lunch tray card was reviewed. The tray card indicated, Regular CCHO diet. There was no indication of the fortified component on the tray card as required by the physician's order. The TN acknowledged the finding, and confirmed tray card did not match the physician order.</p> <p>During an interview on April 3, 2025, at 10:57 AM, with the Registered Dietitian (RD), the RD stated the staff should have followed the correct diet as prescribed by the physician.</p> <p>During a concurrent interview and record review, on April 4, 2025, at 9:47 AM, with the Director of Nursing (DON), the DON reviewed the facility's policy and procedure (P&amp;P) titled Tray Cards dated January 2025, which indicated, Procedure: 1. Upon receipt of diet communication slip from nursing containing a new or changed diet order, the dietary staff will prepare a tray card for that resident. 2. Tray card should list the resident's name . diet order . 3. If permanent tray card are used, before each meal service, dietary staff will check the tray cards against a master list . The DON stated the policy was not followed.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51815</b></p> <p>Based on observation, interview, and record review, the facility failed to coordinate and arrange the dialysis (procedure to remove waste products and excess fluid from the blood) appointment for one of one resident (Resident 36) reviewed for dialysis.</p> <p>This failure had the potential to place Resident 36 at risk of complications due to fluid overload (body has too much water).</p> <p>Findings:</p> <p>During a review of Resident 36's face sheet (contains demographic and medical information), it indicated Resident 36 was admitted on [DATE], with diagnoses of end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis) and diabetes (blood sugar is too high).</p> <p>During a review of Resident 36's physician's order, dated March 15, 2025, it indicated Will have an extra dialysis on March 17, 2025, per dialysis center due to fluid overload.</p> <p>During a concurrent observation and interview, with Resident 36, on April 4, 2025, at 9:07 AM, in Resident 36's room, Resident 36 was sitting on her wheelchair, alert and oriented. Resident 36 stated she missed some of her additional dialysis schedule because transportation did not arrive.</p> <p>During an interview with the Social Services Designee (SSD), on April 4, 2025, at 9:11 AM, the SSD stated she was off when Resident 36 received an order to have additional dialysis for March 17, 2025. The SSD further stated Resident 36 missed the dialysis appointment because she failed to arrange transportation, which was part of her responsibility.</p> <p>During a concurrent interview and record review on April 4, 2025, at 9:37 AM, the Director of Nursing (DON) reviewed the policy and procedure (P&amp;P) titled Dialysis Services revised on January 2024, which indicated . 4. Coordination of care may include the following . b. Transportation Arrangements and Transportation Appointments 1. Nursing arranges outside appointments and makes social services aware, 2. Social Services will coordinate transportation and notify family member or responsible party to accompany residents to outside appointment, 4. License Personnel will call the transportation 1 hour prior to the appointment of the resident to verify pick up and return. The DON stated that the policy was not followed.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>51269</p> <p>Based on observation, interview, and record review, the facility failed to follow their daily approved menu for lunch on April 1, 2025, and April 2, 2025, when:</p> <ol style="list-style-type: none"> <li>On April 1, 2025, Dietary [NAME] 1 (Cook 1), served puree (food that has been blended, pressed or ground to have a creamy texture) lasagna with #8 scoop (1/2 cup). The menu indicated the portion should be 1 cup.</li> <li>On April 1, 2025, [NAME] 1, for the large portion orders served 1 1/2 of lasagna. The menu indicated that it should be 1 1/2 garlic bread not lasagna.</li> <li>On April 2, 2025, Dietary [NAME] 2 (Cook 2), for the mechanical soft (foods that are easily swallowed) orders served #16 scoop (1/4 cup). The menu indicated the portion should be #10 scoop (3/8 cup).</li> </ol> <p>These failures had the potential to compromise resident's nutritional status, when menus were not followed for 18 of 55 medically compromised residents (on puree, on large portion, or mechanical soft diets) who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During a review of a facility document titled Orders Listing Report [contains the resident's diet], it indicated the following residents had an order for puree diet: Residents 27, 3, 47, 17, 30, 29, and 42.