STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055830	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Post Acute	425 E Barcellus Ave Santa Maria, CA 93454

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49405 Based on interview and record review, the facility failed to obtain an informed consent for the use of psychotropic medications (medications which affects mood or behavior) for one of 20 sampled residents (Resident 37). This failure violated Resident 37's right to make an informed decision regarding the use of psychotropic medications and had the potential to result in resident misinformation regarding its benefits and side effects. Findings: During a review of Residen 37's, Admission Records, dated 02/28/24, the records indicated Resident 37 was admitted to the facility on [DATE], with admission diagnoses including but not limited to: Other psychotic disorder not due to a substance or known physiological condition, Vascular Dementia (problems with thought processes caused by brain damage from impaired blood flow to your brain), Unspecified severity with agitation, Other specified depressive episodes, and Chronic Post-traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety). During a review of Resident 37's, Order Summary Report (OSR), dated 02/28/24 the OSR indicated the physician orders, Seroquel (antipsychotic - a medication used to treat certain mental and/or mood disorders) 25 mg (milligram - unit of measure), give 1/2 tablet every 8 hours as needed for agitation/anxiety and Olanzapine (antipsychotic) 5 mg tablet, give 1 tablet at bedtime for PTSD. During a concurrent interview and record review on 06/05/24 at 11:09 a.m. with the Assistant Director of Nursing (ADON), Resident 37's form, Facility Verification of Resident Informed Consent for Psychotherapeutic Medications, was reviewed and indicated, the informed consents for Seroquel and Olanzapine were not signed by Resident 37 (or the resident's representative) prior to the resident initially receiving the medications. ADON confirmed the informed consents for the medications were not signed and verbalized they should have been signed by the resident (or the resident's representative) prior to initiating the medications. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P) titled, Psychotropic Drug Use, dated 11/2023, the P&P indicated in part, Upon initial comprehensive assessment, the Social Services designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or physician's orders for psychotropic medications . to ensure: . Informed consent was obtained prior to medication use.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49405 Based on interview and record review, the facility failed to complete and accurately document a Physician Order for Life Sustaining Treatment (POLST - care directives during life threatening situations) and Advance Directive (legal documentation consistent with the known requests or desires of the patient's medical preference) for two of 20 sampled residents (Residents 5 and 37). These failures had the potential to result in the delay of necessary treatment compatible with the legally recognized decision maker wishes during an emergency situation. Findings: During a review of Resident 5's, Admission Record, dated 04/20/24, the Record indicated in part, Resident 5 was admitted to the facility on [DATE] with admission diagnoses including but not limited to, Urinary Tract Infection (UTI - an infection in the urinary system of the body), generalized muscle weakness, Type 2 Diabetes Mellitus with other skin complication, and Congestive Heart Failure. During a concurrent interview and record review on 06/04/24 at 12:11 p.m. with licensed nurse (LN 3), Resident 5's Clinical Record was reviewed. Resident 5's record did not include the resident's POLST. LN 3 verbalized the POLST and consent forms were signed today. LN 3 produced the signed POLST form, dated 06/04/24, confirming it was only signed by the resident today. During an interview on 06/04/24 at 12:45 p.m. with Resident 5, Resident 5 verbalized just signed a bunch of papers that were not previously signed on admission to the facility on [DATE]. During a concurrent interview and record review on 06/05/24 at 3:15 p.m., with with the Assistant Director of Nursing (ADON), Resident 37's clinical record was reviewed. ADON acknowledged Resident 37's POLST form was not signed and noted the resident as having the capacity to make healthcare decisions. During a concurrent interview and record review on 06/05/24 at 3:15 p.m. with ADON, Resident 37's Physician Orders were reviewed. A Physician Order dated 02/28/24 at 11:20 a.m. indicated, DNR (Do Not Resuscitate - restrictions to perform life-saving treatment if a patients stops breathing or heart stops beating). An order dated 02/28/24 at 2:41 p.m. indicated, Full Code (perform all life saving measures if a patient stops breathing or heart stops beating). Review of Resident 37's Advanced Directive dated 03/27/24 indicated, Patient 37 wished to have restrictions on end-of-life treatment (DNR). ADON acknowledged the change in physician orders from DNR to Full Code and the POLST form should have been updated to reflect the wishes of the resident. