STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055799	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyard Care Center	1090 East Dinuba Avenue Reedley, CA 93654

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48739 Based on interview and record review, the facility failed to report an unwitnessed fall with injury to the California Department of Public Health within the required time frame for one of three sampled residents (Resident 13) when Resident 13 fell from her wheelchair on 1/8/25, hit her head and was unconscious which led Resident 13 being transferred to the General Acute Care Hospital for further evaluation. This failure resulted in Resident 13's fall not investigated timely within the required time frame and had the potential to result in Resident 13's safety needs not met. Findings: During an observation on 2/18/25 at 10:30 a.m. in Resident 13's room, Resident 13 was observed dressed asleep in bed, fall mat observed on left side. During a review of Resident 13's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/24/25, the AR indicated Resident 1 was admitted to the facility from the acute care hospital on 10/19/20 with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and history of falling. During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/9/24, the MDS section C indicated Resident 13 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 99 which indicated Resident 13 was unable to complete the interview. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 2/21/25 at 3:24 p.m. with the Infection Preventionist (IP), Resident 13's Progress Note, dated 1/9/25 was reviewed. The Progress Note indicated, . Interdisciplinary Team (IDT) review of : Witnessed fall . LN (Licensed Nurse) witnessed resident lean forward and fall out of her wheelchair (w/c) in front of nurse's station and hit her head . per the LN the resident was unresponsive and not able to respond to her Name or pain . Emergency Medical Service (EMS) was called . Director of Nursing (DON) notified by phone . The IP stated if a resident fell , and needed to be sent to the hospital, the nurse would have completed an investigation packet and would have filled out forms for notifications to Responsible Party (RP), physician, DON and Administrator (ADM). The IP stated there was not a form in the packet to notify the State or Authorities. The DON and ADM would have determined if the fall needed to be reported to the State office. During a concurrent interview and record review on 2/21/25 at 5:05 p.m. with the DON, Resident 13's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 1/8/25 was reviewed. The SBAR indicated Resident 13 had a post fall assessment with abnormal neuro (relating to the nervous system) checks and unable to answer questions. The DON stated the facility would have reported incidences to the State Office if a resident fell with a major injury, or closed head injuries with altered consciousness. The DON stated Resident 13 had a loss of consciousness which was a reportable incident. During an interview on 2/24/25 at 9:50 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was washing her hands with her back to the resident, when she heard a loud noise. LVN 1 stated Resident 13 was observed on the floor, lying on her right side. LVN 1 stated Resident 13 had hit her head and was unconscious. LVN 1 stated she performed a sternal rub (a method of applying pain by rubbing the center of the chest with the knuckles of closed fist to determine if a person is unresponsive), to Resident 13 and Resident 13 was non-responsive. LVN 1 stated she called EMS and continued performing sternal rub on Resident 13. LVN 1 stated Resident 13 opened her eyes when EMS arrived. LVN 1 stated she faxed the transfer notice to the ombudsman. LVN 1 stated Resident 13's fall happened after breakfast in the morning, and the DON and ADM were present. During an interview on 2/24/25 at 10:31 a.m. with the ADM, the ADM stated after Resident 13's fall was brought to her attention, she reviewed Resident 13's fall incident and submitted a late report to the State office, as the report was not submitted at the time of Resident 13's fall. During a review of the facility policy and procedure (P&P) titled, Unusual Occurrence Reporting, dated 12/2007, indicated, . as required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors . our facility will report the following events to appropriate agencies: . falls with major injury (e.g., .closed head injuries with altered consciousness .) . unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations . a written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency . within forty-eight (48) hours of reporting the event .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of 10 sampled residents (Resident 25) when Resident 25 did not have a care plan for behavior monitoring while receiving an anti-psychotic (a medication used to treat a collection of symptoms that affect your ability to tell what's real and what is not) medication. This failure had the potential to result in Resident 25's prescribed anti-psychotic medication not having measurable objectives in place to meet Resident 25's mental and psychosocial needs. Findings: During a concurrent observation and interview on 2/18/25 at 10:47 a.m. with Resident 25 in Resident 25's room, Resident 25 was observed dressed, laying in bed, listening to music on her phone. Resident 25 stated she was doing good, then stated she did not want to answer questions. Resident 25 stated she did not know how long she had been at the facility, and she was unable to walk. During a review of Resident 25's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 25 was admitted to the facility from the acute care hospital on 9/14/22 with diagnoses of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/19/24, the MDS section C indicated Resident 25 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 25 was moderately impaired. During an interview on 2/20/25 at 3:12 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNAs would have documented if a resident had behaviors and would have informed the Charge Nurse. CNA 1 stated there was a behavior monitoring questionnaire for different types of behaviors, such as excessive picking at wounds or aggressive behavior that the CNAs completed when the resident had behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/24/25 at 9:54 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 25's Care Plan, undated was reviewed. Resident 25's care plan did not have a behavior monitoring. LVN 1 stated there should have been a care plan for behavior monitoring for anti-psychotic medication for Resident 25. LVN 1 stated a care plan for behavior monitoring wound have ensured Resident 25 received the best care and minimal side effects from the use of the anti-psychotic medication. LVN 1 stated staff would have monitored Resident 25 to verify if the anti-psychotic medication was working for Resident 25 or if it was not working. During an interview on 2/24/25 at 2:30 p.m. with the Pharmacy Consultant (PC), the PC stated her expectations were to have resident behaviors monitored if the resident was taking an anti-psychotic or psychotropic (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medication. The PC stated monitoring resident behaviors helped her to know if the medication was working. The PC stated monitoring resident behaviors was proof the psychiatrist looked at for a reason to increase the medication, or if no behavior maybe a lower dose would be required. The PC stated she reviewed resident monitoring in the facility's electronic chart in the behavior section, not in the Medication Administration Record (MAR). The PC stated the residents should have had a care plan for behavior monitoring if on an antipsychotic or psychotropic medication. During an interview on 2/24/25 at 4:47 p.m. with the Administrator (ADM), the ADM stated every resident should have an individualized care plan. The ADM stated individualized care plans were important since every resident was different and required different care. The ADM stated the individualized care plan indicated what care was needed for each resident. During a review of the facility's policy and procedure (P&P) titled, Person Centered Care Planning, dated 9/27/24, indicated, . the care planning process will include an assessment of the resident's strengths and needs . During a review of the facility's P&P titled, Behavior Management, undated, indicated, . to assure that each resident receives an appropriate assessment of their behavioral symptoms with appropriate interventions prior to starting psychotherapeutic medications as well as after starting psychotherapeutic medications . the attending physician is to assess and document the behavior or manifestation of disorder thought process that is to be treated with the medication . the resident's care plan is to be updated with the behavior . being treated . as well as data to be collected in order to determine effectiveness of the medication . During a review of the facility's P&P titled, [NAME] Care Group, dated 9/27/24, indicated, . residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition . demonstrated by monitoring and documentation of the resident's response to the medication(s) . the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis in accordance with nurse assessments and medication monitoring .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48739 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for one of eight sampled residents (Resident 3) when Resident 3 was receiving oxygen at 2.5 Liters Per Minute (L/min - a unit of measurement for oxygen flow rate) instead of the physician prescribed 3 L/min. This failure placed Resident 3's respiratory needs to go unmet and increased her risk to experience episodes of shortness of breath, fatigue and respiratory distress. Findings: During a concurrent observation and interview on 2/18/25 at 10:13 a.m. with Resident 3 in Resident 3's room, Resident 3's oxygen was at 2.5 L/min. Resident 3 stated she had been at the facility for two to three years. During a review of Resident 3's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/24/25, the AR indicated Resident 3 was admitted to the facility from the acute care hospital on 5/25/22 with diagnoses of Congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), morbid obesity (a serious health condition that results from an abnormally high body mass) due to excess calories, shortness of breath (SOB), end stage renal disease (ESRD - a condition where the kidneys can no longer function on their own and dialysis [a process of removing excess water, and waste products from the blood] or kidney transplant is required to survive), chronic gout (repeated episodes of pain and inflammation of a joint caused by the buildup of uric acid [a waste product in the body]), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (feeling of sadness and loss of interest). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/30/24, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 3 was cognitively intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview and record review on 2/20/25 at 5:48 p.m. with Licensed Vocational Nurse (LVN) 1 in resident 3's room, LVN 1 stated Resident 3's oxygen was at 2.5 L/min. LVN 1 reviewed Resident 3's Order Summary Report, dated 2/24/25 which indicated, . Oxygen Therapy Continuous - 3 Liters/Per Minute Via Nasal Cannula. Every shift for (SOB related: ESRD) . order date . 7/26/23 . LVN 1 stated Resident 3's oxygen rate should have been set to 3L/min. LVN 1 stated Resident 3 could experience shortness of breath and not get enough oxygen. LVN 1 stated Resident 3 could die from being deprived of oxygen. LVN 1 stated every LVN was responsible for checking resident's oxygen rate settings. LVN 1 stated it was important to follow physician orders to prevent errors that could lead to resident complications and make residents' conditions worse. During an interview on 2/21/25 at 10:11 a.m. with the Director of Nursing (DON), the DON stated the Licensed Nurses should have followed the physician's order for setting the resident's oxygen rate. The DON stated it was important to set the oxygen at the correct liter flow rate to ensure the resident was getting the proper dose of oxygen. The DON stated if the resident's oxygen was not at the correct rate, the resident could have had a low saturation reading of oxygen in the blood (de-sat) or had a change in condition. The DON stated the resident could have had respiratory issues and potentially had a change in their level of conscious (awareness of one's surroundings). The DON stated the Licensed Nurses were responsible for residents' oxygen to be at the correct setting. The DON stated the resident's oxygen setting should have been checked at least once per shift and as needed. During a review of the facility policy and procedure (P&P) titled, Oxygen Administration, dated 10/2010, indicated, .The purpose of this procedure is to provide guidelines for safe oxygen administration . verify that there is a physician's order for this procedure. Review the physician's orders . start the flow of oxygen . adjust the oxygen delivery device so it is comfortable for the resident and the proper flow of oxygen is being administered .

