

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055839	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER San Luis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 709 N Street Newman, CA 95360	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food and ice were stored, prepared, distributed, and served in accordance with professional standards for food service safety when:1. [NAME] substances were found inside the bin in one of one ice machines located in the facility's kitchen.2. Food Service Worker (FSW) 4 was observed utilizing the kitchen sanitation bucket to sanitize food carts that did not contain the recommended concentration levels of quaternary ammonium (a group of chemicals used for killing bacteria, fungi, and viruses) for sanitization (to reduce the number of disease-causing pathogens).3. Expired items were found in the residents' food refrigerator in the facility's break room and there was no thermometer in the residents' food in the freezer in the facility's break room. These failures had the potential to cause the growth of microorganisms (organisms that are too small to be seen with the naked eye) and spread foodborne illness (disease or period of sickness caused by food contamination) to the 66 residents that were served meals from the kitchen. Findings:1. During an observation in the kitchen on 3/03/2026 at 11:46 a.m., FSW 3 was observed putting ice from the ice machine in a resident water pitcher and then giving to someone who came to the door. During concurrent observation in the kitchen and interview on 3/3/26 at 2:45 p.m. with Maintenance Director (MD), the facility's ice machine was observed to have a large area of a white substance throughout back of bin and ice was full and up to the top of the water trough in the bin. The MD confirmed the white substance and stated the facility had very hard water. The MD stated the ice machine is cleaned and sanitized once a month and when cleaned the white substance would come off and get removed. During an interview with the Dietary Manager (DM) on 3/5/26 at 11:40 a.m., DM stated there is only one ice machine in the facility. During a review of facility document titled Ice Machine- Cleaning Log, undated, the document indicated the ice machine was descaled (to remove [scale] a layer of hard white material from something) and sanitized on 2/20/26. During a telephone interview on 3/5/26 at 10:58 a.m. with Registered Dietitian (RD), the RD was informed of the white substance in the ice machine and asked if she looked at the inside of the ice machine. The RD stated she did not recall looking at the inside of the ice machine when she was onsite at the facility on 1/6/26 and 1/7/26. During a review of facility document titled Ice Machine- Manufacturer's Guide, no date, the document indicated in section 4- . De-scaling and sanitizing. if the ice machine requires more frequent de-scaling and sanitizing, consult a qualified service company to test the water quality and recommend appropriate water treatment. 2. During a concurrent observation, interview and record review on 3/4/2026 at 8:42 a.m. with FSW 4 in the facility's kitchen, FSW 4 was observed wiping the food cart with a rag from a red sanitation bucket. FSW 4 stated the red bucket contained sanitizer used to minimize cross contamination. FSW 4 demonstrated the test strip used to test the level of the sanitizer in the red bucket. The strip was in the sanitizer for 18 seconds and when removed it was about 150 ppm (parts per million). FSW 4 stated the test strip was supposed to be dipped in sanitizer for 10 seconds. FSW 4 was asked to recheck the level again for 10 seconds and the test strip result was about 100 ppm -150 ppm. FSW 4 stated there was a need to change out the sanitizer since it needed to be between 200 ppm and 400 ppm. FSW 4 stated the sanitizer solution in the red bucket was last filled up at around 6 a.m. on 3/4/26. During an interview on 3/04/2026 at 4:25 (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 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** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals (define) were locked and labeled in accordance with current accepted professional standards of practice and facility procedures for one of five sampled residents (Resident 48) and two of three medication carts when: 1. [NAME] wing medication cart contained Resident 48's inhaler medication (pressurized canister that delivers a precise, pre-measured puff of medication directly into the lungs) Budesonide-Formoterol Fumarate Aerosol (treatment for asthma and chronic obstructive pulmonary disease [COPD-chronic lung disease causing difficulty in breathing]) was found to not have an open date and beyond use date (BUD- the last date you can safely use a medication). This failure had the potential for Resident 48's medication to be administered past the discard date which could result in loss of effectiveness of the medication leading to poor management of Resident 48's condition. 2. Registered Nurse (RN) 1 left her medication cart unlocked, unsupervised, and not within her visual area in the west wing hallway outside of room [ROOM NUMBER] when she walked inside room [ROOM NUMBER] to administer medications to resident in bed C farthest from the door. This failure had the potential for passing residents, staff, and visitors to have access to medications in the medication cart and take medications which could lead to adverse reaction leading to serious health conditions. 3 a. In one of two medication carts, two Controlled Drug Record (CDR - record of when and how many controlled medications were received) were not filled out. This failure had the potential for missing medications and drug diversion (drug diversion is the illegal transfer of prescription medicines from their rightful source to the street for misuse). b. One bottle of insulin (regulates blood sugar levels, preventing them from getting too high) did not have an open or expiration date. This failure had the potential for residents to receive the wrong and or expired medication. c. Two bottles of ear wax removal drops did not have resident labels and opened date. This failure had the potential for residents to receive the wrong and or expired medication. d. Open wound care supplies were stored with medications in the medication cart. This failure had the potential for residents to receive medication that could have been exposed to contagions (any disease or sickness that can be easily spread from one person to another), from being next to open wound care supplies. Findings: 1. During a concurrent observation and interview on [DATE] at 10:50 a.m. during initial tour in Resident 48's room, Resident 48 was observed sitting up in bed and appropriately dressed. Housekeeping Supervisor (HS) was in the room and stated Resident 48 was Spanish Speaking only and interpreted for Resident 48. Resident 48 stated he was happy and felt safe in the facility and was not sure how long he had been in the facility. During a concurrent observation and interview on [DATE] at 3:58 p.m. during medication administration in the west wing with RN 1, RN 1 prepared Resident 48's medications including metered dose inhaler (MDI) Budesonide-Formoterol Fumarate Aerosol. The MDI did not have open date and beyond use date. RN 1 stated she did not know why there was no open date and used by date. RN 1 stated the medication should have been labeled with the opened date and used by date when it was first opened. RN 1 had no answer when asked what happened when a medication was administered past its used by date. During a review of Resident 48's admission Record (AR- a document containing resident profile (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information), dated [DATE], the AR indicated Resident 48 was admitted to the facility on [DATE] with diagnoses which included COPD, shortness of breath and muscle weakness. During a review of Resident 48's Order Summary Report, dated [DATE], the Order Summary Report indicated, . Budesonide-Formoterol Fumarate Inhalation Aerosol .2 [two]puff inhale orally two times a day for COPD Rinse mouth with water after use. Do not swallow . Order Date: [DATE] . During an interview on [DATE] at 2:45 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the MDI should be labeled with the opened date and used by date when it was first opened. LVN 3 stated it was to ensure all staff knew when to get rid of the medication and avoid administering medications past its used by date. LVN 3 stated administering medications past its used by date could the medications to be ineffective and residents may not receive the correct dose of medication which may not help the resident for its intended use. During an interview on [DATE] at 10:48 a.m. with LVN 2, LVN 2 stated the practice was to label the MDI with the opened date and used by date when first opening the medication. LVN 2 stated labeling the MDI with the used by date ensured medications were not administered after the used by date. LVN 2 stated medications lose their effectiveness past its used by date and when administered to a resident will not be as effective and not help improve the resident's condition. During an interview on [DATE] at 11:12 a.m. with LVN 1, LVN 1 stated the nurse opening the MDI should label the date the medication was opened and the used by date. LVN 1 stated once a MDI was opened we no longer go by the manufacturer expiration date. LVN 1 stated medications past its used by date did not have the same effectiveness when administered. During a review of facility's policy and procedure (P&P) titled, General Dose Preparation and Medication Administration, dated [DATE], the P&P indicated, . Facility staff should enter the date opened on the label of medications with shortened expiration dates . Facility staff may enter the expiration date based on date opened on the label of medications with shortened expiration dates . 