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policies and procedures (P&P) titled, Advanced Directives, POLST, dated 11/2023, the P&P indicated, Prior to, upon, or immediately after admission, Social Services or Licensed Nursing Staff will ask residents, and/or their family members, about the existence of any advance directive . resident or surrogate decision maker will be offered and assisted by facility staff (usually SSD [Social Services Department] or Licensed Nursing Staff) to complete a POLST (Physician's Orders for Life Sustaining Treatment) document to formulate decisions regarding Life Sustaining Treatment. A copy of this document will be in the Medical Record of resident . The facility will also notify the attending physician of advance directives so that, if necessary, appropriate orders can be documented in the resident's medical record and plan of care.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47112 This is the incorrect tag Based on observation, interview, and record review, the facility failed to follow their policy and procedure regarding loss or theft of resident property. Findings: During an observation on 6/3/24 at 2:10 p.m., a brown wallet containing a driver's license, social security card and military identification was observed in medication cart number one, located in a locked medication drawer. During a concurrent interview and record review on 6/3/24 at 2:15 p.m. with licensed nurse (LN 2), discharged residents in Point Click Care (PCC) (point click care is a cloud-based software platform used by some health care providers to monitor and track patient care) were reviewed. PCC indicated, Resident was discharged AMA (against medical advice) on 9/8/23. LN 2 verbalized, they did not know if the former resident has been contacted, the wallet should not have been kept in the medication cart. LN 2 further verbalized, the wallet should have been taken to social services. During a review of the facility's policy and procedure (P&P) titled, Theft and Loss Policy, dated 10/22, The P&P indicated, Loss or theft of resident property worth $25 or more will be documented and reported to the administrator (or designee) for investigation, police reporting or other appropriate action. Documentation of the lost or stolen residence property with a value of $25 or more shall include: A. Description of the lost or stolen article. B. Estimated value. C. Date and time the loss or theft was discovered. D. If determinable, the date and time the lost or theft occurred. E. Action taken.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on record review and interview, the facility failed to ensure a significant change in status was comprehensively assessed for one of four sampled residents (Resident 15) using the CMS (Centers for Medicare and Medicaid Services) specified Resident Assessment Instrument (RAI - Resident Assessment Instrument [a standardized tool used to evaluate and document clients in long term care {LTC} settings] process). This failure had the potential to result in compromised quality of care for Resident 15. Findings: During a review of Resident 15's Medical Record, the Medical Record indicated, Resident 15 was readmitted to the facility on [DATE] from the hospital. The psychologist's progress note dated 4/16/24, indicated, Pt. (patient) was taken off his anti-psych medications recently (when d/c'd [discharged] from hospital) & he's become increasingly disorganized since then. Physician: please re-start Pt. on his previous level of Seroquel [an antipsychotic medication] that had been working very well. Further record review revealed the facility failed to initiate a comprehensive assessment after a significant change of condition. During an interview on 6/6/24 at 11 a.m. in the DON's (Director of Nursing) office, with the DON, MDS1 (Minimum Data Set - nurses responsible for collecting and submitting assessment data for nursing home patients) and MDS2 nurses. The DON and MDS's 1 and 2 concurred the significant change in status assessment was not done for Resident 15 following a significant change of condition. During a review of the facility's policy and procedure (P&P) titled, Change of Condition - Assessment and Reporting, dated 11/2021, the P&P indicated, PURPOSE: To clearly define guidelines for a timely notification of a change in resident condition, and, Follow-up #3. Resident Assessment Instrument/Comprehensive Care Plan completed/modified as needed.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR - a federally mandated process to help ensure that individuals are evaluated for a mental illness and/or intellectual disability and are not inappropriately placed in nursing homes for long term care) Level II evaluations (a person-centered evaluation that is completed for anyone identified by the Level I screening as having, or suspected of having serious mental illness, intellectual disability, developmental disability, or related condition) were completed for three of 20 sampled residents (Residents 15, 37 and 66) when: 1. A significant decline in Resident 15's mental health condition was assessed. 