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51593 Based on interview and record review, the facility failed to implement an effective discharge planning process for one of four sample residents (Resident 60) when Representative (RP) 2 was not involved and notified of Resident 60 ' s discharge from the facility on 12/22/24. This failure resulted in Resident 60 being discharged without RP 2 ' s knowledge or consent and placed Resident 2 ' s safety at risk. Findings: During a review of Resident 60's Admission Record (AR), dated 2/24/25, the AR indicated, Resident 60 was admitted to the facility on [DATE] with diagnoses which included stable burst fracture (an injury in which the vertebra, the primary bone of the spine, breaks in multiple directions) of the lumbar (the lower part of the back) vertebra, fracture with routine healing, and unspecified dementia (the loss of the ability to think, remember, and reason to levels that affect daily life and activities). During a review of Resident 60's Progress Note dated 12/20/24, the Progress Note indicated, .past medical history of .dementia . The Progress Note indicated, Family unable to take care of patient and wanting placement .patient becomes agitated and uncooperative at times .patient was discharged to .nursing facility for further rehab (rehabilitation-the the process of returning to a healthy or good way of life) management on 12/19/24 . During a review of Resident 60's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 12/22/24, the MDS section C indicated, Resident 60 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 5 (a score of 0 - 7 indicated severe impairment, 8 - 12 indicated moderate impairment, and 13 - 15 indicated minimal to no impairment). During a review of Resident 60's Against Medical Advice (AMA- a decision made by the patient to leave the healthcare facility before the treating physician recommends discharge) form dated 12/22/24, the AMA form indicated, Other Family (OF) 1 signed as the representative. Resident 60's admission record dated 2/24/25 was reviewed. The admission record indicated RP 2 was Resident 60's designated representative. During a telephone interview with RP 2 with the assistance of a Spanish interpreter on 2/24/25 at 9:18 a.m., RP 2 stated, They took her out of there without my consent .they didn't let me know. RP 2 indicated Resident 60 left with OF 1 and no one from the facility contacted her. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/24/25 at 9:36 a.m. with the Social Services Director (SSD), Resident 60's AR dated 2/24/25 was reviewed. The AR indicated, RP 2 was Resident 60's designated representative. The SSD stated, .daughter is the representative, RP 2. Resident 60's Progress Note dated 12/22/24 was reviewed. The Progress Note indicated, .resident's family signed AMA . OF 1 . signed the paperwork . The SSD stated, It is not documented anywhere that I spoke with the representative. The SSD stated, It should have been documented. The SSD stated, It is important to call the representative because they are responsible for the resident. During a concurrent interview and record review on 2/24/25 at 10:28 a.m. with the Director of Nursing (DON), Resident 60's AR dated 2/24/25 was reviewed. The AR indicated, RP 2 was Resident 60's designated representative. The DON stated, RP 2 is listed as the representative. Resident 60's Progress Note dated 12/22/24 was reviewed. The Progress Note indicated, .[Resident 60's family] signed AMA .OF 1 .signed the paperwork . The DON stated, This documentation is not sufficient. The DON stated, It should say the representative was made aware. The DON stated, If a resident wants to go AMA and another person comes to sign out the resident, you still have to go through the representative. During a review of the facility's policy and procedure (P&P) titled, Discharging a Resident without a Physician's Approval, dated October 2012, the P&P indicated, If the resident .insists upon being discharged without the approval of the attending physician, the resident and/or representative (sponsor) must sign a release of responsibility form .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one of three sampled residents (Resident 21) when Resident 21 had an order of prn (as needed) oxygen and received oxygen continuously due to episodes of increasing shortness of breath and Licensed Nurses (LNs) did not notify his Attending Physician (AP) of the change of condition. This failure placed Resident 21's respiratory needs to go unmet and increased his risk to experience frequent episodes of shortness of breath. Findings: During an observation and interview on 2/18/25, at 11:12 a.m. in Resident 21's room, Resident 21 was using oxygen via nasal cannula (N/C- a medical device that provides supplemental oxygen therapy to people who have lower oxygen levels). Resident 21 stated he was using the oxygen continuously and was short of breath without it. During an interview on 2/20/25 at 3:23 p.m. with License Vocational Nurse (LVN) 1, LVN 1 stated Resident 21 was using oxygen continuously for more than one month. LVN 1 stated she should have notified Resident 21's AP of the continuous use of oxygen. LVN 1 stated, continuous use of oxygen was considered a change in condition. LVN 1 stated, Resident's 21 care plan should have been updated to reflect the new baseline (starting point used for comparisons). LVN 1 stated the care plan and physician order should have been updated to state Resident 21 was using the oxygen continuously. During an interview on 2/21/25 at 10:12 a.m. with the Director of Nursing (DON), the DON stated Licensed Nurses should have notified the AP when Resident 21 was using oxygen continuously for more than three days. The DON stated the License Nurse should have contacted the AP to get an order for continuous oxygen for Resident 21. The DON stated it was a change in condition when Resident 21 required the use of oxygen continuously and not as needed. The DON stated the care plan should have been updated to reflect the continuous use of oxygen. The DON stated the Licensed Nurses were responsible to notify the AP regarding the change in condition. The DON stated the oxygen order should have been changed to give Resident 21 proper care. During a review of Resident 21's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/21/25, the AR indicated Resident 21 was admitted on [DATE], with diagnoses of shortness of breath (difficulty breathing), acute respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately exchange oxygen, leading to a dangerously low level of oxygen in the blood (hypoxia), heart failure (a serious condition that occurs when the heart can't pump enough blood and oxygen to the body)), hypertension (high blood pressure), obstructive sleep apnea (a sleep disorder characterized by recurrent episodes of complete or partial blockage of the upper airway during sleep, leading to reduced or absent breathing) and muscle weakness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/25/24 the MDS section C indicated Resident 21 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 21 was cognition intact. During a review of the facility's policy and procedure (P&P), titled, Change in a Resident's Condition or Status, dated revised 11/15, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician .The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: e. A need to alter the resident's medical treatment significantly .A Significant change of condition is a decline or improvement in the resident's status that. revision to the care plan .