</li> </ol> <p>During a review of a facility document titled Spring Cycle Menu, dated April 1, 2025, it indicated for the Puree meal portion 8oz= 1 cup of Zesty Lasagna.</p> <p>During a trayline (system used in hospitals to assemble and deliver meals to residents) observation on April 1, 2025, at 11:39 AM, in the kitchen, [NAME] 1 used #8 scoop (1/2 cup) to serve puree lasagna for Resident 27.</p> <p>During a continued trayline observation on April 1, 2025, at 11:40 AM, in the kitchen, [NAME] 1 used scoop #8 (1/2 cup) to serve puree lasagna for Resident 47.</p> <p>During further trayline observation on April 1, 2025, at 11:41 AM, in the kitchen, [NAME] 1 used scoop #8 (1/2 cup) to serve puree lasagna for Resident 3.</p> <p>During an interview on April 2, 2025, at 8:34 AM, with [NAME] 1, [NAME] 1 acknowledged he used the incorrect scoop to serve the puree Lasagna. [NAME] 1 further stated the menu should have been followed.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on April 2, 2025, at 8:39 AM, with the Dietary Service Supervisor (DSS), the DSS stated two #8 (1/2 cup) scoops should have been served. The DSS further stated the menu should have been followed.</p> <p>During an interview on April 3, 2025, at 10:44 AM, with the Registered Dietician (RD), the RD stated the expectation was for the menu portions to be followed. The RD further stated a review of portion sizes with the cooks might be needed.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled Food Preparation, it indicated, Food shall be prepared by methods that conserve nutritive value, flavor, and appearance . The facility will use approved recipes, standardized to meet the resident census .</p> <p>2. During a review of a facility document titled Orders Listing Report, it indicated the following residents had an order for large portions: Residents 21, 402, and 6.</p> <p>During a review of the menu titled Spring Cycle Menu dated, April 1, 2025, it indicated for the large portion the resident should get 1 serving of Zesty Lasagna, 1/2 cup of Italian green beans and 1 1/2 Garlic bread.</p> <p>During a trayline observation on April 1, 2025, at 11:39 AM, [NAME] 1 served 1 1/2 servings of lasagna for Resident 21.</p> <p>During further trayline observation on April 1, 2025, at 11:42 AM, [NAME] 1 served 1 1/2 servings of lasagna for Resident 402.</p> <p>During an interview on April 2, 2025, at 8:35 AM, with [NAME] 1, [NAME] 1 stated instead of giving extra 1/2 serving of lasagna, it should have been 1/2 slice more of garlic bread as stated on the menu.</p> <p>During an interview on April 2, 2025, at 8:41 AM, with the DSS, the DSS stated [NAME] 1 should have given 1 1/2 bread instead of addition lasagna. The DSS stated the menu should have been followed.</p> <p>During an interview on April 3, 2025, at 10:45 AM, with the RD, the RD stated the expectation was for the menu portions to be followed.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled Food Preparation, it indicated, Food shall be prepared by methods that conserve nutritive value, flavor, and appearance . The facility will use approved recipes, standardized to meet the resident census .</p> <p>3. During a review of a facility document titled Orders Listing Report, it indicated the following residents had an order for mechanical soft: Residents 155, 6, 21, 37, 15, 31,16, 9, 13, and 12.</p> <p>During a review of the menu titled Spring Cycle Menu dated April 2, 2025, it indicated for mechanical soft diet, the portion for roast turkey was #10 scoop (3/8 cup).</p> <p>During a trayline observation on April 2, 2025, at 11:39 AM, in the kitchen, [NAME] 2 used #16 scoop (1/4 cup) to serve the mechanical soft roast turkey.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51100</p> <p>Based on observation, interview, and record review, the facility failed to ensure food preferences were accommodated for one of four residents (Resident 11) reviewed for nutrition when Resident 11 was served green beans for lunch on April 1, 2025.</p> <p>This failure had the potential to result in unmet care of needs for Resident 11 which could potentially affect the resident's nutrition status.</p> <p>Findings:</p> <p>During a review of Resident 11's Admission Record, (contains demographic and medical information), it indicated Resident 11 was admitted to the facility on [DATE], with diagnoses of chronic systolic heart failure (a long-term condition where the heart struggles to pump blood effectively), depression (a persistent mood disorder characterized by a sustained feeling of sadness and loss of interest), and muscle wasting (the loss of muscle mass and strength).</p> <p>During an interview, with Resident 11, in Resident 11's room, on April 1, 2025, at 12:03 PM, Resident 11 stated she often gets served food that does not accommodate her preferences.