2. A positive PASRR Level I (a preliminary assessment for individuals to identify serious mental illness, intellectual disability, developmental disability, or related condition prior to admission to a nursing facility) evaluation was indicated for Residents 37 and 66. These failures in screening for mental health illesses and/or disabilities had the potential to result in these residents not receiving appropriate care and treatment. Findings: 1. During a review of Resident 15's medical record, the medical record indicated Resident 15 was readmitted to the facility, on 4/4/24 from the hospital. The psychologist's progress note dated 4/16/24, indicated, Pt. (patient) was taken off his anti-psych medications recently (when d/c'd from hospital) & he's become increasingly disorganized since then. Physician: please re-start Pt. on his previous level of Seroquel [an antipsychotic medication] that had been working very well. Further record review revealed, the facility failed to initiate a PASRR screening and comprehensive assessment after the significant mental change/change of condition was noted by the psychologist. Admitting diagnoses included in part, Psychosis (mental disorder characterized by a disconnection from reality) and Depression (mental state of low mood and aversion to activity). During an interview on 6/6/24 at 11 a.m. in the DON's (Director of Nursing) office, with the DON, MDS1 (Minimum Data Set - nurses responsible for collecting and submitting assessment data for nursing home patients) and MDS2 nurses. The DON and MDS's 1 and 2 concurred the PASRR screening of Resident 15 for the significant mental change of condition on 4/16/24, as noted by the psychologist, was not done by the facility. During a review of the facility's policies and procedures (P&P) titled, PASRR, dated 11/2023,the P&P indicated, POLICY: It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State, and, PROCEDURES: #3. a. If a resident temporarily went somewhere outside the NF, a new PASRR would not be required unless upon return, there was a significant change in the resident's physical or mental condition. If this happens, then the NF initiates the RR process by submitting a Level 1 Screening, and if needed, arrange for a Level 2 Evaluation to be performed by the state approved contractor to help ensure the individual receives services in the most integrated setting. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49405 2.a. During a review of Resident 37's form titled, Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 02/26/24, the PASRR indicated, a Positive (resident with a mental disorder condition) result. During a concurrent interview and record review on 06/05/24 at 11:26 a.m. with Assistant Director of Nursing (ADON), Resident 37's Clinical Documents, was reviewed. The Documents indicated, a letter from the Department of Health Care Services, dated 02/26/24, Re: Positive Level I Screening Indicates a Level II Mental Health Evaluation is Required. ADON acknowledged that a PASRR II evaluation was overlooked and should have been completed and not done. 49376 2.b. During a review of Resident 66's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 4/01/2024, the PASRR indicated, Resident 66 had a positive Level I screening, due to suspected mental illness (MI). During a review of Resident 66's Positive Level I Screening Indicates a Level II Mental Health Evaluation is Required, dated 04/01/2024, and addressed to Resident 66 the Level I Screening indicated, Resident 66 was positive for suspected mental Illness (MI). During a review of Resident 66's, letter of correspondence from the PASSR Section of the Department of Health Care Services (DCHS), dated 4/2/24, the letter indicated in part, Unable to Complete Level II Evaluation . the individual currently has a duplicate PASRR on file . The case is now closed. To reopen, please submit a new Level I Screening. During an Interview on 06/06/2024 at 9 a.m. with ADON, ADON stated, The PASRR Level I is the only one the facility has on file, and there is no other PASRR II or duplicate available. During an Interview on 06/06/2024 at 9:25 a.m. with DON, Nursing Consultant (NC), and Executive Director (ED), ED and DON stated the facility does not currently have a copy of the duplicate PASRR, and have had this issue in the past with other residents PASRR. During an interview on 06/06/2024 at 11:04 a.m. with the facility's PASSR Consultant (PC), PC verbalized that ([NAME] Medical Center) conducted the PASSR Level I and II evaluations for Resident 66 and was told that the resident's expected hospital stay would be less than 15 days. PC explained that if the resident's hospital stay was less than 15 days, the facility would have no obligation to resubmit a new Level I screening. PC further verbalized that since the resident stayed in the hospital more than 15 days, the facility did in fact have an obligation to resubmit a new Level I PASRR screening.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. 32661 Based on record review and interview, the facility failed to ensure the State mental health authority was notified after a significant decline in the mental health condition of one of four sampled residents (Resident 15) was assessed. This failure had the potential to result in Resident 15 not receiving the necessary mental health care and services which had the potential to affect Resident 15's quality of life and resulted in the mental significant change of condition not having been properly screened/evaluated and reported to the state mental authority. Findings: During record review of Resident 15's Psychologist Progress Notes, dated 4/16/24, the Progress Note indicated, Pt. was taken off his anti-psych medication (when d/c'd from hospital) & he's become increasingly disorganized since then. Physician: please re-start Pt. on his previous level of Seroquel that had been working very well. Admitting diagnoses included in part, Psychoses (mental disorder characterized by a disconnection from reality) and Depression (mental state of low mood and aversion to