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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. 48739 Based on observation, interview, and record review, the facility failed to ensure effective pain management was provided consistent with professional standards of practice and comprehensive person-centered care plan for one of 10 sampled residents (Resident 3) when Licensed Nurses did not address Resident 3's frequent complaints of pain to her right knee. This failure resulted in Resident 3's frequent complaints of pain going unrelieved and limited her ability to participate in physical therapy on multiple occasions meant to support her physical well-being. Findings: During a concurrent observation and interview on 2/18/25 at 10:13 a.m. with Resident 3 in Resident 3's room, Resident 3 was observed laying in bed watching the television (TV) wearing a gown over her shirt and wearing oxygen tubing via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 3 stated she had been at the facility for two to three years because she could not walk. Resident 3 stated she had been having knee pain for four days. Observed a surgical scar over Resident 3's right knee. Resident 3 stated she took a pain medication that helped with her knee pain. During a review of Resident 3's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/24/25, the AR indicated Resident 3 was admitted to the facility from the acute care hospital on 5/25/22 with diagnoses of Congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), Type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), morbid obesity (a serious health condition that results from an abnormally high body mass) due to excess calories, shortness of breath (SOB), end stage renal disease (ESRD - a condition where the kidneys can no longer function on their own and dialysis [a process of removing excess water, and waste products from the blood] or kidney transplant is required to survive), chronic gout (repeated episodes of pain and inflammation of a joint caused by the buildup of uric acid [a waste product in the body]), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (feeling of sadness and loss of interest). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/30/24, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 3 was cognitively intact. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Care Plan, Undated, the Care Plan indicated, . Goal . will maintain and/or improve the current functional status through next review . date initiated: 9/8/24 . interventions . report if resident declines to participate in program to Interdisciplinary Team (IDT) as applicable . date initiated: 09/08/24 . notify nurse and/or physician of complications - pain, discomfort, significant change in range of motion, ambulation . Focus . [Resident 3] has pain to her right knee . date initiated 02/13/25 . Goal . no worsening through review date . Interventions/Tasks . monitor for changes and report to MD . monitor and report changes in Range Of Motion (ROM) ability . therapy to eval (evaluate) . x-ray . During a concurrent observation and interview on 2/20/25 at 12:45 p.m. with Resident 3 in Resident 3's room, Resident 3 was observed lying in bed dressed in a gown over her shirt. Resident 3 stated she still had right knee pain. Resident 3 stated she was not getting physical therapy due to her pain. During an interview on 2/20/25 at 3:31 p.m. with CNA 1, CNA 1 stated if a resident complained of pain, the CNAs should have informed the Charge Nurse. CNA 1 stated Resident 3 had not been getting physical therapy (PT) due to right knee pain. CNA 1 stated she was not sure what was happening with Resident 3's therapy. During a concurrent interview and record review on 2/20/25 at 5:48 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 3's Progress Notes, dated 2/13/25 and 2/14/25 were reviewed. The Progress Notes indicated, . 09:51 . resident complained of (c/o) right knee pain 3/10 . resident medicated [brand name] prn with effective outcome . resident requesting x ray . received new orders for x ray to right knee and therapy to eval . author: (LVN 2) 16:17 . LATE ENTRY . Resident refuses Restorative Nursing Assistant (RNA) due to pain in left knee . author: (LVN 2) . Resident 3's Progress Note, dated 2/14/25 was reviewed. The Progress Note indicated, right knee x ray results reviewed . no acute concerns . continue to monitor . LVN 1 stated pain medication [brand name] had been helping Resident 3's pain. LVN 1 stated if Resident 3 was not getting therapy due to pain, the Restorative Nursing Assistant (RNA) should have informed the LVN she was refusing therapy. LVN 1 stated she had not been notified Resident 3 had been refusing therapy. During an interview on 2/21/25 at 10:45 a.m. with the RNA, the RNA stated Resident 3 had been refusing therapy last week and yesterday. The RNA stated Resident 3 would get therapy three times a week on her non-dialysis days. The RNA stated Resident 3 was refusing therapy by pointing to her knee and saying no. The RNA stated Resident 3 had refused two times since last week. The RNA stated he had already reported Resident 3's refusal for therapy to the Licensed Nurse. The RNA stated he was not aware of a new therapy evaluation request. During an interview on 2/21/25 at 4:41 p.m. with the Infection Preventionist Nurse (IP), the IP stated the Licensed Nurse should have been notified of a resident refusing therapy due to pain every time the resident refused. The IP stated the physician should have been notified after the third refusal of therapy due to pain, or if there were consecutive refusals due to pain. The IP stated if a resident was having increased pain, it would be considered a change of condition, and a change of condition should have been done. (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 2/21/25 at 5:05 p.m. with the Director of Nursing (DON), the DON stated if a resident was refusing therapy due to pain, the Licensed Nurse should have notified the physician to get an order to pre-medicate the resident prior to therapy. The DON stated the Licensed Nurse should have given the resident pain medication prior to therapy to prevent refusal of therapy. The DON stated if a resident was refusing therapy due to pain, the Licensed Nurse should have notified the physician right away and not have waited for further refusals. During an interview on 2/24/25 at 4:47 p.m. with the Administrator (ADM), the ADM stated resident change of conditions were important for updating resident status. The ADM stated everything needed to be captured. The ADM stated it was hard to say what could have happened if a resident's status was not updated. The ADM stated resident care plans needed to be revised and individualized, if the care plan was not updated it was not considered individualized care for the resident. The ADM stated Individualized care plans were important because every resident was different, with different things going on. The ADM stated the care plan indicated the care for each resident and each resident needed to have a care plan that reflected their individualized care. During a revie of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated 10/2015, indicated, . the purposes of this procedure are to promote residents' quality of life, to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain . pain management is a multidisciplinary care process that includes . assessing the potential for pain . effectively recognizing the presence of pain . developing and implementing approaches to pain management . assess or observe the resident's pain and consequences of pain at each shift to identify or ascertain acute pain or significant changes in levels of chronic pain . observe the resident for . signs of pain . resisting care . review the medication record . review the resident's treatment record . identify any situations or interventions where an increase in the resident's pain may be anticipated, for example . ambulation or physical therapy . During a review of the facility P&P titled, Restorative Nursing Documentation, dated 9/2/2022, indicated, . treatment provided as part of a restorative nursing program will be documented on a daily basis by the restorative aide . if the treatment is refused or withheld, a narrative note will be written explaining why . the licensed nurse will document an evaluation . the resident's plan of care will be updated at routine intervals and as indicated . During a review of the facility's job description document titled, Restorative Nursing Assistant, dated 11/1/2022, indicated, . honor the resident's refusal of treatment request. Report such requests to your supervisor .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51223 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored and labeled in accordance with current accepted professional principles when: 1.15 of 383 sampled medication blister packs (a form of tamper-proof packaging where an individual pushes individually sealed tablets through the foil to take the medication) were without a visible expiration date. 2. A liquid narcotic medication was found expired in medication cart one for one (Resident 16) of 56 sampled residents. These failures had the potential for medications without a visible expiration date to be administered to residents which can lead to medication errors and placed residents' safety at risk. 3.An unlocked medication cart was found on the back patio which contained 10 unidentified loose pills. This failure had the potential for unauthorized access of medications by residents, staff and visitors which increased the risk of medication errors. Findings: 1. During a concurrent observation and interview on 2/19/25, at 3:38 p.m., with the Director of Nursing (DON) at medication cart 1, seven medication blister pack labels were observed without an expiration date. The DON stated, Medications should have an expiration label. The DON stated, the medication needs to be reordered. The DON stated, If a medication is not labeled with an expiration date, it could be expired. During a concurrent observation an interview on 2/19/25 at 4:10 p.m., with Licensed Vocational Nurse (LVN) 1 at medication cart 2, eight medication blister pack labels were observed without an expiration date. LVN 1 stated, The expiration date should show on the label. During an interview on 2/20/25 at 11:41 a.m. with LVN 4, LVN 4 stated, We .check something on the medication carts every day, including the resident medication blister packs to see what .is expired. During a telephone interview on 2/24/25 at 2:08 p.m. with the Pharmacy Consultant (PC), the PC stated, she checks the medication carts. The PC stated, the medication labels should have a visible expiration date. The PC stated, If not labeled with an expiration date, the staff should contact the pharmacy to get a new label or a new medication. The PC stated, If a medication is given to a resident without an expiration date, you worry about the effectiveness of the medication. The PC stated, If a resident takes a medication that is not effective, then the dosage may need to be increased when it should not. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 2/24/25 at 2:35 p.m. with PC 2, PC 2 stated, We had an issue with our printer . and the labels .got off the lines a little bit. PC 2 stated, The expiration date should always be on the medications. During a review of the Licensed Vocational Nurse Job Description dated 11/16, the LVN Job Description indicated, Implement and maintain established policies and procedures . During a review of the Director of Nursing Job Description dated 11/16, DON Job Description indicated, Manage the delivery, central storage, and disposal of medication. During a review of the [Name of Pharmacy] LTC Pharmacy: Pharmaceutical Services Agreement (undated), the Pharmaceutical Services Agreement indicated, The facility will be responsible for the implementation of the Pharmacy's policies and procedures upon the commencement of this agreement. During a review of the facility's Policy and Procedure titled, [Name of Pharmacy] LTC Pharmacy: Medication Ordering and Receiving from Pharmacy, dated January 2018, indicated, B. Each prescription medication label includes: 8) Beyond use (or expiration) date of medication. During a review of the facility's Policy and Procedure titled, [Name of Pharmacy] LTC Pharmacy: Consultant Pharmacist Services Provider Requirements, dated 1/22, indicated, Specific activities that the consultant pharmacist performs included, but it not limited to .Checking the . medication carts (at least quarterly), for proper storage and labeling of medications . During a review of the facility's Policy and Procedure titled, [Name of Pharmacy] LTC Pharmacy: Provider Pharmacy Requirements, dated January 2022, indicated, Labeling all medications dispensed in accordance with the medication labeling policy .and with state and federal requirements. During a review of the facility's Policy and Procedure titled, Medication Storage, dated 9/2/22, indicated, The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for .missing labels. 2. During an observation on 2/19/25 at 4:03 p.m. at the nursing station, medication cart one had Resident 16's liquid narcotic with an expiration date of 8/30/24 stored in the locked drawer. During an interview on 2/19/25 at 4:03 p.m. with LVN 1 at the nurses' station, LVN 1 stated the liquid narcotic was for Resident 16 who was on hospice. LVN 1 stated when medication is expired, the Licensed Nurse will review with the DON who will log the expired narcotic and hold it in a double locked area until pharmacy comes to review, sign and dispose the expired medication. During a record review of Resident 16's Admission Record (AR), dated 2/21/25, the AR indicated, Resident 16 was admitted to the facility on [DATE] for hospice (care focused on comfort and quality of life for a person approaching the end of life) care with diagnoses: Alzheimer's (brain disorder causing memory loss and thinking problems) Disease, Dementia, Schizophrenia, Major Depressive Disorder (a serious medical illness where the feelings of sadness does not go away and affect everyday life) and anxiety (feelings of worry, tension and stress). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 16's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/21/25, the MDS section C indicated, Resident 16 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 99, which indicated Resident 16 was unable to complete the interview. During an interview on 2/21/25 at 3:34 p.m. with the DON, the DON stated the Licensed Nurse was responsible to check the expiration dates on all medication. The DON stated the Pharmacist Consultants (PC) review the medication carts for expired medications and the pharmacist and the DON waste narcotic monthly. During a telephone interview on 2/24/25 at 2:08 p.m. with the PC, the PC stated the pharmacist was responsible to check on staff and ensure medications are safe and in order, destroy narcotics and spot check the medication cart for discontinued, defective, outdated or deteriorated medications, illegible or missing labels. The PC stated the pharmacist is onsite once a month to destroy narcotics and expired or discontinued medication. The PC stated there would be potential risk that expired medication may not work as well as the potency may be affected which could lead to a risk of increased dosing when the medication should not be increased. During a telephone interview on 2/24/25 at 2:35 with the PC 2, the PC 2 stated the contracted pharmacy would deliver ordered medication and provided pharmacy consultant onsite monthly to dispose of medication, conduct facility audits such as medication storage inspection. The PC2 stated the pharmacy consults was supposed to review the medication carts, medication storage room to pull expired medications. The PC 2 stated there would be little risk if a resident was given an expired medication as the medication does not usually lose potency. During a review of Resident 16's Order Summary Report, dated 2/21/25, Morphine Sulfate (Concentrate) Oral Solution 20 milligrams (a unit of mass that is equal to 0.001 grams)/milliliter (ml-one thousandth of a liter) give 0.25 ml by mouth every six hours as needed for pain/shortness of breath under the tongue was ordered 8/22/23. During a review of Job Description Position Titled: Director of Nursing, dated 11/1/16, the Essential Duties indicated .manage the delivery, central storage and disposal of medications . During a review of the job description Job Title: Consultant Pharmacist, not dated, the Position Summary indicated the consultant pharmacist will be responsible for performing drug regimen reviews and nursing unit inspections. The Essential Duties indicated 6. Assist client facilities in developing and implementing policies and procedures .9. Perform duties as outline in Star Pharmacy Pharmacist Consultant Standards. During a review of the facility's policy and procedure titled, Administering Medications, dated 2/19, the policy interpretation and implementation indicated 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. During a review of the facility's policy and procedure titled, Medication Storage, dated 9/22/22, the Policy Explanation and Compliance Guidelines indicated 8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated .medications. These medications are destroyed accordance with facility policy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, [Name of Pharmacy] LTC Pharmacy ID1: Storage of Medications, dated 1/22, the policy indicated Expiration Dating (Beyond-use dating) A. Expiration dates (beyond-use date) of dispensed medications shall be determined by the pharmacist at the time of dispensing .12. The expiration/beyond use date on the medication label is check prior to administering . During a review of [Name of Pharmacy] LTC Pharmacy Pharmaceutical Services Agreement, dated 1/12/23, the II Facility Obligations indicated 2.1 Operational. The Facility will be responsible for the implementation of the Pharmacy's policies and procedures upon the commencement of this agreement .2.8 Clinical Monitoring. Facility shall be responsible for the overall clinical monitoring of a patient's drug therapy . 3. During a concurrent observation and interview on 2/18/25 at 3:02 p.m. with the Maintenance Director (MAIND), an unlocked medication cart containing 10 unidentified, loose pills were observed. The MAIND stated, The cart was brought out last night to be pressure washed. The MAIND stated, If an unlocked cart is found outside .with pills in it, all kinds of things could happen. During an interview on 2/18/25 at 3:02 p.m. with the Director of Staff Development (DSD), the DSD stated, Nurses are in charge of cleaning out the carts before they are brought outside. The DSD stated, For anything that was spilled in the cart, it should be emptied. The DSD stated, The pills should have been taken out. The DSD stated, With the pills, we do not know what interactions someone could have if they take them. During an interview on 2/18/25 at 3:35 p.m. with the DON, the DON stated, I don't know what the pills are. The DON stated, It would be hard to tell what they are since they are not in a package. The DON stated, We do not know what medication is there, so there could be a possible overdose or allergic reaction. The DON stated, Before this cart came out, everything should have been properly disposed. During an interview on at with LVN 4, LVN 4 stated, We clean out medication carts once a week. LVN 4 stated, Any loose pills .goes back to the DON. During an interview on 2/21/25 at 3:34 p.m. with the DON, the DON stated, For the Deep Clean Medication Cart Policy, the licensed nurse would be responsible for removing the medications from the cart . During a telephone interview on 2/24/25 at 2:08 p.m. with the PC, the PC stated, .medications in the cart should not be loose. The PC stated, That should be brought to the attention of the DON or pharmacist. The PC stated, They should document if the medications are loose .the pharmacy should be contacted so new medications can be sent. The PC stated, We need to know how the medication is stored for the safety of the resident. The PC stated, We don't want anyone taking the medication because we don't know what side-effects they can have. The PC stated, If we don't know what medication someone has taken, we don't know how to treat them. The PC stated, It could cause serious injury. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 2/24/25 at 2:35 p.m. with the PC 2, the PC 2 stated, It is not acceptable to have a medication cart outside, unlocked, with loose medications in the drawer. The PC 2 stated, The risk is going to be that someone gets a hold of something they should not have. The PC 2 stated, There could be negative side-effects or allergic reaction since they don't know what they're taking. During a review of the Licensed Vocational Nurse Job Description dated 11/16, the LVN Job Description indicated, Implement and maintain established policies and procedures . During a review of the Director of Nursing Job Description dated N 11/16, DON Job Description indicated, Manage the delivery, central storage, and disposal of medication. During a review of the facility's Policy and Procedure titled, Policy and Procedure for Deep Cleaning a Medication Cart (undated), the P&P indicated, Ensure all medications are properly labeled and organized . During a review of the facility's Policy and Procedure titled, Medication Storage dated 9/2/2022, the P&P indicated, All drugs and biologicals will be stored in locked compartments (i.e. medication carts .) .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 49949 Based on observation, interview, and record review, the facility failed to ensure Dietary [NAME] (DC) 1, DC 2 and Maintenance Director (MAIND) had the appropriate competencies to carry out the functions of the food and nutrition services safely and effectively for 50 of 51 residents when: 1. MAIND did not demonstrate or verbalize proper cleaning procedure for the ice machine according to the manufacturer's guideline. This failure had the potential for contaminated ice to be served to residents and placed residents at risk of foodborne illness and infection. 2. DC 1 did not demonstrate or verbalize the proper use of a test strip (paper that measure the concentration of quaternary ammonium compounds [chemicals that kills germs on surfaces]) for the sanitizing bucket (a container used to store and mix a chemical solution that reduces germs on surfaces). This failure had the potential to result for improper disinfection and sanitation of surfaces which could increase the risk of pathogen transmission and foodborne illness among residents. 3. DC 2 did not demonstrate or verbalize recalibration of thermometer according to the facility's policy and procedure (P&P) titled, Thermometer Calibration. This failure had the potential for incorrect temperature reading during food preparation which placed residents at risk of foodborne illness. Findings: 1. During a concurrent observation and interview on 2/18/25 at 3:28 p.m. in the dining room with the MAIND, the MAIND mixed four ounces (oz-unit of measurement) of ice machine sanitizer with four gallons of water and used the solution to clean inside the ice machine. The MAIND stated he sanitized the ice machine monthly. The MAIND stated he emptied, cleaned, and sanitized the components inside the ice machine every three months. The MAIND stated, I took everything out, washed and sanitized it and rise it in hot water. The MAIND stated, We cleaned the parts of the ice machine with four oz. of [Brand name] ice machine sanitizer with four gallons of water. The MAIND stated he soaked the components in in the solution mixed with four oz of sanitizer mixed with four-gallon solution. The MAIND used the solution to wipe the inside of the ice machine. The MAIND stated, I do not take the grate apart; after I wipe it, I let the machine run one cycle. The MAIND stated, I cleaned the back of the ice machine, rise and then put the components back. The MAIND stated, I had no training. I use my training from my previous job to clean the ice machine. I piece it together using personal experiences. The MAIND stated he did not know what the buttons for on the ice machine were for. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/25 at 11:51 a.m. with the Directory of Culinary Services (DCS), the DCS stated the ice machine was cleaned every six months. The DCS stated the ice machine was purchased on 11/6/24. The DCS stated the MAIND did not demonstrate competency in cleaning the ice machine and should have used the right solution mixture to clean it. The DCS stated the ice-machine was used for residents and was a big issue if not cleaned correctly. The DCS stated, It is easy to spread black mold in the ice machine when not cleaned properly. The DCS stated the black mold could have caused cross-contamination and gotten resident sicks. The DCS stated it was the responsibility of the MAIND to learn how to clean the ice machine correctly. The DCS stated the kitchen staff cleaned the outside of the ice-machine and not the inside. The DCS stated the facility should have trained more than one person to clean the ice machine. During an interview on 2/20/25 at 12:38 p.m. with the Registered Dietitian (RD), the RD stated, The person who is servicing [ice-machine] should be competent in knowing what they are doing. The RD stated, It is important to make sure they are removing pathogen and bacterial from the ice. The RD stated, Resident could have gotten foodborne illness and cause death from cross-contamination The RD stated, It might not be safe for now. The RD stated the ice machine should have been spotless. The RD stated the MAIND was not competent in cleaning the ice machine when he did not follow the manufacturer's guidelines. During a review of the facility's policy and procedure (P&P) titled, Cleaning Instructions: Ice Machine and Equipment the P&P indicated, Ice machine and equipment will be kept clean and sanitized, according to the manufacturer's procedure . During a review of the manufacturer's operation instruction titled, [Brand name] Undercounter Ice Machines Installation, Operation and Maintenance Manual dated 8/22, the manufacturer's operation instruction indicated, .While components are soaking, use half descaler and water solution to clean all foodzone surfaces of the ice machine and bin .Mix a solution of sanitizer with warm water. Solution type: sanitizer. Water: 3 gal (gallon-unit of measurement) Mixed with: 2 oz (60 ml (milliliter- a unit used to measure capacity) . 2. During a concurrent observation and interview, on 2/19/25, at 8: 43 a.m. in the kitchen, DC 1 placed a test strip into the red sanitizing bucket. DC 1 took out the test strips and compared the color of the strips to the bottom and stated it was at 400 ppm (parts per million- a unit of measurement used to describe the concentration of a substance in a mixture). DC 1 stated 400 ppm was good. DC 1 stated she was responsible to prepare the sanitizing bucket. DC 1 stated, I put the test strip in the red bucket until it changes color. DC 1 stated, I put the test strip in the bucket for 20 seconds. DC 1 stated the strip color should range between 400-500 ppm. The DC stated she received some training at her job last year from another facility and four days of training from the DCS. DC 1 stated it was important to properly test the sanitizing to ensure the solution was within range. DC 1 stated when the range was not correct, she would repeat it. DC stated the solution in the bucket was used to clean the germs in the kitchen. DC 1 stated residents could get sick from cross contamination. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/25 at 11:46 a.m. with the DCS, the DCS stated, DC 1 should have grabbed the test strip and put into the sanitation solution for 10 seconds and removed the test strip and compare it to the bottle. The DCS stated the acceptable range for the test strips should have been between 150-200 ppm. The DCS stated it was important to ensure the sanitizing solution was within acceptable range to disinfect the kitchen. The DCS stated sanitizing solution below 150 ppm would have not killed the bacterial and potentially spread the bacteria. The DCS stated residents could have gotten foodborne illness. The DCS stated DC 1 should have followed the direction on the test container and did not demonstrate competency in checking the sanitation bucket. During an interview on2/20/25 at12:32 p.m. with the RD, the RD stated, DC 1 should have grabbed a test strip and check for the expiration date before putting it into the sanitizing bucket. The RD stated DC 1 should have counted for 10 seconds before removing the test strip from the sanitizing bucket. The RD stated DC 1 did not demonstrate competency in testing the solution for the sanitizing bucket. The RD stated, Low levels of sanitizing solution concentration would have not sanitized anything. The RD stated, High levels of sanitizing bucket solution could have been a chemical hazard for residents. The RD stated, There can be cross-contamination, food borne illness since we are not following the sanitization procedure. The RD stated, Residents can become sick and potentially die. The RD stated the DCS and RD were responsible to ensure the DC 1 demonstrate competency in checking the sanitizing solution bucket. During a review of the facility's P&P titled, Sanitizing and Disinfectant Solutions dated 2020, the P&P indicated, if a solution must be prepared, guidelines for preparation will be posted or available to staff. The staff member will prepare the solution in accordance with the posted or available instruction and test with a test tap/strip before use . During a review of the manufacture's instruction titled, [Manufacture's name] QT-40 Instructions dated no date the Manufacture's Instruction indicate, Dip paper in quat solution not foam surface, for 10 seconds . 3. During a concurrent observation and interview, on 2/19/25, at 10:35 a.m. with DC 2, DC 2 placed a thermometer into a cup of ice water letting the tip of the thermometer hit the bottom of the cup. DC 2 stated she placed the thermometer in the ice cup water for five minutes and waited until the thermometer reaches a temperature of 32 F (Fahrenheit-unit of measure for temperature). DC 2 stated it was important to make sure the thermometer was calibrated correctly to ensure food was checked at the correct temperature. DC 2 stated thermometer with an incorrect calibration could have resulted in food being in the danger zone and could have gotten residents sick with foodborne illness. DC 2 stated she could not remember when her last training on thermometer recalibration was. During an interview on 2/20/25 at 11:39 a.m. with the DCS, the DCS stated he expected all the dietary cooks to be able to recalibrate the thermometer. The DCS stated it was important to calibrate the thermometer correctly so make sure the food was in the right temperature. The DC stated DC 2 did not demonstrate competency in calibrating the thermometer. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/25 at 12:19 p.m. with the RD, the RD stated she had an in-service with the dietary cooks, and they should have been able to recalibrate the thermometer. The RD stated the tip of the thermometer should have not touch the bottom of the cup. The RD stated, The temperature of the food would not have been accurate, food can be under cook or higher than what it was. The RD stated residents could have gotten foodborne illness which can be deadly especially to the geriatric (older) population. The RD stated, the DSC and RD were responsible and should have made sure DC 2 demonstrate competency to recalibrate the thermometer. During a review of the facility's P&P titled, Thermometer Calibration dated 2020, the P&P indicated, One of the two following procedures shall be used to recalibrate thermometers: Fill a large container (16 oz) with finely crushed ice, add clean tap water to fill the glass, stir well. Immerse thermometer stem a minimum of two inches, touching neither the sides nor the bottom of the glass, and hold for minimum of 30 seconds. Without removing stem from glass, hold and adjust the thermometer head with an appropriate tool and turn head so pointer reads 32 F .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review, the facility failed to ensure the menus for proper portion control were followed for Resident 54 when the roast turkey was not weighed in accordance with the dietary spreadsheet (a spreadsheet that tracks food intake and other dietary information). This failure had the potential for Resident 54 to receive an incorrect amount of food portion which could lead to an unplanned weight gain. Findings: During an observation on 2/19/25 at 11: 40 a.m., during the tray line (food service system where workers assemble meals), Dietary [NAME] (DC) 2 grabbed the roast turkey from the regular portion container and started cutting the meat without weighing it. During an interview on 2/19/25 at 1:00 p.m . with DC 2, DC 2 stated she did not weigh the roast turkey prior to cutting up and serving it. DC 2 stated it was important to weigh the meat to ensure the meat was at 2 oz (ounces-unit of measurement). DC 2 stated Resident 54 could have consumed more than the amount ordered and could have gained weight. DC 2 stated she should have followed the dietary spreadsheet and meal card (print ticket with diet order). During an interview on 2/20/25 at 11:42 a.m. with the Director of Culinary Services (DCS), the DCS stated, DC 2 should have prepared the cooked roast turkey by cutting the meat and weighing the portion prior to putting it into the steam table. The DCS stated Resident 54 could have gained weight when the portion was not weighed out. The DCS stated DC did not follow the dietary spreadsheet and small portion size on the meal card when she grabbed the roast turkey from the regular portion without weighing it. During an interview on 2/20/25 at 12:26 p.m. with the Registered Dietitian (RD), the RD stated She [DC 2] should have used the scale to measure it [roast turkey]. The RD stated, It is important to make sure Resident 54 was getting the correct calories and proteins for his therapeutic diet (a specialized meal plan designed to treat or manage specific medical conditions). The RD stated the therapeutic diet for small portion was not accurate when DC 2 did not weigh the roast turkey. The RD stated Resident 54 could have experience unplanned weight gain since the roast turkey was not followed according to the dietary spreadsheet small portion size and meal card. During a review of Resident 54's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/20/2025, the AR indicated Resident 54 was admitted on [DATE], with diagnoses of type 2 diabetes mellitus (a chronic condition that happens when you have persistently high blood sugar level), atrial flutter (a type of abnormal heart rhythm where the upper chambers of the heart (atria) beat rapidly and regular) hypertension (high blood pressure) and abnormal weight gain. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/8/25 the MDS section C indicated Resident 54 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 54 was cognitively intact. During a review of Resident 54's Meal Card, dated 2/20/25, the meal card indicated, Order Summary: NAS Small Portion diet Chopped Meat Texture, Regular (thin) consistency . During a review of the facility's Diet Spreadsheet (DS) titled, Diet Spreadsheet Menu: [Facility name] Southwest Menu, dated 2024, the DS indicated, [box] Small Portion .[Box] Roast Turkey 2 oz . During a review of the facility's policy and procedures (P&P) titled, Portion Variations dated 2011, the P&P indicated, Information on the meal card and other communication tool is used to guide serving served .