</p> <p>During an observation and concurrent interview, with Resident 11, on April 1, 2025, at 12:26 PM, Resident 11's lunch was delivered to her room. Resident 11 was sitting up on her bed with the lunch plate on her table. The lunch tray included a pork patty with gravy, noodles, and green beans. Resident 11's meal ticket was inspected, and it indicated green beans was one of her dislikes. Resident 11 stated And there isn't anything I can do about it [being served food she did not like].</p> <p>During a concurrent interview and record review on April 1, 2025, at 12:35 PM, with the Director of Nursing (DON), in the presence of the Administrator (Admin), Resident 11's meal ticket was reviewed and compared to Resident 11's food tray. The DON and the Admin verified green beans were served to Resident 11 despite it being listed as part her dislikes.</p> <p>During a concurrent interview and record review, on April 1, 2025, at 3:50 PM, with the DON, the DON reviewed the facility's undated policy and procedure (P&amp;P) titled, Resident Nutrition Services, which indicated, It is the policy of this facility that each resident shall receive the correct diet, with preferences accommodated, as feasible, and shall receive prompt meal services and appropriate feeding assistance . (2.) Prior to serving the food tray, the nurse aide/feeding assistant must check the tray card to assure that the correct food tray is being served to the resident . The DON stated the policy was not followed but should have been.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2025
NAME OF PROVIDER OR SUPPLIER  Montclair Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5119 Bandera Street Montclair, CA 91763	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51269</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food preparation, and storage practices in the kitchen when:</p> <ol style="list-style-type: none"> <li>1. The ice machine had yellow grime (dirt clinging to or rubbed into a surface) in the ice chute (a passage, often filled with ice). This had the potential for contribution of microorganism (tiny living things like bacteria, fungi and algae that are too small to be seen with the naked eye) growth.</li> <li>2. The floor under the reach-in refrigerator had a black grime and trash. This had the potential of pathogenic (something that can make you sick like germs or viruses) microorganisms to accumulate and attract pests.</li> <li>3. Inside the refrigerator, the chicken was thawing (to unfreeze) over another set of meat. This had the potential of cross-contamination (contamination between two things).</li> </ol> <p>These failures had the potential to cause food-borne illness (a condition that occurs when a person consumes food or beverages contaminated with harmful microorganisms, toxins, or chemicals) and to attract pests for 54 medically compromised residents who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on April 1, 2025, at 9:25 AM, in the hallway, with the Maintenance Supervisor (MS), the ice machine was inspected. The ice machine had yellow discoloration on the ice chute. A white paper towel was used to wipe the yellow slime, which was located on the ice chute.</li> </ol> <p>During an interview on April 1, 2025, at 9:26 AM, with the MS, the MS stated perhaps he has to clean the ice machine weekly for it to be kept clean.</p> <p>During an interview on April 3, 2025, at 10:36 AM, with the Registered Dietician (RD), the RD stated the ice chute should definitely be cleaned, since the ice is used for resident's drinks and water pitchers.</p> <p>During a concurrent interview and record review, on April 3, 2025, at 10:37 AM, with the RD, the facility's ice machine manual titled [Brand Name of Ice Machine] was reviewed. Under a section titled Cleaning and Maintenance Instructions, it indicated .[Brand Name of Ice Machine] recommends cleaning this unit at least once a year. More frequent cleaning, however, may be required in some existing water conditions . The RD stated the ice machine should be maintained cleaned at all times even if manual states annually cleaning.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the FDA [Food and Drug Administration] Federal Food Code, dated 2022, under 4-602.11, it indicated, .Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as . ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime [a moist, soft, slippery substance], mold [a type of fungus that grows in damp, warm places and can look like fuzzy spots or patches], or soil residues [remain] that may contribute to an accumulation [build up] of microorganisms .</p> <p>2. During an observation on April 1, 2025, at 8:25 AM, in the kitchen, the floor under the reach-in freezer had black grime build-up, trash, and a fork.