activity). The facility documented the change of condition for 72 hours, as reflected in the reviewed nursing documentation. However, the facility failed to initiate a PASSAR screening, to accurately screen/evaluate Resident 15's mental health status. During an interview on 6/5/24, at 11 a.m., in the DON's office, with the DON, MDS1 nurse, and MDS2 nurse (Minimum Data Set [nurses assigned to collect and assess information for the health and well-being of residents in Medicare and Medicaid certified nursing homes]). The DON and both MDS nurses concurred the PASSAR screening of Resident 15 for the significant mental change of condition on 4/16/24, as noted by the psychologist, was not done by the facility. During a review of the facility's policy and procedure titled, Change of Condition - Assessment and Reporting, dated 11/2021, the facility's policy and procedure indicated, PROCEDURES: Follow-up #3. Resident Assessment Instrument/Comprehensive Care Plan completed/modified as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13095 Based on observation, interview, and record review, the facility failed to ensure: 1. A box of expired Povidone-Iodine prep pads. (antiseptic pads saturated with povidone iodine solution to help control bacteria and minimize infection) was discarded. 2. An opened vial of purified protein derivative (PPD - solution used in a skin test to help diagnose tuberculosis [a serious lung infection caused by bacteria]) solution was dated. 3. An open container of glucose test strips (used in a device to measure the amount of sugar in the blood) was dated. 4. Barium Sulfate (a contrast agent used to diagnose disorders of the esophagus, stomach and intestines) stored in the medication refrigerator had a documented physician order for specific resident use. These failures had the potential for the residents to receive expired, ineffective and unprescribed medications and treatments. Findings: During an inspection on [DATE] at 9:30 a.m. of the medication storage area, the following were observed: 1. One box of expired Povidone-Iodine prep pads with an expiration date ,d+[DATE]. 2. One vial of PPD was opened and not dated. During a review of the facility's policy and procedures (P&P) titled, Storage of Medications, dated 2023, The P&P indicated in part, Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock disposed of according to procedures for medication disposal. The P&P further indicated, All PPD bottles are to be dated when opened and discarded after 30 days of opening. 3. One container of diabetic glucose test strips that was opened and undated. During a review of the facility's P&P titled, Infection Control, Glucometer Cleaning and Decontamination, dated ,d+[DATE], the P&P indicated in part, Test strips will be used according to manufacturer's guidelines. During a review of manufacturer's guidelines for diabetic glucose test strips, the guidelines indicated, Use within three months of opening the vial. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Barium Sulfate, stored in the facility's medication refrigerator had no physician order for specific resident use. During a review of the facility's P&P titled, Resident Assessment, Physician Orders, dated ,d+[DATE], the P&P indicated in part, It is the policy of this facility that drugs or biologicals shall be administered only upon written order of a person duly licensed and authorized to prescribe such drugs . Drugs and biologicals orders must be recorded on the physicians order sheet in the resident chart. During a concurrent interview and record review on [DATE] at 1:05 p.m. with the Director of Nursing (DON), physician orders for all residents were reviewed. After a thorough review of all resident physician orders, DON verbalized that no orders were found in the facility's electronic or paper charting system for Barium Sulfate. 47112

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 13095 Based on observation and record review, the facility failed to: 1.Store Schedule II Drugs (schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence) under double lock per facility's policy and procedure (P&P). 2.Sign the drug count sheet after administering medication per facility P&P. 3.Maintain refrigerator temperatures. These failures had the potential to result in (1) schedule II drugs being available to residents and visitors; (2) for drug diversion; and (3) medications to not be effective. Findings: During an inspection on 6/3/24 at 9:30 a.m. of the medication storage area, the following were observed: 1.Schedule II Drugs were not stored under double lock. During a review of the facility's P&P titled, Medication Administration, dated 11/2023, the P&P indicated, Medications listed in schedules II, III, IV, and V are stored under double lock in a locked cabinet or safe designated for that purpose, separate from all other medications. 2.One controlled drug count sheet had not been signed after medication was administered as directed by the facility's P&P. Further review of the facility's P&P titled, Medication Administration, dated 11/2023, the P&P indicated, When a controlled medication (a controlled medication is a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction) is administered the licensed nurse administering the medication immediately enters all of the following information on the accountability record: *Date and time of administration *Amount administered. *Signature of the nurse administering the dose, completed after the medication is administered. 3. The facility refrigerator log listed out of range temperatures, for April, May and June of 2024 resulting in multiple episodes of the refrigerator being out of range for optimal medication storage. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Storage of Medications, dated 2023, the P&P indicated, Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring. 47112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055830	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Post Acute	425 E Barcellus Ave Santa Maria, CA 93454