2. During a concurrent observation and interview on [DATE] at 4:14 p.m. in the west wing during medication observation with RN 1, RN 1 prepared Resident 22's medications and entered Resident 22's room and left the medication cart unlocked and unsupervised. RN 1 stated when she left the medication cart open, residents and staff could access the medications, and take the medications which could cause residents to experience side effects of the medication like increase or decrease in their blood pressure. RN 1 stated she was too nervous, she forget to lock the medication cart. RN 1 stated the practice was to ensure the medication cart was locked at all times. During an interview on [DATE] at 11:45 a.m. with LVN 1, LVN 1 stated the practice was to make sure medication cart was locked at all times when not within our sight. LVN 1 stated there were residents walking by all the time and could access the medications and when taken could cause a reaction leading to a serious health condition. LVN 1 stated staff could also take the medications which could lead to drug diversion (illegal transfer of prescription drugs for personal use, sale, or profit). During an interview on [DATE] at 11:40 a.m. with the Director of Nursing (DON) the DON stated the nurse opening the MDI should label the date opened and used by date to ensure efficacy of the medication. The DON stated the medication should not be administered past its used by date because it is not as effective. The DON stated her expectation was for the licensed nurses to ensure to lock their medication carts at all times when they turned their back away from the medication cart. The (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated there were residents walking by and could access the medications and when taken, could cause adverse reactions leading to serious health conditions. During an interview on [DATE] at 1:25 p.m. with the Administrator (ADM), the ADM stated, Some medications you have to put the date when it was first opened and used by date. The ADM stated labeling medications to ensure medications were not administered past its used by date. The ADM stated the medication concentration was not the same and was not as effective when past its used by date. The ADM stated she expected licensed nurses to ensure medication carts should be locked at all times. The ADM stated any residents walking by could get medications and when taken, could lead to adverse effects of the medications. During a review of facility's policy and procedure (P&P) titled, General Dose Preparation and Medication Administration, dated [DATE], the P&P indicated, .Facility should take all measures required by facility policy and applicable law, including, but not limited to the following . Facility should not leave medications or chemicals unattended . Facility should enter the date opened on the label of medications with shortened expiration dates .During medication administration, facility staff should take all measures required by facility policy and applicable law . Facility staff should ensure that medication carts are always locked when out of sight or unattended. 3. During a concurrent observation and interview on [DATE] at 8:45 a.m. with Licensed Vocational Nurse (LVN) 1, in medication cart two of two, a bottle of insulin did not have an opened or expiration date, two bottles of ear wax removal drops had no resident label or opened date and opened wound care supplies were stored with resident medications. LVN 1 stated, . If the bottles of medications get separated from the box, they could be given to the wrong resident or medication past the expiration date could be given to residents. The opened wound supplies could contaminate the medication in medication cart. The CDR must be filled out completely per policy and to keep inventory in control to prevent drug diversion . During an interview on [DATE] at 11:25 a.m. with the Director of Nursing (DON), the DON stated only medications should be stored in the medication cart, the wound care supplies have been opened and used on residents and could be contagious. The DON stated bottles of medications should be labeled with the resident's information and an opened and expiration date. During a review of the facility's P&P titled, Storage and Expiration Dating of Medications and Biologicals, dated [DATE], the P&P indicated, . Facility should ensure external use medications and biologicals are stored separately from internal use medications and biologicals . Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler).		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure two Food Service Workers (FSW 2 and FSW 3) were competent to safely and effectively carry out the functions of food and nutrition services when: 1. FSW 2 did not follow recipes during meal preparation of Turkey Sandwiches on 3/3/2026 and Chicken Enchiladas on 3/4/2026 and was not aware of what the use by date should be after mighty shakes (nutritional supplement) was thawed in the kitchen fridge on 3/1/26. 2. FSW 3 was not aware of appropriate temperature for the dishwashing machine. These failures had the potential to result in residents' diet orders and facility menus not being followed which can affect residents' nutritional and medical status and to increase the growth of microorganisms and spread foodborne illness (disease or period of sickness caused by food contamination) to the 66 residents that were served meals from the kitchen. Findings: 1. a. During a concurrent observation and interview on 3/3/26 at 3:04 p.m. with FSW 2 in the facility's kitchen, FSW 2 was observed preparing turkey sandwiches with 2 slices of cheese, 4 slices of deli turkey meat and two slices wheat bread. FSW 2 stated the sandwiches were for the regular diet. During a review of the dinner meal on 3/3/26, indicated deli Sandwich, pasta with ranch dressing, and mashed potatoes was to be served for the following diets: Regular, Consistent Carbohydrate Diet (CCD), Heart Healthy (Cardiac), soft and bite sized diets. During a review of the facility recipe titled Sandwich Turkey & Cheese [3] (Turkey & Cheese Sandwich), indicated for 50 servings to use cheese, American white sliced- Preparation step- To assemble sandwich, place 1 slice of cheese and 2 ounces (oz - unit of measurement) of turkey between 2 slices of bread. b. During an observation on 3/4/26 at 10:06 a.m. with FSW 2 in the facility's kitchen, FSW 2 was observed placing 60 x 3 ounces chicken enchiladas from box into a hotel pan, then 2 #10 cans of red sauce and one small can of green enchilada sauce were opened. The red sauce was poured over the chicken enchiladas. FSW 2 was observed grabbing 3 handfuls mozzarella cheese and then a handful of shredded cheddar cheese for each hotel pan of chicken enchiladas and all pans were placed in one of the facility's ovens. During a review of the lunch meal on 3/4/26, indicated Chicken enchiladas, Spanish rice, Whole kernel corn and sliced peaches was to be served for the following diets: Regular, Consistent Carbohydrate Diet (CCD), Heart Healthy (Cardiac), soft and bite sized diets. During a review of the facility recipe titled BVH Chicken Enchiladas (Chicken Enchiladas), indicated for 110 servings to use 7 pounds (lbs. - unit of measurement) of Cheese, [NAME] Shredded and 7 lbs. of cheese, cheddar shredded. Preparation step- Top with enchilada sauce and cheese. FSW 2 did not mix the water and vegetable base with the enchilada sauce. It was unclear how much cheese should be used for the approximate 60 servings for the facility. During a review of the facility recipe titled Enchilada Chicken [3] for 50 servings, indicated to mix water, tomato paste and seasonings together in a saucepan, heat then pour over enchiladas. Then to cover with 10.5 oz of shredded mozzarella cheese. It was unclear how much cheese should be used for the approximate 60 servings for the facility and what recipe FSW 2 should have used for the lunch meal. During an interview with the DM on 3/5/26 at 9:41 a.m., the DM stated she had only done a couple of in-services for kitchen staff since she started at the end of December and was trying to locate any from the past manager. During a review of kitchen in-services dated 1/21/26 and 2/6/26, the in-services did not show any topics about following recipes. During a telephone interview on 3/5/26 at 10:58 a.m. with Registered Dietitian (RD), the recipe for the turkey sandwich was discussed, the RD stated she would expect the dietary staff to following the recipe of one slice of cheese and 2oz of turkey. The RD stated she did not recall