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51223 Based on observation, interview, and record review, the facility failed to provide food prepared in a form designated to meet individual needs for one of 10 sampled residents (Resident 311) on a mechanical soft (chopped, ground and pureed food designed for people who have trouble chewing and swallowing) diet was served with a regular diet. This failure placed residents with difficulty chewing or swallowing and, on a physician prescribed mechanical soft diet at risk of choking. Findings: During an observation on 2/18/25 at 11:50 a.m. with Resident 311 in the dining room, Resident 311 was served a plate with chunks of cooked meat in an orange gravy, yellow tinted rice with flecks of green leaves, a whole flour tortilla and a side dish of fresh tomato cut into small pieces. Resident 311 was alert, sitting in a wheelchair with a cloth drape to protect her clothing. Resident 311 had eaten less than 10% of her food. The lunch meal ticket, dated 2/18/25, indicated, Resident 311 was on a mechanical soft diet. During a review of Resident 311's Admission Record (AR), dated 2/21/25, the AR indicated, Resident 311 was admitted to the facility on [DATE] for hospice (care focused on comfort and quality of life for a person approaching the end of life) care with diagnoses: Alzheimer's (brain disorder causing memory loss and thinking problems) Disease, depression (a serious medical illness where the feelings of sadness does not go away and affect everyday life), anxiety (feelings of worry, tension and stress), and Type 2 Diabetes Mellitus (a condition that happens when your blood sugar is too high). During a review of Resident 311's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/21/25, the MDS section C indicated, Resident 311 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3, which indicated Resident 311 was severely cognitively impaired (someone with significant difficulty with thinking, remembering and reasoning abilities). During an interview on 2/21/25 at 10:36 a.m. with the Activities Assistant (AA) in the hallway next to the kitchen, the AA stated she worked as a Certified Nurse Assistant (CNA) for 6 years and recently changed positions to the AA. The AA stated as a CNA, she would compare the resident's meal ticket to what was plated to ensure the meal matched the diet order before delivering the meal to the resident. The AA stated if the CNA noted a resident on a mechanical soft order was served a regular diet, they would alert the Licensed Nurse and return the tray to the kitchen for correction. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/21/25 at 12:14 p.m. in the dining room with the Dietary [NAME] (DC) 3, the 2/18/25 lunch photo for Resident 311 was reviewed. The lunch photo indicated, Resident 311's meal ticket noted mechanical soft diet was prescribed and a plate with chunks of cooked meat in an orange gravy, yellow tinted rice with flecks of green leaves, a whole flour tortilla and a side dish of fresh tomato cut into small pieces. DC 3 stated the food on the plate was a regular diet meal and she did not know why the resident was not served a mechanical soft meal. DC 3 stated mechanical soft protein would be prepared with a food processor to chop the meat. DC 3 stated mechanical diet texture were for residents with swallowing issues. DC 3 stated there would be an increased risk of choking for residents on mechanical soft diet who were served regular diet texture foods. During a concurrent interview and record review on 2/21/25 at 12:20 p.m. in the dining room with Dietary Aide (DA) 2, the 2/18/25 lunch photo for Resident 311 was reviewed. The lunch photo indicated Resident 311's meal ticket was noted mechanical soft diet as prescribed and a plate with chunks of cooked meat in an orange gravy, yellow tinted rice with flecks of green leaves, a whole flour tortilla and a side dish of fresh tomato cut into small pieces. The DA 2 stated the plate in the photo had a regular diet texture as regular meat would be in one-piece and mechanical soft would be blended/crumbled. DA 2 stated the resident would be at risk of choking if served the wrong textured food. During a concurrent interview and record review on 2/21/25 at 12:29 p.m. with the Director of Culinary Services (DCS) in the dining room, the 2/18/25 lunch photo for Resident 311 was reviewed. The lunch photo indicated, Resident 311's meal ticket was noted mechanical soft diet as prescribed and a plate with chunks of cooked meat in an orange gravy, yellow tinted rice with flecks of green leaves, a whole flour tortilla and a side dish of fresh tomato cut into small pieces. The DCS stated the photo did not reflect ground Chile Verde was served and stated the meal served is pretty close. The DCS stated there would be an increased risk of choking if a resident received a regular diet meal instead of the prescribed mechanical soft diet. During a concurrent interview and record review on 2/21/25 at 3:06 p.m. with the Registered Dietician (RD) in the conference room, the 2/18/25 lunch photo for Resident 311 and the Diet Spreadsheet were reviewed. The lunch photo indicated, Resident 311's meal ticket mechanical soft diet as prescribed and a plate with chunks of cooked meat in an orange gravy, yellow tinted rice with flecks of green leaves, a whole flour tortilla and a side dish of fresh tomato cut into small pieces. The Diet Spreadsheet indicated Ground Pork Chile Verde for mechanical soft lunch. RD stated the lunch photo did not reflect ground Chile Verde, and the resident was not served the correct textured food for lunch. The RD stated there would be a potential risk of choking and/or death to a resident who was served a regular diet textured meal when a mechanical soft diet was ordered. During an interview on 2/21/25 at 3:34 p.m. with the Director of Nurses (DON), the DON stated the Licensed Nurse would check the meal trays and compare the meal ticket to what was plated and once verified, the CNA would be cleared to pass the tray to the resident. The DON stated the risk of a resident not receiving a mechanical diet textured meal could lead to aspiration (sucking food into the airway), choking or death. During a review of Resident 311's Order Summary Report, the Dietary-Diet indicated consistent carbohydrate diet (equal number of fruits, vegetables, grains, dairy products with each meal to avoid high blood sugar)-mechanical soft texture . (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the List of Residents on Therapeutic Diets, not dated, indicated Residents 4, 13, 212, 161, 211, 311, 6, 39, 47, 10 were on a mechanical soft diet. During a review of Ground Pork Chile Verde recipe, dated 2024, the recipe indicated, 1. Season pork cubes with salt and pepper .2. [NAME] the cubes .remove from pan and place in the food processor. Grind to the size and texture of fine hamburger . During a review of Job Description Position Title: Dietary Aide, dated 3/19/23, the Position Summary indicated .is responsible for taking food orders, accurately communicating .orders to the kitchen and then delivering or serving the food as ordered . During a review of Job Description Position Title: Cook, dated 11/1/16, the Position Summary indicated the cook is Responsible for preparing meals .in accordance with the menu, approved recipes, standards, and federal, state and local regulations . During a review of Job Description Position Title: Certified Dietary Manager, dated 11/1/16, the Essential Duties indicated the and essential duty is to .implement and maintain departmental policies. Ensure staff is aware of and follows established policies. During a review of Job Description Position Title: Registered Dietician (RD), dated 11/1/16, the Essential Duties indicated the RD will .ensure patient's meal trays are consistent with the prescribed diet . During a review of the facility's policy and procedure (P&P) titled, Food Preparation Guidelines Policy Explanation and Compliance Guidelines, dated 12/19/22, the P&P indicated 4. Food shall be provided in a form (i.e. regular, cut, chopped, ground, pureed) that meets each resident's individual needs in accordance with his or her assessment, Diet Rx and care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety for 50 of 51 residents who received food in the kitchen when: 1. A open box of green tea was not labeled with an open and received date. 2. An expired ground rosemary seasoning was found on the shelf with other seasonings. 3. Black particles were found on top of a red wine vinegar bottle. 4. Spider cobwebs and brown and black particles were found behind the ice machine. 5. Maintenance Director (MAIND) did not wear a beard net when cleaning the ice-machine. 6. Black substances were found inside the ice compartment during cleaning. These failures placed residents at risk for foodborne illness (a condition where a person becomes sick after consuming contaminated food or beverages. It is caused by the ingestion of harmful microorganisms, such as bacteria, viruses, parasites, or toxins). Findings: 1. During a concurrent observation and interview, on [DATE], at 8:53 a.m. with the Directory of Culinary Services (DCS), an open box of green tea was not labeled. The DCS stated the open box of green tea should have been labeled with an open date and received date. The DSC stated it was important to have an open and received date to ensure the residents were not served with an expired tea. The DSC stated residents had the potential to get sick from drinking an expired green tea. The DSC stated it was the kitchen aid's responsibility to label the green tea with its open and received date and the kitchen aid did not do it. During an interview on [DATE] at 12:45 p.m. with the Registered Dietitian (RD), the RD stated The [kitchen] staff should have labeled the [green tea box] with its receive, open and use-by-date. The RD stated, It was important to know how long [green tea box] was sitting there and to know when it was [expired]. The RD stated facility staff could have served expired items to residents. The RD stated residents had the potential top get sick with foodborne illness. The RD stated the pantry should have been checked by the dietary cooks, dietary aides, and DSC daily and the RD monthly to ensure all items were labeled and not expired. During a review of the facility's policy and procedure (P&P) titled, Food Storage (Dry, Refrigerated, and Frozen) dated 2020, the P&P indicated, .1. General storage guidelines to be followed: a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on [DATE] at 9:40 a.m. in the kitchen shelf, a rosemary spice bottled was labeled with an open date of [DATE] and a use-by-date of [DATE]. During an interview on [DATE] at 11:59 a.m. with the DCS, the DCS stated the kitchen staff should have tossed the expired items. The DSC stated the kitchen should not have any expired items. The DCS stated expired items were spoiled and not recommended for use. The DCS stated expired food items had the potential to not be palatable and could cause foodborne illness. During an interview on [DATE] at 12:44 p.m. with the RD, the RD stated expired items in the kitchen should have been tossed. The RD stated dietary cooks, dietary aides and DCS should have checked the items daily. The RD stated she checked kitchen items monthly. The RD stated residents could get sick with foodborne illness. During a review of the facility's P& titled, Food Storage (Dry, Refrigerated, and Frozen) dated 2020, the P&P indicated, C. Discard food that has passed the expiration date, and discard food that has been prepared in the facility after 7 days of storing under proper refrigeration . 