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

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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** 49405 Based on observation, interview and record review, the facility failed to ensure: 1. Pasteurized eggs were used for egg preperations not cooked through completely according to the facility's policy and procedures (P&P). 2. Food was stored properly in accordance with professional standards of food service safety when an uncovered and undated bag of shredded mozzarella cheese was found in the refrigerator and an opened staff personal water bottle was stored in the freezer. 3. Resident food refrigerator temperatures located in the nursing station were monitored daily and corrective actions implemented for out-of-range temperature readings by the food and nutrition representative according to the facility's P&P on foods brought by family or visitor. 4. An appropriate drainage piping material was used to drain the ice machine and an appropriate air gap was maintained between the ice machine and floor drains to prevent contaminated water from backing up into the ice machine should drainage problems arise. These failures had the potential to place the residents at an increased risk for contracting foodborne illness (any illness caused by consuming food or beverages contaminated with harmful pathogens - such as bacteria, viruses and fungi - or their toxins). Findings: 1. During a concurrent observation and interview on 06/04/24 at 09:05 a.m. with the Dietary Supervisor (DS) and Registered Dietician (RD), the inside of refrigerator #2 was observed. There was an open box of unpasteurized eggs. RD acknowledged the eggs were not pasteurized and there were no fresh pasteurized eggs in the facility. During an interview on 06/04/24 at 10 a.m. with RD and Morning [NAME] (AMC), RD verbalized the facility only cooks fried eggs cooked through. AMC verbalized if a resident requests an over easy (fried egg with under cooked yolk) egg or other egg not fully cooked he will cook it on their request. RD acknowledge that they stopped buying pasteurized eggs because of expense. During a concurrent interview and record review on 06/04/24 at 5:15 p.m. with RD, the P&P titled, Procedure For Refrigerated Storage was reviewed. The P&P indicated, 11. Raw eggs shall be obtained pasteurized . RD verbalized and acknowledged the facility P&P was not followed. 2. During a concurrent observation and interview on 06/03/24 at 09:57 a.m. with the RD in the kitchen, inside the kitchen refrigerator #5 was an open bag of mozzarella cheese stored uncovered and in Freezer #8 an opened bottle of water was found on the floor of the freezer. RD acknowledged that the cheese found in refrigerator #5 should not be opened stating, should be rolled with a clasp and labeled. RD acknowledged that the open bottle of water found in freezer was half full and was a staff members personal water and should not be in the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Procedure for Refrigerated Storage, dated 2023, the P&P indicated, . Food should be covered and stored loosely . 3. During a concurrent interview and record review on 06/04/24 at 4:00 p.m. with Assistant Director of Nursing (ADON), resident refrigerator temperature logs were reviewed. ADON verbalized the resident refrigerator is kept on Nurses Station 1 and it is the responsibility of the nurses every a.m. and p.m. shifts to check temperatures in both refrigerators and the freezer. The ADON acknowledged the refrigerator logs have been checked but only on PM shift from January 2024 through June 2024. During a concurrent interview and record review on 06/06/24 at 11:55 a.m. with the Assistant Administrator (AADM) AADM, resident refrigerator temperature logs and facility P&P titled, Foods [NAME] by Family or Visitor, were reviewed. AADM acknowledged that according to this policy, the temperature logs for the resident refrigerator should be checked daily by nursing staff and verified by a dietary representative. AADM acknowledged that any out of range temperatures should be reported to maintenance for corrective action and documented on the log. AADM acknowledged that the refrigerator temperature on 1/24/24 was 46 degrees Farenheit (F) and on 1/25/24 the temperature was 44 degrees F and no documentation of correction actions were noted on log. AADM acknowledged there was no documentation of corrective action for out of range temperatures on these dates. A review of the facility's P&P titled, Food Brought by Family or Visitor, dated 05/09/2018, the P&P indicated, 9. The temperature of the refrigerator and freezer will be monitored and logged by Station 3 Nursing staff no less than once a day and verified by a food and nutrition representative once daily in accordance with the facility professional food safety standards. Any deviations from the correct temperature's standards will be reported to the Maintenance Department and / or the DSS (Department Staff Services) for guidance and correction. 