observing food production or FSW using the recipes while onsite in the facility on the 1/6/26 and 1/7/26. The RD stated FSW not referencing the recipes was odd. The RD stated the expectation from the FSW was to ensure the menus and recipes were followed. c. During concurrent observation and interview on 03/03/2026 at (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:06 a.m. with the Dietary Manager (DM) during the initial kitchen tour, the fridge in the kitchen had a box of mighty shakes- strawberry flavor with a pull out date of 3/1/26 and use by date of 3/22/26, there was a box of mighty shakes- chocolate flavor with no pull out date or use by date. The DM stated the pull out date should have been on the box. The DM stated the information sheet on fridge indicated the use by date was based on the manufacturer's instructions. During a concurrent observation, interview and record review on 03/03/2026 at 3:09 p.m. with FSW 2 and the DM in the facility's kitchen, the kitchen fridge was opened and the box of mighty shakes- strawberry flavor in fridge dated 3/1 with use by date 3/22 was reviewed. The DM stated, the carton should have stated 15 days after 3/1. FSW 2 stated she thought it should be 3 weeks. FSW 2 was referred to a carton of mighty shakes with manufacturers instruction. The manufacturer's instruction indicated .once thawed to use within 14 days. FSW 2 read the carton and stated, oh it states 14 days. During a review of the facility information sheet displayed on the front of the refrigerator dated 1/2023. The information sheet indicated . Food item- health shake (Thaw), use by date- 2weeks. During a concurrent interview and record review on 03/5/2026 at 9:01 a.m. with the Director of Staff Development (DSD), FSW 2's employee file (EF) was reviewed, the EF indicated FSW 2 was hired on 8/26/25. FSW 2 did not have competency or skills check completed. The DSD stated after one year of employment, there would be an evaluation of facility staff. The DSD stated the DM was responsible for the department training. The DSD stated her department had no record of any competency or training for the kitchen department and thought the DM would have them. During an interview with the DM on 3/5/26 at 9:41 AM, the DM stated when she hired staff, she would give them one week of training and then determine when they can work solo. DM stated she was not sure what was done in the past since she had been here since the end of December. DM stated she had been trying to locate if there was any documentation of staff competencies for any kitchen staff. DM stated she had only done a couple of in-services for kitchen staff since she started and was trying to locate any from the past manager. During a review of kitchen in-services dated 1/21/26 and 2/6/26, the in-service topics were on food temperatures and produce preparation. There were no in-services provided regarding following recipes or nutritional supplements storage dates. During a review of the facility's job description document titled, Nutrition Services Cook, dated 2022, the document indicated, .Summary/ Objective: prepare food in accordance with prescribed resident diet specifications, facility procedures and dietary and sanitary regulations under the supervision of the dietary services manager. Essential functions. Food preparation and serving- prepare and serve food and meals food in accordance with planned menu, diet plans, recipes, portion and temperature control procedures and facility policies. During the survey, there was no documentation provided for kitchen staff competencies for FSW 2. 2. During a concurrent observation and interview on 03/03/2026 at 2:38 p.m. with FSW 3 in the facility's kitchen, FSW 3 was observed was running the dishwashing machine. The temperature was 128 Fahrenheit (F- a scale for measuring temperature). When asked what the temperature of the dish machine should be at, FSW 3 stated she was not sure what temperature the dish machine needed to be but would write it down on the log. When asked if it mattered what the temperature of the dish machine needed to be, FSW 3 stated she did not know. The temperature log for the dish machine was reviewed, the document indicated for low temp dish machine, temperature needed to be 120 F -140 F. During a concurrent interview and record review on 03/5/2026 at 9:01 a.m. with the Director of Staff Development (DSD), FSW 3's EF was reviewed, the EF indicated FSW 3 was hired on 8/26/25. FSW 3 did not have competency or skills check completed. The DSD stated after one year of employment, there would be an evaluation of facility staff. The DSD stated the DM was responsible for the department training. The DSD stated her department had no record of any competency or training for the kitchen department and thought the DM would have them. During a review of the facility's job description for FSW 3 titled, Nutrition Service Aide, signed and dated 8/26/2025, the document indicated, . Summary/ Objective: . assist in maintaining clean and sanitary condition in the kitchen. essential functions . assist in cleaning and sanitizing work areas, equipment. dishes and (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	utensils .During an interview with the DM on 3/5/26 at 9:41 AM, the DM stated when she has hired staff, she will give them one week of training and then determines when they can work solo. DM stated she was not sure what was done in the past since she has been here since the end of December. DM stated she has been trying to locate if there was any documentation of staff competencies for any kitchen staff. DM stated she had only done a couple of in-services for kitchen staff since she started and was trying to locate any from the past manager. During a review of kitchen in-services dated 1/21/26 and 2/6/26, the in-service topics were on food temperatures and produce preparation. During the survey, there was no documentation provided for kitchen staff competencies for FSW 3. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services - Qualified Dietary Staff, dated 7/2018, the P&P indicated, . Purpose: to provide food and nutrition services by employing . qualified staff with appropriate competencies and skill sets. Policy: the facility will employ sufficient staff with the appropriate competencies and skill set to carry out the function of the food and nutrition service . Guidelines: .3 the facility will provide sufficient support staff to safely and effectively provide the functions of the food and nutrition services. 5. The dietitian or the other qualified nutrition professional will be responsible for tasks related to nutritional and diabetic needs of residents and the management of the food and nutrition services. These tasks include but are not limited to .e. food preparation service and storage .		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure food maintained its nutritional value when the cooked asparagus prepared for the lunch meal on 3/05/26 was not palatable and lacked flavor. This failure had the potential to result in residents having a decrease in oral intake which could lead to weight loss. The facility census was 66. Findings: During an interview on 3/3/26 at 10:57 a.m. with Resident 62, Resident 62 stated the facility needed to upgrade their food choices. Resident 62 stated the food served did not taste like it should. During an interview on 3/3/26 at 11:23 a.m. with Resident 31, Resident 31 complained of the facility's food having no flavor. During a review of the lunch meal on 3/5/26, indicated Marinated pork loin, parsleyed potatoes, and red pepper asparagus was to be served for the following diets: Regular, Consistent Carbohydrate Diet (CCD), Heart Healthy (Cardiac), soft and bite sized diets. During a concurrent lunch meal test tray observation and interview on 3/5/26 at 12:46 p.m. with the Dietary Manager (DM) in 100 East Wing Hallway. The temperatures of the food were taken, and the regular and puree test tray were sampled. The regular and pureed asparagus tasted bland and lacked flavor. The DM acknowledged the asparagus lacked flavor and tasted bland. During an interview on 3/5/26 at 12:59 p.m. with FSW 1 and the DM, FSW 1 stated she was unable to recall the quantity of items used to flavor the asparagus. FSW 1 stated she eyeballed the salt and pepper to taste and used margarine. FSW 1 stated the quantity of items put on the asparagus was not measured. FSW 1 stated the asparagus was a frozen product and she did not want to use the oven since the facility had one working oven. FSW 1 stated the asparagus was prepared on the stove for about 30 minutes and then it was put on the steam table at 11am. FSW 1 stated she liked to start tray line or meal service around 11:40 a.m. or 11:45 a.m. FSW 1 stated the outcome of the asparagus could be due to the length of time it was cooked. The DM stated food should not be on the steam table longer than 30 minutes. During a review of the facility recipe titled Asparagus with Red Pepper (fzn) AV (Red Pepper Asparagus -TM), indicated for 50 servings to use 10 pounds of frozen cuts of asparagus with one cup of canned diced red peppers, with 1/2 cup of margarine. It indicated under notes, recommended seasonings include basil, chives, coriander, dill, garlic powder, ginger, marjoram, oregano, rosemary, tarragon, herbes de [NAME], salt free herb seasonings. Add 2 1/2 tablespoons seasoning of choice per 10 pounds. During an interview with the DM on 3/5/26 at 9:41 a.m., the DM stated she had only done a couple of in-services for kitchen staff since she started at the end of December and was trying to locate any from the past manager. During a review of kitchen in-services dated 1/21/26 and 2/6/26, the in-services did not show any topics about following recipes. During a review of the facility's job description document titled, Nutrition Services Cook, dated 2022, the document indicated, .Summary/ Objective: prepare food in accordance with prescribed resident diet specifications, facility procedures and dietary and sanitary regulations under the supervision of the dietary services manager. Essential functions. Food preparation and serving- prepare and serve food and meals food in accordance with planned menu, diet plans, recipes, portion and temperature control procedures and facility policies. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services - Food and Drink, dated 7/2018, the P&P indicated, . Purpose: to provide residents with food and drink that is nutritive, appealing and meets their needs. Policy: the facility will prepare food and drinks in methods that conserve nutritive value, flavor and appearance. Food and drink will be palatable, attractive and at a safe, appetizing temperature. It further indicated under the section titled Guidelines 1. To maintain nutritive value of food, the food will not be . b. held for prolonged times on a steam table .		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interviews and review of facility documents, the facility failed to ensure the puree vegetables were in proper form when there were stringy pieces of asparagus throughout the food mixture on the lunch meal test tray on Thursday, March 5, 2026. Failure to properly process the puree food can result in choking for the five residents (Residents 6, 22, 50, 55, 69) on a puree diet at the facility. Findings: During an observation of the lunch meal test tray for a puree and regular diet in the presence of the Dietary Manager (DM) on 3/5/26 at 12:46 p.m. on the 100 East wing hallway, once all the trays were passed to the residents. The puree and regular food items were tasted by the surveyors and the DM as well as the DM took temperatures of the foods at this time. The puree asparagus had multiple strings and thin pieces throughout the portion on the plate. During a concurrent interview with the DM, DM acknowledged the strings in the puree asparagus and stated they should not be there. During an interview with the Food Service Worker (FSW) 1 on 3/5/26 at 12:59 p.m., FSW 1 stated she uses frozen asparagus, cooks for 30 minutes then will add the broth to thin to the appropriate consistency. FSW 1 stated she is looking at the back of the spoon and to have the food stick to it. FSW 1 stated she always has trouble with having strands when she makes the pureed asparagus. During an interview with the DM on 3/05/2026 at 11:47 a.m., DM stated she would expect staff to test for consistency for International Dysphagia Diet Standardization Initiative (IDDSI). During a review of the lunch meal tray tickets dated 3/5/26, indicated there were five residents (Residents 6, 22, 50, 55, 69) receiving a level four puree texture and received the puree asparagus. During a review of the facility document titled Standards of Professional Practice: Diet Guide for the IDDSI for Level 4: Pureed Food, undated, indicated foods are to be smooth, and lump-free, not firm or sticky, requires no chewing or bolus formation, fall off the spoon as an intact spoonful, and hold shape on a plate. During a review of the facility recipe titled PU4 Asparagus with Red Pepper (fzn), indicated to measure desired number of servings into food processor. Blend until smooth. Use Fork Drip Test & Spoon Tilt Test to confirm texture is within IDDSI Level 4 specifications. During a review of the facility policy and procedures titled Food and Nutrition Services Menus and Therapeutic Diets dated 7/18, indicated the purpose is to have menus that are developed and prepared to meet resident choices while meeting their nutritional needs and in the appropriate form.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain infection prevention and control program for a safe, sanitary, and comfortable environment for three of 12 sampled residents (Residents' 46, 47, and 79) when: 1. Handheld nebulizer (HHN) masks (a medical device accessory that covers the nose and mouth, allowing patients to inhale aerosolized medication directly into the lungs) for Resident 46 and Resident 47 were not labeled with the date it was first used and was observed placed directly on top of each resident's bedside table. These failures had the potential for Resident 46 and Resident 47 to be exposed to cross contamination (unintentional transfer of harmful germs or allergens from one surface or object to another) when the nebulizer masks were used by the residents. 2. Physical Therapy Assistant (PTA) did not wear appropriate personal protective equipment (PPE-specialized clothing, equipment, and supplies worn by healthcare staff to protect residents and themselves from potential infectious hazards) while transferring Resident 79 from bed to wheelchair. Resident 79 was on an enhanced barrier precaution (EBP - measures used in healthcare settings to prevent the spread of infections) due to the presence of a urinary catheter (a tube that drains urine from the bladder into a bag) and a nephrostomy tube (a tube from the kidney to the outside of the body to drain urine when normal flow is blocked). This failure had the potential to cause Resident 79 a catheter-associated urinary tract infections (a urine or bladder infection that happens because of a urine catheter) and contamination of the nephrostomy site. Findings: 1. During a concurrent observation and interview on 3/3/26 at 11:35 a.m. during the initial tour in Resident 46's room, Resident 46's bedside tabletop had a hand held nebulizer mask with no date. Resident 46 stated she used the handheld nebulizer mask every day for her breathing. Resident 46 stated she was not sure where the mask should be placed and was not sure when they replaced it last. During a concurrent observation and interview on 3/3/26 at 11:40 a.m. during initial tour in Resident 47's room, Resident 47's bedside tabletop had a nebulizer mask with no date. Resident 47 was lying in bed and stated she remembered she used the nebulizer mask in the morning and used it every day for her breathing problem. During a review of Resident 46's admission Record (AR-a document containing resident profile information), undated, the AR indicated Resident 46 was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure (a life-threatening, medical emergency where lungs suddenly cannot get enough oxygen into the blood or remove enough carbon dioxide), heart failure (heart muscle is too weak or stiff to pump blood efficiently), and shortness of breath. During a review of Resident 47's AR, undated, the AR indicated Resident 47 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty breathing), muscle weakness, and dysphagia (difficulty swallowing). During a review of Resident 47's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 1/13/26, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 3 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 47 had severe (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive impairment. During a concurrent observation and interview on 3/3/26 at 11:45 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 observed Resident 46 and Resident 47's HHN masks and stated Resident 46 and Resident 47's HHN mask did not have dates and were placed on top of their bedside tables. LVN 2 stated HHN masks should have been labeled with the date they were first used and stored in a bag and not placed directly on top of the bedside tables. LVN 2 stated HHN masks were replaced every week. LVN 2 stated, I am not sure if it was night shift licensed nurses or the infection preventionist. LVN 2 stated not having the HHN mask labeled and placed in a bag was an infection control issue. LVN 2 stated bacteria could build up in the HHN masks and tubing and when used, residents could inhale bacteria which could go straight into their lungs making them sicker. During an interview on 3/6/26 at 11:20 a.m. with LVN 1, LVN 1 stated the practice was to make sure HHN masks were labeled with the date they were replaced and stored in a bag. LVN 1 stated HHN masks should not be placed directly on top of a surface like the bedside table. LVN 1 stated HHN tubing and masks were changed every week and labeled with the date and placed in a bag because it was an infection control issue. During an interview on 3/6/26 at 11:47 a.m. with the Director of Nursing (DON), the DON stated her expectation was licensed nurses should change HHN masks weekly and should be bagged because the masks got dirty, it was an infection control. The DON stated the IP was responsible to make sure oxygen tubing, HHN masks and tubings' were replaced and labeled. The DON stated, The infection preventionist did not do his rounds this week. During a review of facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Non-Critical Resident Care Items, dated 10/18/22, the P&P indicated, .Single resident use items are for single resident use only. [NAME] with the resident's name and/or room number and discard upon transfer or discharge . Critical items consist of items that carry a high risk of infection if contaminated . Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g., [for example] respiratory therapy equipment). Such device should be free from all microorganisms . Dedicated, single resident -use items are labeled with the resident name . 2. During an observation on 3/3/26 at 11:15 a.m. outside of Resident 79's room, an EBP sign and cart were placed outside prior to entry into the room. The cart was stocked with gowns and gloves for use before entering the room. During a concurrent observation and interview on 3/3/26 at 11:20 a.m. with the PTA inside Resident 79's room, the PTA transferred Resident 79 from bed to wheelchair and was wearing gloves but not wearing a gown. The PTA stated, Resident 79 is scheduled for a physical therapy today. The PTA stated they had not been informed about the EBP sign posted on the door and reported that the EBP sign is sometimes not updated. During an interview on 3/3/26 at 12:04 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 79 was on EBP due to the presence of a urinary catheter and a nephrostomy tube. LVN 2 stated, prior to working with Resident 79, the facility staff including the PTA, were required to wear PPE to protect the resident from germs. During an interview on 3/5/26 at 9:26 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand hygiene must be performed before applying PPE, including a gown and gloves used for EBP, when assisting the residents with activities of daily living (the basic things a person needs to do every day to take care of themselves). During an interview on 3/5/26 at 12:03 p.m. with the Infection Preventionist (IP), the IP stated the EBP applied to all Licensed Nurses, Certified Nursing Assistants, Physical Therapists and Physical Therapy Assistants when providing care to residents, including transfers from bed to wheelchair. The IP stated the purpose of EBP was to prevent cross-contamination (germs spreading from one place or object to another) and ensure the residents' safety from infection. The IP stated the EBP sign posted outside Resident 79's room was updated to ensure facility staff were aware of the necessary precautions before entering the room. The IP stated the EBP sign is updated weekly and as needed. During an interview on 3/6/26 at 12:35 p.m. with the Director of Nursing (DON), the DON stated facility staff were expected to always follow the EBP to protect residents from infection and to prevent the spread of germs within the facility. During a review of the facility's policy and procedures (P&P) titled, INFECTION CONTROL: Standard Precautions, Enhanced Barrier Precautions, and Transmission-Based Precautions, dated 3/26/24, the P&P indicated, .EBP is employed when performing the following high-contact resident care activities: .when anticipating close physical contact while assisting with transfers and mobility.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure essential equipment was maintained in safe operating condition when: one of two kitchen ovens were not working and unable to be used. This failure to have an operational oven could result in the food taking longer to cook resulting in delayed meal times, inconsistent food quality, and inefficient workflows. The facility census was 66. Findings:1. During an observation on 3/4/26 at 10:06 a.m., Food Service Worker (FSW) 2 was preparing three hotel pans of chicken enchiladas with red sauce and one quarter hotel pan with chicken enchiladas with green sauce. All pans were placed in one of the kitchen ovens. During an interview on 3/4/26 at 11:42 a.m. with FSW 2, FSW 2 stated only one oven was working and the nonworking oven has not worked for about five months. FSW 2 stated she was told it could not be fixed and now they just had to try to time things and just use the one oven. During an interview on 3/5/26 at 9:30 a.m. with the Maintenance Director (MD), the MD stated the oven pilot had went out last week but thought everything was working since then. The MD stated the staff will use their system to let him know about maintenance issues. The MD stated two months ago that he did the pilot assembly and then it was working. The MD stated he relied on the kitchen staff to let him know about things going wrong in the kitchen. The MD stated he would find receipts of pilot assembly from two months ago and the engines done a month ago. During a review of the facility document titled, work order #1502, dated 12/10/25, the work order indicated the right oven was out and pilot light was on. Under comments it indicated checked oven and found switch was not on, working properly and the timeline indicated it was completed on 12/12/25. During a review of the facility policy and procedures titled, Physical Environment Essential Equipment, Safe Operation Condition, dated 7/18, the policy indicated, The facility will maintain mechanical, electrical and patient care equipment in safe operating condition.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a comfortable environment for four of 31 sampled residents (Residents 14, 41, 51, and 80), when vertical blinds had missing slats, horizontal blinds were broken, and resident room walls had scratches and missing paint. These failures created an environment that was not homelike and had the potential to decrease the residents mood and potentially lead to depression. Findings: During a concurrent observation and interview on 3/5/26 at 3:27 p.m. with Resident 41 in her room, Resident 41 was lying in bed on her back with the sun streaming on her face. Resident 41 stated, . the sun shines off the cars in the parking lot and right into my face from the hole in the blinds, it causes me to get a headache. The blinds have been broken since I was admitted .During a concurrent observation and interview on 3/5/26 at 3:28 p.m. with Resident 80's family member in her room, Resident 80's family member stated, In my home I would not have so many slats missing from the blinds, I would prefer [Resident 80] have complete blinds. During a concurrent observation and interview on 3/5/26 at 3:40 p.m. with the Maintenance Director (MD) in Resident 41's and Resident 80's room, the MD stated, in reference to Resident 41 and 80's room . This is not a home like environment, the blind slat should not be on the floor, and if I would not like to have the sun shining in my eyes . During a concurrent observation and interview on 3/5/26 at 3:45 p.m. with the MD, in Resident 14's, and Resident 51's room. The horizontal blinds were broken with missing slats, and the residents' room walls had scratches and missing paint. The MD stated, . the resident should not have to look at the wall and blinds that are not repaired. I will be repairing the blinds and the wall . During a concurrent observation and interview on 3/5/26 at 4:49 p.m. with Certified Nurse Assistant (CNA 4), CNA 4 stated I would not want my family to be in a room that had all the damage to the wall. During a concurrent observation and interview on 3/5/26 at 4:53 p.m. with CNA 5, CNA 5 stated, Missing blinds are a pet peeve of mine and if I was stuck in bed looking at scraped wall and missing blinds it would make me depressed. During a review of Resident 14's admission Record (AR), dated 3/6/26, the AR indicated Resident 14 was admitted to the facility on [DATE] from a Skilled Nursing Facility (SNF) with the diagnosis of Hemiplegia (the severe or total loss of voluntary movement [paralysis] on one vertical side of the body [left or right], weakness, pain, dysphagia (difficulty swallowing, causing pain or trouble moving food/liquids from the mouth to the stomach), and cognitive communication deficit (difficulty in communication). During a review of Resident 41's AR, dated 3/6/26, the AR indicated Resident 41 was admitted to the facility from an acute care hospital on 2/10/26 with the diagnosis of closed right femur (long bone in the thigh) fracture (define), right patella (knee) fracture, right humerus (long bone of upper arm) fracture?, and general weakness. During a review of Resident 51's AR, dated 3/6/26, the AR indicated Resident 51 was admitted to the facility from a SNF on 1/20/23 with diagnosis of Chronic Obstructive Pulmonary Disease (COPD- a progressive, irreversible lung disease-primarily caused by smoking or pollution-that restricts airflow, making it difficult to breathe), muscle wasting, Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out simple tasks), and Type 2 Diabetes Mellitus (DM - a chronic metabolic disease characterized by high blood sugar (glucose) levels, occurring when the body cannot properly produce or use insulin). During a review of Resident 80's AR, dated 3/6/26, the AR indicated Resident 80 was admitted to the facility from an acute care hospital on 2/25/26 with the diagnosis of Neoplasm of the bone (an abnormal growth or lump of cells within the bone, essentially a bone tumor), Human Immunodeficiency Syndrome Virus (HIV- a virus that attacks the body's immune system, specifically CD4 cells [T cells]), and Sepsis (a life-threatening medical emergency caused by the body's extreme, overactive response to an infection). During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 1/2018, the P&P indicated . 