3. During a concurrent observation and interview on [DATE] at 9:50 a.m. in the kitchen, a bottle of red wine vinegar had black particles on top of it. The DCS stated the black particles could have been dust from the top drawn when staff opened it. The DCS stated the black particles should have been cleaned. The DCS stated the red wine vinegar could have been contaminated from the black particles. The DCS stated the black particles could have contained spores (reproductive cell that can survive harsh conditions and can develop into a new organism without fusing with another reproductive cell). The DCS stated, the spores could have cause cross-contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another) and resident could have gotten sick. The DCS stated. I am responsible to check on it [the bottle]. During an interview on [DATE] at 12:48 p.m. with the RD , the RD stated the kitchen staff were expected to clean and check on the wine vinegar bottles daily. The RD stated the black particles on the wine vinegar bottle could have caused physical contamination (when food is contaminated by foreign objects, such as sharp objects, dirt, or animal parts) in the resident food. The RD stated the physical contaminated food was a risk for residents to develop foodborne illness.The RD stated Dietary aides and the DCS should have checked on food items daily as part of the kitchen task. The RD stated the food was not free from contaminate when black particles were on top of the red wine vinegar bottle. During a review of the facility's P&P titled, Food Storage (Dry, Refrigerated, and Frozen) dated 2020, the P&P indicated, Food shall be stored on shelves in a clean, dry area free from contaminants . 4. During a concurrent observation and interview, on [DATE] at 3:02 p.m., with Dietary Aide (DA), in the dining room, the DA stated there were spider webs and black and brown particles behind the ice-machine. The DA stated it should have not been there. The DA stated housekeeping were responsible for cleaning the dining area. The DA stated the spider webs and brown and black particles could have attracted bugs and could have contaminated the ice. The DA stated cross-contaminated ice could make residents sick. The DA stated it should have been cleaned. The DA stated she should have notified the DCS to let him know the area was not cleaned. The DA stated the morning and afternoon kitchen staff should have checked on the area daily. The DA stated she did not check it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyard Care Center	1090 East Dinuba Avenue Reedley, CA 93654

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on ,d+[DATE].25 at 3:19 p.m. with the DCS, the DCS stated there were spider webs and black and brown particles behind the ice machine. The DCS stated the area could have attracted pest. The DCS stated pest, black and brown particles could have contaminated the ice and make the residents sick. During a concurrent interview and record review, on [DATE], at 12:09 p.m., with the DCS, the facility's P&P titled, Cleaning Instructions: Ice and Equipment dated 2020 was reviewed. The P&P indicated, Clean underneath and around the machine . The DCS stated the facility did not follow the P&P. During an interview on [DATE] at 12:51 p.m. with the RD, the RD stated, The area behind the ice machine should be cleaned all the time. The RD stated, I am not sure who is responsible for cleaning. The RD stated spider webs and black and brown particles could contaminate the ice. The RD stated, Residents could have gotten sick and can potentially die from consuming the cross-contaminated ice. 5. During an observation on [DATE] at 3:28 p.m., with the MAIND, the MAIND did not wear a beard net while cleaning the ice machine. The MAIND stated, I should have worn a beard net when handling the ice. The MAIND stated, I normally have my beard shorter. The MAIND stated, It is important to wear a beard net to prevent cross-contamination. The MAIND stated, Residents could have gotten sick from consuming the cross-contaminated ice. During an interview on [DATE] at 12:57 p.m. with the RD, the RD stated kitchen staff should always have a hair net and beard net when handling ice machine. The RD stated it was important to have a beard net to prevent hair from falling into the ice. The RD stated the hair from the beard could contaminate the ice and had the potential to cause foodborne illness. The RD stated the MAIND did not follow the policy and procedure. During a review of the review of the facility's P&P titled, Hair Restraints dated 2020, the P&P indicated, Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Facial hair is discouraged. Any facial hair that is longer than the eyebrow shall require coverage with a beard guard in the production and dishwashing areas . 6. During an observation on [DATE] at 3:35 p.m., with the MAIND, the ice machine had black substance on a towel when it was wiped down. The MAIND stated the ice machine was due for cleaning and the black substance was a little build up from the ice. During an interview on [DATE] at 12:38 p.m. with the RD, the RD stated there should not be any black substance in the ice machine. The RD stated it was important to remove black substance from the ice machine. The RD stated the black substance could have been from dust, bacteria, mold, and other pathogen build up. The RD stated the black substance could have contaminated the ice. The RD stated residents could get sick with foodborne illness from consuming cross-contaminated ice. The RD stated the ice was not stored in a sanitary manner. During a review of the facility's P&P titled, Ice-Handling and Cleaning dated 2020, the P&P indicated, Ice will be stored and served to residents in a sanitary manner .ice machine will be emptied at least quarterly and thoroughly cleaned with an approved sanitizer to remove any settlement or mineral build-up in the ice discharged area .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48739 Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program for one of eight sampled residents when: 1. Registered Nurse (RN) 1 did not change her gloves after cleansing a wound, and before applying medication and a clean dressing to Resident 41 during a dressing change. RN 1 did not perform hand hygiene after removing her gown and exiting Resident 41's room after performing the dressing change on Resident 41 who was on Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of resistant organisms [bacteria that have become resistant to certain antibiotics] that requires gown and glove use during high contact resident care activities). 2. Licensed Vocational Nurse (LVN) 1 did not perform hand hygiene before entering and exiting resident's rooms and in-between residents during the administration of medications to residents in one of three facility wings (wing C [a designated area where residents reside]). These failures placed residents at risk for cross-contamination. Findings: 1. During a concurrent observation and interview on 2/18/25 at 11:07 a.m. with Resident 41, in Resident 41's room, an EBP sticker was posted next to Resident 41's name tag outside his room. There was a cart with gowns and gloves outside Resident 41's room. Resident 41 had a visitor in his room and the visitor was observed to lift and bend Resident 41's legs while Resident 41 was lying in bed. Resident 41's visitor did not wear a gown. Resident 41 had difficulty answering questions. During a review of Resident 41's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/24/25, the AR indicated Resident 41 was admitted to the facility from the acute care hospital on 2/4/23 with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following a cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), dysphagia (difficulty swallowing), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/1/25, the MDS section C indicated Resident 41 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 41 was moderately impaired. During a review of Resident 41's Order Summary Report, dated 2/24/25, the Order Summary Report indicated, . EBP Precautions . order date . 02/18/25 . During a review of Resident 41's Care Plan Report CP), undated, the CP indicated, . **ENHANCED BARRIER PRECAUTIONS** Resident requires enhanced barrier precautions during high-contact resident care activities due to the presence of Chronic Wound(s) .interventions . hand hygiene utilizing alcohol-based hand rub . During a concurrent observation and interview on 2/19/25 at 11:21 a.m. with RN 1 in Resident 41's room, RN 1 started to prepare the dressing change for Resident 41's sacral (the triangular shaped bone at the base of the back) wound. RN 1 stated she was the wound nurse for the facility. RN 1 wore gloves to get supplies out of the treatment cart (a cart that holds supplies for resident treatments). Certified Nursing Assistant (CNA) 1 donned a gown and gloves to clean Resident 41 and assist with Resident 41's wound dressing change. RN 1 stated Resident 41 was bedridden and incontinent. RN 1 donned a gown and gloves and entered Resident 41's room with the treatment supplies, placed the supplies on Resident 41's bedside table, next to his water pitcher without sanitizing the table. CNA 1 completed changing Resident 41's soiled brief, then moved to the other side of the bed to hold Resident 41 on his side and did not change her gloves. CNA 1 discarded the soiled dressing while holding Resident 41 on his side. RN 1 applied a new dressing on Resident 41's wound without changing her gloves. RN 1 discarded her supplies and gloves and performed hand washing. RN 1 removed her gown before exiting Resident 41's room and proceeded to chart and did not perform hand hygiene after discarding the used gown. RN 1 stated she should have discarded her gloves after she removed Resident 41's soiled dressing. RN 1 stated she should have donned a new pair of gloves before applying medication and a new dressing to Resident 41's wound. RN 1 stated not changing gloves was an infection control risk and had the potential to transmit viruses or bacteria to Resident 41. RN 1 stated not performing hand hygiene or using a sanitizer after removing a dirty gown had the potential to transfer viruses and bacteria to other residents. RN 1 stated it was important to perform hand hygiene as part of infection safety protocol and to avoid cross-contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/21/25 at 10:11 a.m. with the Director of Nursing (DON), the DON stated RN 1 should have performed hand hygiene before starting a dressing change. The DON stated RN 1 should have removed her used gloves after removing a soiled dressing, performed hand hygiene and donned new gloves. The DON stated RN 1 should have removed her gloves and sanitized her hands after the dressing change was completed and after she left the resident's room, RN 1 should have performed hand hygiene. The DON stated if RN 1 performed treatment on a resident with EBP, RN 1 should have performed hand hygiene after removing her gown and re-sanitized her hands after leaving the resident's room. The DON stated if RN 1 did not change her gloves during the resident's treatment, RN 1 could have introduced bacteria to the resident, which was a potential for the resident to get an infection. The DON stated RN 1 should have performed hand hygiene after leaving the resident's room. The DON stated RN 1 could have transferred bacteria to the next resident she treated and there was the potential to spread bacteria to other residents. The DON stated the facility had a compromised, vulnerable population and some residents could have been exposed to bacteria and infection easier than others. 2. During an observation on 2/19/25 at 7:36 a.m. with LVN 1 in the C-Wing Unit, LVN 1 was observed passing medications to the resident in bed A without performing hand hygiene after gathering bed A's medication and entering the resident's room. LVN 1 gathered and administered medications for the resident in bed B. LVN 1 did not perform hand hygiene after she exited the room and began gathering medications for the next resident's medications in another room. During an interview on 2/19/25 at 8:47 a.m. with LVN 1, LVN 1 stated she should have performed hand hygiene when she entered and exited resident rooms prior to pulling medications. LVN 1 stated hand hygiene between each resident's medication pass was important to not contaminate medications and to not transfer germs to other residents. During an interview on 2/21/25 at 10:11 a.m. with the DON, the DON stated the License Nurse passing medications should have performed hand hygiene before entering and after exiting resident rooms and between each resident's medication pass. The DON stated the License Nurse could have transferred germs to the next resident if she did not perform proper hand hygiene. During an interview on 2/24/25 at 4:47 p.m. with the Administrator (ADM), the ADM stated her expectation was that all staff adhere to infection control policies to prevent the spread of infection. The ADM stated all standards of infection control were important, including hand hygiene, wound care, medication passes, all resident care. The ADM stated all residents require infection control. The ADM stated License Nurses should be following infection control practices for appropriate PPE and hand hygiene. (continued on next page)