4. During an observation on 06/03/24 at 10:45 a.m., in a separate locked closet outside of the kitchen. [NAME] plastic pipe [PVC - Polyvinyl chloride] drain from ice machine draining into floor drain black plastic pipe with black funnel attached to the black pipe in floor drain was observed. The white drainage pipe appeared to be approximately 1 inch below the flood level rim of floor drain. During a review of an email communication on 06/04/24 at 11:33 a.m. with the Department of Health Care Access and Information (HCAI), the e-mail indicated, PVC and ABS [Acrylonitrile Butadiene Styrene - type of drainage pipe] are both prohibited. During a concurrent observation and interview on 06/05/24 at 10:01 a.m. with the Director of Maintenance (DM),the ice machine was observed. DM acknowledged the air gap from the ice machine should be one inch above the top of the floor drain. DM also acknowledged the drainage pipe is below the top of the floor drain and there is not an appropriate air gap. DM verbalized the plastic PVC pipe to drain the ice machine was appropriate material to drain the ice machine. During a review of an email communication on 06/06/24 at 08:20 a.m. from HCAI to surveyor, the email indicated, ABS and PVC drainage fittings which is a code violation per CPC 701.2(2)(b) [California Plumbing Code]. During a concurrent interview and record review on 06/06/24 at 09:45 a.m. with DM, the CPC 701.2(2)(b) code was reviewed. DM acknowledged the CPC code 701.2(2)(b) is the plumbing regulation to be followed and that per PCP 701.2(2)(b) PVC pipe should not be used to drain ice machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Food and Drug Administration Food Code (FDAFC), dated 2022, the FDAFC indicated, 5202.13 Backflow Prevention, Air Gap. An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUEPMENT, or non FOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25mm (1 inch). During a review of the Food and Drug Administration Food Code Annex (FDAFCA), dated 2022, the FDAFCA indicated, Backflow Prevention, Air Gap . Providing an air gap between the water supply outlet and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow. During a review of CPC 2022, Chapter 7, 701.2 Drainage Piping, the CPC indicated, Materials for drainage piping shall be in accordance with one of the referenced standards in Table 701.2 except that: . (2) ABS and PVC DWV piping installations shall be installed in accordance with applicable standards referenced in Table 701.2 and the firestop protection requirements in the California Building Code. (b) [OSHPD 1,2,3,4 & 5] ABS and PVC installations are not allowed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49405 Based on observation, interview, and record review, the facility failed to implement transmission-based precautions (infection control measures specific to how an infection is spread) for one of 20 sampled residents (Resident 5) when the resident was diagnosed with a known Multidrug Resistant Organism (MDRO - a germ that is resistant to many antibiotics). These failures had the potential to result in the spread of harmful microorganisms to staff, residents and visitors. Findings: During a concurrent interview and record review on 06/05/24 at 10:00 a.m. clinical record with Assistant Director of Nursing (ADON), Resident 5's History and Physical (H&P), dated 04/20/24, was reviewed. Resident 5's H&P indicated, . Patient was found to have UTI [urinary tract infection] with history of ESBL ., . continue with contact isolation . ADON acknowledged Resident 5 was colonized (presence of bacteria without causing an active infection but can be spread to others) with Extended-spectrum beta-lactamases (ESBL - enzymes (special proteins) that are made from bacteria that are resistant to antibiotics) on admission and should have been placed on Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of MDROs in nursing homes, https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html). During an interview on 06/05/24 at 10:09 a.m. with Licensed Nurse (LN 2), LN 2 verbalized Resident 5 is not on any isolation including, EBP. LN 2 verbalized Resident 5 had completed treatment for an ESBL infection. During an interview with Infection Preventionist (IP) on 06/05/24 at 10:35 a.m. IP acknowledged that Resident 5 is not on contact isolation and not on EBP. IP acknowledged that ESBL is a condition that is considered colonized (germs on or in the body but do not have symptoms of infection) and resident should have been placed on EBP on admission. During a review of facilities policy and procedure titled, IPCP Standard and Transmission-Based Precautions, dated 04/2024 indicates, . 3. Enhanced Barrier Protection (EPB): used in conjunction with standard precautions [precautions required to achieve a basic level of infection control used for all residents] and expand the use of PPE [personal protective equipment] through the use of gown, and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff ., a. PPE: The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply . ii. MDRO infection or colonization. The policy states, b. Multi-drug Resistant Organisms (MDRO) - the MDROs for which the use of EBP applies are based on local epidemiology. At a minimum, they should include resistant organisms targeted by CDC . ESBL - producing Enterbacterales .