2. The facility staff and management (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maximize, to the extent possible, the characteristics of the facility that reflect a personalized, home-like setting. These characteristics include: a clean, sanitary, and orderly environment .		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with dignity and respect in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for one of three sampled residents (Resident 79), when Resident 79's urinary catheter (tube inserted into the bladder through the urethra [urine tube], to drain urine freely into a connected bag) bag was not placed in a dignity bag (a bag the catheter drainage bag is placed into, to cover the resident's urine from view). This failure resulted in Resident 79's urinary catheter bag to be uncovered in full view for others to see and having the potential for Resident 79 to feel his privacy and dignity were not respected. Findings: During a review of Resident 79's admission Record (AR), dated 03/6/26, the AR indicated, Resident 79 was admitted to the facility on [DATE] with diagnosis which included Acute kidney failure (kidney suddenly stop cleaning the blood), obstructive and reflux uropathy (blockage in the urine tubes), Hydronephrosis with renal and ureteral calculous obstruction (swollen kidney, kidney stones blocking the flow of urine), and other artificial openings of urinary tract status (surgically made opening to drain urine). During a review of Resident 79's Order Summary Report (OSR), dated 3/6/26, the OSR indicated, .Foley catheter to gravity drain. [catheter] size 16 .every shift. During a concurrent observation and interview on 3/5/26 at 9:26 a.m. with Certified Nurse Assistant (CNA) 3 in Resident 79's room, Resident 79's urinary catheter bag was hung on the side of the bed and uncovered. The urinary catheter bag was visible upon entry to Resident 79's room. CNA 3 stated Resident 79's catheter bag was not covered. CNA 3 stated, The catheter bag should be covered with a dignity bag at all times to provide privacy and dignity to the resident. During an interview on 3/5/26 at 10:58 a.m. with Licensed Vocation Nurse (LVN) 2, LVN 2 stated, a urinary bag must always remain covered when inside or outside the resident's room, to protect the resident's' privacy and maintain dignity. During an interview on 3/5/26 at 12:03 p.m. with the Infection preventionist (IP), the IP stated, a urinary bag cover must always remain in place to prevent exposure of the urine bag to other residents and visitors and to maintain resident privacy and dignity. During an interview on 3/6/26 at 9:25 a.m. with the Director of staff development (DSD), the DSD stated, a urinary bag cover was used to maintain residents' privacy, dignity and comfort while preventing embarrassment. During an interview on 3/6/26 at 12:25 p.m. with the Director of Nursing (DON), the DON stated, a urinary bag cover should be always applied as a best practice to maintain and promote residents' dignity. During a review of the facility's policy and procedure (P&P) titled, RESIDENT RIGHTS, dated 9/20/2022, the P&P indicated, .The resident has the right to be treated with respect and dignity.		

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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** Based on observation, interview, and record review, the facility failed to ensure a physician informed consent (the process in which residents are given information of the possible risk and benefits of psychoactive medications (change brain function, altering perception, mood, consciousness, and behavior) for the use of psychotropic medications (medication capable of affecting mind, emotions and behavior) was obtained for one of six sampled residents (Resident 32), when Resident 32 was administered lorazepam (medication used to treat anxiety (excessive, persistent fear or worry that interferes with daily life)) on 3/1/26 and 3/2/26 and informed consent was not obtained prior to medication administration. This failure resulted in Resident 32 to be administered psychotropic medication and not be fully informed of the risks and benefits and did not have the knowledge to make an informed decision which placed Resident 32 at potential risk for negative side effects. During a concurrent observation and interview on 3/3/26 at 10:06 a.m. during initial tour in Resident 32's room, Resident 32 was observed standing next to his bed with certified nursing assistant (CNA) 1, Resident 32's bed was in the lowest position and a fall mat was at bedside. Resident 32 did not answer question, CNA 1 stated Resident 32 was confused and Spanish Speaking only. During a review of Resident 32's admission Record (AR-a document containing resident profile information), dated 3/5/26, the AR indicated Resident 32 was admitted to the facility on [DATE] with diagnoses which included anxiety, dementia (a progressive state of decline in mental abilities) and repeated falls. During a review of Resident 32's Order Summary Report, dated 3/5/26, the Order Summary Report indicated, .[brand name] 2 (two) [milligram/milliliter-unit of measurement (MG/ML)] (LORazepam) Inject 1 (one) mg intramuscularly [into muscle tissue] every 12 hours as needed . Order Date: 2/25/26 . During a review of Resident 32's Medication Administration Record (MAR- a document that shows the medication ordered and taken by a resident), dated 2/1/26-2/28/26 and 3/1/26-3/31/26, the MAR indicated lorazepam was administered on 3/1/26 and 3/2/26. During a concurrent interview and record review on 3/5/26 at 9:25 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 32's clinical record, dated 3/5/26 was reviewed. LVN 2 stated Resident 32's lorazepam was ordered on 2/25/26. LVN 2 stated she did not find an informed consent for lorazepam. LVN 2 stated lorazepam should not have been administered without an informed consent. LVN 2 stated licensed nurses were responsible to make sure informed consent were signed prior to administering psychotropic medications. LVN 2 stated informed consent were important to educate residents and family of the side effects and benefits of the medications. During a concurrent interview and record review on 3/5/26 at 3:08 p.m. with the Unit Manager (UM), Resident 32's clinical record, undated was reviewed. The UM stated the clinical record indicated a consent for Resident 32's lorazepam was not found. The UM stated the licensed nurse who received the order should have made sure informed consent was signed prior to administering the medication. The UM stated lorazepam should not have been administered to Resident 32 without a signed informed consent. During a concurrent interview and record review on 3/6/26 at 11:32 a.m. with the Director of Nursing (DON), Resident 32's clinical record, undated was reviewed. The DON stated the clinical record indicated Resident 32's lorazepam was changed from oral to injection. The DON stated her expectation was for the licensed nurse to ensure the lorazepam informed consent was signed. The DON stated, The consent should have been signed before it was administered. The DON stated it was the right of the resident and family to be aware of the medications they are receiving and given a chance to decide whether they wanted to receive the medication. During an interview on 3/6/26 at 1:05 p.m. with the Administrator (ADM), the ADM stated her expectation was to ensure informed consent for psychotropic medications were signed prior to administering medications. The ADM stated informed consents explained the risks and benefits of medications, so residents and family could then decide whether they wanted the medication or not. During a review of facility's policy and procedure (P&P) titled, Freedom from (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse, Neglect and Exploitation, Abuse, dated 11/17, the P&P indicated, .The facility will provide a safe environment and protect residents from abuse .This includes freedom from . physical or chemical restraint not required to treat the resident's medical symptoms . During a review of facility's P&P titled, Psychotropic Medication Use, dated 12/1/07, the P&P indicated, Psychotropic medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use . Facility staff should inform the resident and/or resident representative of the initiation, reason for use and the risks associated with the use of psychotropic medications .		