</p> <p>During an interview on April 3, 2025, at 10:38 AM, with the RD, the RD stated the expectation was for kitchen's floors to be maintained clean.</p> <p>During a review of the FDA Federal Food Code, dated 2022, under 4-601.11, it indicated, .Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris [scattered pieces of waste or remains] .in addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted.</p> <p>3. During an observation on April 1, 2025, at 8:18 AM, in the kitchen, with [NAME] 1, the refrigerator was inspected. Inside the refrigerator, there was chicken thawing in a metal pan, and packages of chicken were hanging over the side of the pan, thawing over a raw turkey. In the front was a container of raw beef.</p> <p>During an interview on April 1, 2025, at 8:20 AM, with [NAME] 1, [NAME] 1 stated the chicken should not be hanging over the side of the metal pan.</p> <p>During an interview on April 1, 2025, at 11:02 AM, with the DSS, the DSS acknowledged that the chicken was hanging over the raw turkey.</p> <p>During an interview on April 3, 2025, at 10:39 AM, with the RD, the RD stated the chicken should be kept contained in its own metal container.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Thawing of Meats, dated 2023, it indicated, .use a drip pan under food being thawed so drippings do not contaminate other food .</p> <p>During a review of the FDA Federal Food Code dated 2022, under 3-302.11, it indicated, .(2) Except when combined as ingredients, separating types of raw animal FOODS from each other such as beef, FISH, lamb, pork, and POULTRY [chicken, turkey, ducks, [NAME]] during storage, preparation, holding, and display(2) Except when combined as ingredients, separating types of raw animal FOODS from each other such as beef, FISH, lamb, pork, and POULTRY during storage, preparation, holding, and display by: (a) Using separate EQUIPMENT for each type, (b) Arranging each type of FOOD in EQUIPMENT so that cross contamination of one type with another is prevented .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46917</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper and safe infection control practices were followed when:</p> <ol style="list-style-type: none"> <li>1. A Certified Nursing Assistant (CNA 1) did not wear a protective gown while providing care for Resident 31, who was on enhanced barrier precautions (EBP- infection control intervention designed to reduce the transmission of harmful germs by wearing gown and gloves during high-contact care activities).</li> <li>2. Resident 18's oxygen tubing (tube that contains two open prongs intended to deliver oxygen into the nose) was not changed in accordance with the facility's policy.</li> </ol> <p>These failures had the potential to result in cross-contamination (the transfer of harmful bacteria) causing a preventable infection to 54 highly vulnerable residents whose health conditions were already compromised.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 31's Admission Record (contains demographic and medical information), it indicated Resident 31 was admitted to the facility with the diagnoses of cardiomegaly (enlarged heart), type 2 diabetes mellitus with diabetic neuropathy (elevated blood sugars with nerve damage), and chronic mastoiditis, right ear (infection of the bone located behind the ear).</li> </ol> <p>During a review of Resident 31's physician order, dated May 30, 2024, it indicated Enhanced Barrier Precaution when performing high-contact resident care activities related to resident with wound.</p> <p>During an observation on April 2, 2025, at 9:00 AM, there was a sign posted by the door of Resident 31's room. The sign indicated Resident 31 was on EBP. CNA 1 was providing care to Resident 31 without wearing a protective gown.</p> <p>During an interview on April 2, 2025, at 9:09 AM, with CNA 1, CNA 1 stated she did not wear a gown because Resident 31 was not on EBP.</p> <p>During a concurrent interview and record review, on April 2, 2025, at 9:12 AM, with Licensed Vocational Nurse (LVN 1), LVN 1 reviewed Resident 31's medical records and stated he has a physician's order for EBP.</p> <p>During an interview on April 2, 2025, at 9:14 AM, with the Infection Preventionist Nurse (IPN), the IPN stated Resident 31 was on EBP and CNA 1 should have worn a gown while providing care for Resident 31.</p> <p>During an interview on April 2, 2025, at 9:16 AM, with CNA 1, CNA 1 stated she was unaware Resident 31 remained on EBP. CNA 1 further stated she should have worn a gown.