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F 0880 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, Handwashing/Hand Hygiene, dated 8/2019, indicated, .this facility considers hand hygiene the primary means to prevent the spread of infections . all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections . all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations . before and after direct contact with residents . before preparing or handling medications . before handling clean or soiled dressings, gauze pads, etc. before moving from a contaminated body site to a clean body site during resident care . after contact with a resident's intact skin . after handling used dressings, contaminated equipment, etc. after removing gloves . before and after entering isolation precaution settings . hand hygiene is the final step after removing and disposing of personal protective equipment . During a review of the facility's P&P titled, Administering Medications, dated 4/2019, indicated, . staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 51223 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment when: 1. The housekeeping closet on Wing B was found to have brown/gray and white residue on the floor, 2. The walls were missing plastic baseboards exposing multiple layered hole near the base of the left wall. 3. A metal drain was found to have rust colored debris and uneven untiled surface, the front of the sink piping had peeling paint and brown colored staining. These failures had the potential to result in cross contamination (the spread of harmful bacteria, viruses, or parasites from one person, object or place to another) between staff, residents and visitors which could lead to illness, sepsis (a life-threatening condition and occurs when the body's immune system overreacts to an infection) or death. Findings: During a concurrent observation and interview on 2/21/25 at 10:20 a.m. with the housekeeper (HSKP) in the doorway of the housekeeping closet on Wing B, the closet had a large hole on the bottom of the left wall where the vacuum was stored. The view from the door revealed sink piping with dark and light brown staining and a peeling paint exposed the uneven surfaces. The tile flooring was spotted with dark and light gray staining throughout. A square area on the floor had a raised metal drain in the middle of an untiled uneven surface that was sprinkled with pieces of white paper and plastic debris. The back left wall of the closet had white patched areas at the level of the sink. The flooring beneath the sink was covered in a thick layer of fine gray particles extending from where the pipe connected to the floor to the back wall along the gray colored plastic baseboard. The floor had multiple shaped debris some chunk sized others smaller (shades of white, a dark loose screw, white specks, tan/white). The sink had uneven surfaces exposed rust colored staining, greenish residue with peeling, scraped and oxidizing paint. The wall behind the sink was uneven, with a peeling white material covered with fine gray particles nestled into the cracks of the uneven surface near where the pipe connects into the wall. The right side of the closet had a tile stained with various small and large gray spots. The right-side walls were missing the baseboard which exposed damaged uneven wall surfaces and peeled paint where the floor and wall connect. The HSKP stated the janitor was responsible to clean the closet. During an interview on 2/21/25 at 10:23 a.m. with the Administrator (ADM) and the Infection Preventionist/Minimum Data Set Nurse (IP/MDSN) at the nursing station, the IP/MDSN stated there was no janitor on duty until the evening shift. The IP/MDSN stated the janitor was scheduled for the evening shift. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview, on 2/21/25 at 10:25 a.m. at the doorway of the housekeeping closet on Wing B, the closet had a large hole on the bottom of the left wall where the vacuum was stored. The door view of the sink piping had dark and light brown staining with peeling paint leaving uneven surfaces. The tile flooring was spotted with dark and light gray staining throughout. A square area was noted on the floor with a raised metal drain in the middle of untiled uneven surface that was sprinkled with white paper and plastic debris. The wall to the left of the closet entry had white patched areas at the level of the sink. The flooring beneath the sink was covered in a thick layer of fine gray particles extending from where the pipe connected to the floor to the back wall along the gray colored plastic baseboard. The floor had multiple shaped debris some chunk sized others smaller (shades of white, a dark loose screw, white specks, tan/white). The sink had uneven surfaces exposed rust colored staining, greenish residue with peeling, scraped and oxidizing paint. The wall behind the sink was uneven, peeling white material covered with fine gray particles nestled into the cracks of the uneven surface near where the pipe connects into the wall. The right side of the closet had tile stained with various small and large gray spots. The right-side walls were missing the baseboard which exposed damaged uneven wall surfaces and peeled paint where the floor and wall connect. The ADM stated the closet dry wall needed to be swept, the floors striped and waxed for stains on the tile. The ADM stated the area under the sink needed to be striped and waxed. The ADM stated she would expect the floor to be cleaned as needed and deep cleaned on the 6th of the month per the Deep Clean Schedule. During an interview on 2/21/25 at 10:25 a.m. with the IP/MDSN at the doorway of the housekeeping closet wing B, the IP/MDSN stated the floor was stained and the facility had many stains. The IP/MDSN stated the closet floor should be swept and the current condition of the closet would require as needed cleaning. During an interview on 2/21/25 at 2:43 p.m. with the IP/MDSN at the nursing station, the IP/MDSN stated the if the facility had rust, that would be a general concern because a rusty pipe could leak and cause other problems. The IP/MDSN stated the rusty pipe may be an infection control concern. The IP/MDSN stated uneven surfaces may pose a safety hazard as someone could trip and fall. During a concurrent observation and interview on 2/21/25 at 2:52 p.m. with Maintenance Director (MAIND) and the IP/MDSN at the doorway of the housekeeping closet on Wing B, the floor was cleared of equipment and was in the wax stripping process. The tiled floor had brown liquid covering areas with darker debris and liquid streaks, patches of gray spot and debris throughout the flooring. A square section of the floor was missing a tile in front of the sink. A raised round metal drain lay in the middle of the tile-free uneven surface section of floor. The wall to the left of the doorway had a large hole which exposed multiple layers of wall components. The MAIND stated the wall damage was from the vacuum hitting against the wall without the baseboard protector. The MAIND stated the liquid was stripper fluid and the debris was the wax lifting off the floor. The MAIND stated the plastic baseboards had dislodged from the wall which exposed unfinished wall surface. The MAIND stated the wall would need to be repaired with cement compound before replacing the plastic baseboards. The IP/MDSN stated the uneven drain surface in the housekeeping closet was not a surface that could be sanitized. The IP/MDSN stated the staff's shoes could create a mode for cross contamination which could result in residents getting sick and was an infection control issue. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/24/25 at 3:17 p.m. with the ADM, the ADM stated the facility should always be maintained in a safe, clean and sanitary manner and was part of her role as the facility's ADM. The ADM stated the facility had many active performance improvement projects which included the physical environment. The ADM stated the facility had limited resources within the building and continued to struggle with barriers such as budgeting, scheduling and provider availability. During a review of Deep Cleaning Schedule, dated 2/25, the housekeeping closets were scheduled to be deep cleaned on the 6th day of the month and were initialed completed. During a review of Job Description Position Titled: Housekeeper (HSKP), dated 3/7/24, the Position Summary indicated the HSKP Reports to: Maintenance Director (MAIND). The Essential Duties indicated the HSKP ensure cleaning and work schedules are followed .Responsible for ensuring infection control and universal precautions and best practices are followed at all times when performing housekeeping duties . Maintain a safe and secure environment for all staff, residents and guests, following established safety standards. During a review of Job Description Position Title: Maintenance Director (MAIND), dated 12/18/23, the Position Summary indicated the MAIND is Responsible for the building, the equipment and other materials located in and around the physical property. Implementing .and organized system to maintain the operations of the property and maintain it in good, clean and safe order .Reports to: Executive Director. During a review of Job Description Position Title: Infection Preventionist (IP/MDSN), dated 1/1/22, the Essential Duties of the IP/MDSN indicated the IP/MDSN will provide Oversight of the Infection Prevention Control Program (IPCP), which includes at a minimum, the following elements: a system of preventing, identifying .infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals .based upon the facility assessment .and following accepted national standards .Assess the need for, develop, and present IPCP in-service education for individual departments .education includes .cleaning, disinfection, and sterilization. During a review of Administrator Job Description, dated 4/1/12, the Administrative Functions indicated, the ADM will .maintain written policies and procedures that govern the operation of the facility .Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed .Ensure that all facility personnel .follow established safety regulations, to include .infection control . During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 9/22/22, the P&P indicated, . This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary .environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . The 4. Standard Precautions: e, indicated, environmental cleaning and disinfection shall be performed according to the facility policy. All staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department . (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure titled, Policy and Procedure on Housekeeping and Facility Cleanliness, the policy indicated .housekeeping staff will follow a standardized cleaning protocol to minimize the risk of infection and maintain the overall cleanliness of the facility .