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a new Preadmission screening and Resident Review (PASARR- a federal requirement to ensure resident with mental disorder or intellectual disorder or intellectual disabilities are not inappropriately placed in a nursing home) level 1 screening for one of six sampled residents (Resident 6) when Resident 6's PASARR level 1 dated 9/9/24 completed prior to admission to the facility did not include diagnosis of psychosis (a severe mental condition in which thought, emotions are so affected that contact is lost with reality) and depression (a serious, persistent mood disorder) and use of psychotropic medication (drugs that affect the mind, emotions, and behavior). This failure had the potential for Resident 6 to not receive the appropriate services related to her diagnoses and medication used. Findings: During a concurrent observation, and interview, on 3/3/26 at 12:05 p.m. in the dining room with Resident 6, Resident 6 was observed sitting up in her wheelchair, appropriately dressed and answered questions. Resident 6 stated she did not remember how long she had been in the facility. Resident 6 stated she was happy and did not have any concerns. During a review of Resident 6's admission Record [AR- a document containing resident profile information], dated 3/5/26, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses which included unspecified psychosis, depression and hemiplegia [total paralysis of the arm, leg and trunk on the same side of the body] and hemiparesis [one-sided weakness or side weakness]. During a review of Resident 6's Order Summary Report [OSR] undated, the OSR indicated, . [brand name] Sprinkles Oral Capsule . 125 [(MG) milligram-unit of measurement] (Divalproex Sodium-medication used to treat seizures). Give 2 capsules by mouth two times a day . yelling out . uncontrollable sobbing . Order Date: 3/14/25 . FLUoxetine [medication used to treat depression] . 60 MG . Give 1 tablet by mouth one time a day for sad facial expression, 2 tearfulness . Order Date: 3/11/25 During an interview on 3/4/26 at 2:41 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 6's care. CNA 1 stated Resident 6 have behaviors like crying and she does not even know why she was crying. CNA 1 stated she did not know if Resident 6 took medication for her crying. During a concurrent interview and record review on 3/5/26 at 9:15 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 6's clinical record, undated was reviewed. LVN 2 stated the clinical record indicated Resident 6 was admitted to the facility on [DATE]. LVN 2 stated Resident 6's divalproex sodium was ordered on 3/17/25 and her fluoxetine was ordered on 3/12/25. During an interview on 3/5/26 at 3:08 p.m. with the Unit Manager (UM), the UM stated, Director of Nursing (DON) and I review admission and ensure there was a PASARR completed prior to admission to the facility. The UM stated she was not sure when a new PASARR should be completed when there was a new order for a psychotropic medication. The UM stated a new PASARR assessment should be completed annually and when a resident was admitted to hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility. During a concurrent interview and record review on 3/6/26 at 9:22 a.m. with the DON, Resident 6's clinical record, undated was reviewed. The DON stated the clinical record indicated Resident 6 was ordered psychotropic medication after the PASARR was completed but was not sure whether a new PASARR should be completed. The DON stated new admission's PASARR were reviewed for any discrepancies but was not sure whether to complete another PASARR assessment and reached out to the company consultant. The DON stated, I was told not to do another PASARR assessment because there was one already completed. During a review of facility policy and procedure (P&P) titled, Resident Assessment Preadmission Screening and Resident Review (PASRR), dated 11/17, the P&P indicated, .Any resident with newly evident or possible serious [Mental Disorder](MD)], or [Intellectual Disability (ID)], or a related condition will be referred by the facility to the appropriate state-designated mental health or intellectual disability authority for (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review . During a review of professional reference from the California Department of Health Care Services (DHCS) (a government agency that provides healthcare services to low-income and disabled Californians) titled, Preadmission Screening and Resident Review, undated, (found at https://www.dhcs.ca.gov/services/MH/Pages/PASRR.aspx), the reference indicated .The (DHCS), PASRR Section is responsible for determining if individuals with serious mental illness (SMI) and/or intellectual/developmental disability (ID/DD) or related conditions (RC) require: Nursing facility services, considering the least restrictive setting, Specialized services. This is achieved by completing the PASRR process. The PASRR process consists of a Level I Screening, Level II Evaluation, and a final Determination. Level I Screening-The Screening is submitted online by the facility and is a tool that helps identify possible SMI and/or ID/DD/RC. Level II Evaluation- If the Screening is positive for possible SMI and/or ID/DD/RC, then a Level II Evaluation will be performed. The Level II Evaluation helps determine placement and specialized services. The Department of Health Care Services (DHCS) is responsible for SMI Level II Evaluations, which by law must be performed by a third-party contractor		

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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** Based on observation, interview, and record review, the facility failed to ensure a comprehensive, person-centered care plan (a plan that provides direction for individualized care of the resident) was developed and implemented to meet the identified needs for one of eight sampled residents (Resident 41), when Resident 41 did not have a care plan for their arm sling (a supportive device-usually a fabric pouch with a strap-used to hold an injured arm, wrist, or shoulder still against the body). This failure placed Resident 41 at risk for delayed healing by not identifying and monitoring for compliance with the arm sling. Findings: During a review of Resident 41's admission Record (AR-a document containing pertinent resident profile information), dated 3/6/26, the AR indicated Resident 41 was admitted to the facility on [DATE] with diagnoses which included fracture (define) of the right femur (long bone of the leg), fracture of the right patella (knee cap), fracture of the humerus (long bone of the arm), and unsteadiness on her feet. During a review of Resident 41's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment, dated 2/16/26, the MDS assessment indicated Resident 41's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 15 out of 15 which indicated Resident 41 had no cognitive deficit. During a concurrent observation and interview on 3/3/26 at 10:40 a.m. with Resident 41 in their room, Resident 41 was lying in her bed without her arm sling. Resident 41 stated she was in the facility for therapy after falling and having surgery on her fractured right leg and right shoulder. Resident 41 stated she was supposed to have her sling on but frequently took it off. During a review of Resident 41's Order Summary Report (OSR-a report of all orders for resident while in facility), dated 3/4/26, the OSR indicated Resident 41 had an order to monitor sling placement to the right upper extremity every shift and for proper placement. During a concurrent interview and record review on 3/4/26 at 1:30 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 41's Electronic Medical Record (EMR), dated 9/12/24 was reviewed. LVN 1 stated the EMR indicated a care plan for Resident 41's right arm sling was not found. LVN 1 stated a care plan was created to instruct nursing on how to care for the resident, if the care plan had missing information, the resident could be at risk for not receiving the care needed to heal. During a concurrent interview and record review on 3/5/26 at 2:00 p.m. with the Unit Manager (UM), Resident 41's care plan, dated 3/5/26 was reviewed. The UM stated she placed the care plan for the sling earlier that day. The UM stated that the intervention should have been placed in the care plan right after the order was placed to give staff directions for care of Resident 41. During an interview on 3/6/26 at 11:57 a.m. with the Director of Nurses (DON), the DON stated Resident 41 did not have a care plan for her sling. Resident 41 should have a care plan to alert nurses that Resident 41 should be wearing her sling. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, dated 11/2017, the P&P indicated, .The care plan will be person-centered. It will drive the type of care and services that a resident receives . a comprehensive care is developed within seven (7) days of completing the resident assessment.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care and services in accordance with professional standards of quality of care for three out of six sampled residents (Residents' 11, 48, and 65) when: 1. Licensed Vocational Nurse (LVN) 3 signed the electronic Medication Administration Record (eMAR- legal record of drug administration to a patient at a facility by a health care professional) prior to administering Resident 11 and Resident 65's received their medications. These failures resulted in inaccurate charting and placed Resident 11 and Resident 65 at risk to not receive the medications ordered. 