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review, on April 3, 2025, at 9:23 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&amp;P) titled, Enhanced Barrier Precautions, dated revised March 2024 was reviewed. The P&amp;P indicated, Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents . 2. EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply . a. gloves and gown are applied prior to performing the high contact resident care activity . The DON stated the P&amp;P was not followed.</p> <p>51815</p> <p>2. During a review of Resident 18's face sheet (contains demographic and medical information), it indicated Resident 18 was admitted on [DATE], with diagnoses of hypoxia (low levels of oxygen in body tissues.) and chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems.)</p> <p>During a review of Resident 18's physician's order, dated December 10, 2024, O2 [oxygen] at 2L [liters] /min [minutes] via nasal cannula (device that delivers extra oxygen through a tube and into your nose) continuously.</p> <p>During a concurrent observation and interview, on April 1, 2025, at 9:35 AM, with the Treatment Nurse (TN), in Resident 18's room, Resident 18 was lying on his bed. An oxygen concentrator (a machine which delivers oxygen) was supplying oxygen through a nasal cannula to Resident 18. The TN inspected the oxygen tubing and noted it was dated 3/23/25 (March 23, 2025). (Nine days ago.) The TN stated their protocol was to change it every Saturdays and as needed. The TN further stated it should have been changed last Saturday.</p> <p>During a concurrent interview and record review on April 3, 2025, at 8:19 AM, with the Director of Nursing (DON) and Administrator (Admin), the DON and Admin reviewed the facility's undated policy and procedure (P&amp;P) titled, Oxygen Therapy, indicated .9. Oxygen tubing is to be replaced once a week. Oxygen masks or nasal prongs are to be replaced once a week. The Admin and DON agreed the policy was not followed.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>51269</p> <p>Based on observation, interview, and record review, the facility failed to ensure two sinks in the kitchen were in safe operating condition when:</p> <ol style="list-style-type: none"> <li>1. The hand washing sink drainpipe (a pipe carrying off dirty water) was not connected and turbid water was leaking on the kitchen floor.</li> <li>2. The dish washing waterline (a hose that carries water into the sink) under the sink was leaking water onto the kitchen floor.</li> </ol> <p>These failures had the potential of causing water damage, mold (a type of fungus that grows in damp, warm places and can look like fuzzy spots or patches) growth, causing staff injury, and contamination compromising the health of the 54 vulnerable residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on April 1, 2025, at 8:00 AM, in the kitchen, with the Dietary Aid, there was a pool of water on the floor next the handwashing sink. The drainpipe of the handwashing sink was not connected, and turbid water was leaking onto the floor.</li> </ol> <p>During an interview on April 3, 2025, at 10:32 AM, with the Registered Dietician (RD), the RD stated the sink should not be leaking. The RD further stated any leakage of water should be reported right away to maintenance.</p> <p>During a review of the facility's policy and procedures (P&amp;P) titled Sanitation, dated 2023, it indicated .all equipment shall be maintained as necessary and kept in working order .</p> <p>During a review of the FDA Federal Food Code, dated 2022, 5-205.11 indicated, (A) A handwashing sink shall be maintained so that it is accessible at all times for employee use. Facilities must be maintained in a condition that promotes handwashing and restricted for that use. Convenient accessibility of a handwashing facility encourages timely handwashing which provides a break in the chain of contamination from the hands of food employees to food or food-contact surfaces. Sinks used for food preparation and ware washing can become sources of contamination if used as handwashing facilities by employees returning from the toilet or from duties which have contaminated their hands</p> <ol style="list-style-type: none"> <li>2. During an observation on April 1, 2025, at 8:06 AM, in the kitchen, with the Dietary Aid, a waterline under the dish washing machine was leaking onto the floor, making a puddle of water.</li> </ol> <p>During an interview on April 1, 2025, at 8:08 AM, with the Maintenance Employee (ME), the ME stated the waterline seal probably needs to be changed to stop the leak.</p> <p>During an interview on April 3, 2025, at 10:33 AM, with the RD, the RD stated part of his responsibilities consisted of doing a kitchen inspection. The RD further stated the waterline should not be leaking, and it should definitely be fixed.</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedures (P&amp;P) titled Sanitation, dated 2023, it indicated .all equipment shall be maintained as necessary and kept in working order .</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46917</p> <p>Based on observation, interview, and record review, the facility failed to ensure ten rooms (Rooms 4, 5, 7, 8, 10, 11, 12, 14, 16 and 18) measured at least 80 square feet per resident.</p> <p>This failure had the potential for the residents housed in Rooms 4, 5, 7, 8, 10, 11, 12, 14, 16, and 18 to not have the ability to move about freely if the square footage limited their personal space.</p> <p>Findings:</p> <p>During a concurrent interview and record review, with the Administrator (Admin), on April 2, 2025, at 2:30 PM, the Admin reviewed the Entrance Conference Checklist and stated the facility had room waivers for Rooms 4, 5, 7, 8, 10, 11, 12, 14, 16, and 18 for less than 80 square feet.</p> <p>During an environmental tour with the Maintenance Supervisor (MS) and the Admin, on April 3, 2025, at 3:35 PM, Rooms 4, 5, 7, 8, 10, 11, 12, 14, 16, and 18 were inspected and the residents' rooms and their measurements of livable space were noted as follows:</p> <ol style="list-style-type: none"> <li>1. room [ROOM NUMBER] (three beds) measured: 237.3 sq. ft. [square feet] (79.1 sq. ft. per resident)</li> <li>2. room [ROOM NUMBER] (three beds) measured: 234.6 sq. ft. [square feet] (78.2 sq. ft. per resident)</li> <li>3. room [ROOM NUMBER] (three beds) measured: 232.8 sq. ft. [square feet] (77.6 sq. ft. per resident)</li> <li>4. room [ROOM NUMBER] (three beds) measured: 233.7 sq. ft. [square feet] (77.9 sq. ft. per resident)</li> <li>5. room [ROOM NUMBER] (three beds) measured: 231.9 sq. ft. [square feet] (77.3 sq. ft. per resident)</li> <li>6. room [ROOM NUMBER] (three beds) measured: 233.7 sq. ft. [square feet] (77.9 sq. ft. per resident)</li> <li>7. room [ROOM NUMBER] (three beds) measured: 232.8 sq. ft. [square feet] (77.6 sq. ft. per resident)</li> <li>8. room [ROOM NUMBER] (three beds) measured: 232.8 sq. ft. [square feet] (77.6 sq. ft. per resident)</li> <li>9. room [ROOM NUMBER] (three beds) measured: 231.0 sq. ft. [square feet] (77 sq. ft. per resident)</li> </ol> <p>(continued on next page)</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>10. room [ROOM NUMBER] (four beds) measured: 308.6 sq. ft. [square feet] (77.1 sq. ft. per resident)</p> <p>During a follow up interview with the Admin, on April 3, 2025, at 3:50 PM, the Admin confirmed the measurements of the ten resident rooms, Rooms 4, 5, 7, 8, 10, 11, 12, 14, 16, and 18, did not meet the 80 square feet per resident.</p> <p>During the survey, the residents occupying Rooms 4, 5, 7, 8, 10, 11, 12, 14, 16, and 18 were interviewed and had no complaints with regards to the size and the space of their rooms. The rooms were not crowded and did not impose any safety hazards to the residents that occupied the rooms.</p> <p>The survey team recommends the approval of the room waiver request for the rooms listed in this deficiency.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>51269</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest (insect or animal such as rodents that can spread disease) control program when in the kitchen, a closet, used to store paper goods (paper cups, paper plates, napkins, etc.), had missing drywall. The hole caused by the missing drywall was covered by a metal mesh wire (a net like material that has holes) cover.</p> <p>This failure had the potential of making an entry for pests and causing food contamination for 54 medically compromised residents who receive food from the kitchen.</p> <p>Findings:</p> <p>During an observation on April 1, 2025, at 8:03 AM, in the kitchen's storage area, a closet, used to store paper goods, had a hole in the wall. Upon further inspection, it was noted that the hole was from a missing drywall. The hole was covered with a metal wire mesh. The openings between the metal mesh wire were about 1/2 inch wide.</p> <p>During an interview on April 3, 2025, at 10:38 AM, with the Registered Dietician (RD), the RD stated the expectation was for all walls to be intact. The RD acknowledged it was possible for pests to get through the metal wire mesh.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Sanitation dated 2023, it indicated .all utensils, counter, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas .</p> <p>During a review of the FDA Federal Food Code, dated 2022, 4-202.16, it indicated Nonfood-Contact Surfaces shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance. In addition, Hard-to-clean areas could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms. Well-designed equipment enhances the ability to keep nonfood-contact surfaces clean.</p>		