2. Registered Nurse (RN) 1 did not shake the inhaler (handheld, pressurized device that delivers a specific, measured dose of medication) before he gave it to Resident 48 to self administer. This failure had the potential to result in Resident 48 not receiving the accurate dose of medication which could lead to Resident 48 not experiencing relief of his condition. Findings: 1. During a concurrent observation and interview on 3/5/26 at 8:25 a.m. with Licensed Vocational Nurse (LVN) 2 in the west wing, LVN 2 was observed preparing Resident 11's medications and stated Resident 11 was the last resident she was administering medications to. LVN 2 exited Resident 11's room after administering Resident 11's medications, opened the medication cart and pulled out a medication cup with pills and stated, I have to give these five pills to Resident 65 in room [ROOM NUMBER]. LVN 2 did not sign or record in the eMAR she administered Resident 11 and Resident 65's medications after administering their medications. LVN 2 stated she documented she administered Resident 11's medication prior to administering her medications. LVN 2 stated she prepared Resident 65's medications earlier and documented she administered medications but Resident 65 did not take his medications. LVN 2 stated she had to go back to administer Resident 65's medications. LVN 2 stated it was her practice to click save in the eMAR indicating medication was administered prior to administering medications to residents. LVN 2 stated the acceptable practice was to administer medications first then document after medications were administered. LVN 2 stated documenting medications were administered prior to administering medications was not the acceptable practice, it could lead to a medication error. During a review of Resident 11's admission Record (AR-a document containing resident profile information), undated, the AR indicated Resident 11 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (irregular heart rhythm, characterized by rapid chaotic electrical signals that causes the heart's upper chambers to quiver), muscle weakness, rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility) and carcinoma (cancer) of the skin. During a review of Resident 65's AR, undated, the AR indicated Resident 1 was re-admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and muscle weakness. During an interview on 3/6/26 at 10:55 a.m. with LVN 2, LVN 2 stated the practice was to pull out one medication at a time, administer the medication then go back in the eMAR and click save indicating the medication was administered. LVN 2 stated medications could not be documented as administered prior to administering medications to residents stating, it is not the right practice. During an interview on 3/6/26 at 11:20 a.m. with LVN 1, LVN 1 stated, I document a medication was administered after I administered the medication and not before. LVN 1 stated the practice in the facility was to ensure medications were administered first then documented to prevent a medication error. 2. During a concurrent observation and interview on 3/5/26 at 3:58 p.m. in the west wing during medication administration observation with RN 1, RN 1 prepared Resident 48's medication including a metered dose inhaler (MDI-handheld, pressurized device that delivers a specific, measured dose of medication) of Budesonide-Formoterol Fumarate Aerosol (used to help control asthma and improve lung function). RN 1 entered Resident 48's room and administered Resident 48's medication. RN 1 (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gave the MDI to Resident 48 without shaking and let Resident 48 self-administer two puffs of the MDI. RN 1 stated she did not shake the MDI because the MDI was already shaken every day. RN 1 stated she was not sure if Resident 48 self-administered the MDI because she had always given the MDI to Resident 48. RN 1 stated not shaking the MDI could result in not delivering the right dose or concentration of medication. During a review of Resident 48's admission Record (AR- a document containing resident profile information), dated 3/6/26, the AR indicated Resident 48 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty inbreathing), shortness of breath and muscle weakness. During a review of Resident 48's Order Summary Report, dated 3/6/26, the Order Summary Report indicated, . Budesonide-Formoterol Fumarate Inhalation Aerosol .2 [two]puff inhale orally two times a day for COPD Rinse mouth with water after use. Do not swallow . Order Date: 05/24/2025 . During an interview on 3/5/26 at 2:30 p.m. with LVN 3, LVN 3 stated the MDI medication should be shaken well to ensure the medication was mixed thoroughly to administer the correct amount of medication. LVN 3 stated not shaking the medication well could lead to residents not experiencing relief because the proper dose or strength was not delivered. LVN 3 stated she was not sure if giving the MDI to Resident 48 to self-administer is considered self-administration. During an interview on 3/6/26 at 10:48 a.m. with LVN 2, LVN 2 stated MDI medications should be shaken well before administration to make sure medications were mixed properly. LVN 2 stated, To make sure resident received the accurate, consistent and effective dose with each spray. LVN 2 stated there was an instruction in the medication package to shake well. LVN 2 stated it was considered self-administration of medication when Resident 48 self-administered the MDI. During an interview on 3/6/26 at 11:23 a.m. with LVN 1, LVN 1 stated, I usually shake MDI before I hand over to residents. LVN 1 stated residents who had inhalers are alert and not sure if evaluation or assessment was needed to check if residents were competent to self-administer medication. LVN 1 stated it was considered self-administration when Resident 48 self-administered the MDI. LVN 1 stated she was not sure if Resident 48 was administering the MDI properly and receiving the correct dose of medication when the MDI was not shaken prior to administration. During a concurrent interview and record review on 3/6/26 at 11:35 a.m. with the Director of Nursing (DON), Resident 48's Self-Administration of Medication (SAM), dated 10/14/25 was reviewed. The DON stated her expectation was for licensed nurses to administer medications first before they saved in the eMAR. The DON stated nurses could place a checkmark next to each medication pulled but do not save because once they clicked save, it meant the medication was already administered. The DON stated, Nurses should know better. The DON stated the MDI should be shaken well to ensure medication was thoroughly mixed. The DON stated her expectation was for licensed nurses to shake medications well to ensure an accurate, consistent and effective dose was administered to the resident. The DON stated the SAM indicated Resident 48 could self-administer medications. The DON stated the evaluation should be renewed every 3 months and Resident 48's evaluation was due in January 2026 but was not completed. During an interview on 3/6/26 at 1:10 p.m. with the Administrator (ADM), the ADM stated it was not acceptable to sign the eMAR before administering medications. The ADM stated it could lead to a medication error because they may not administer the medication since it was already signed. The ADM stated she considered it as self-administration of a medication when a licensed nurse handed over the MDI to a resident. The ADM stated, The resident is pressing down the inhaler/actuation which controls the dose. The ADM stated her expectation was for the licensed nurses to do the right thing.During a review of the facility policy and procedure (P&P) titled, General Dose Preparation and Medication Administration, dated 12/01/07, the P&P indicated, .Facility should take all measures required by facility policy and applicable law .Only prepare medications for one resident at a time . Verify each time a medication is administered that it is the correct medication . Position the resident properly, if necessary . After medication administration, facility staff should take all measures required by facility policy and applicable law . Document necessary medication administration/treatment information [e.g., (for (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	example) when medications are opened, when medications are given, injection site of a medication, if medication are refused, PRN medications, applicable site] on appropriate forms .During a review of the facility P&P titled, Pharmacy Services Medication Administration, dated 08/18, the P&P indicated, .Medications will be shaken according to manufacturer instruction . When administering a metered dose inhaler (MDI), staff will: a. Shake the container well. b. Position the inhaler in front of or in the resident's mouth .		

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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** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services which ensured the administration of medications to meet residents needs were met for one of 10 sampled residents (Resident 31), when Resident 31's buspirone (medication used to treat anxiety (feeling of fear, dread, and uneasiness, often accompanied by physical symptoms)) medication was not available during medication pass on 3/5/26. This failure had the potential for Resident 31's anxiety behavior to increase which could result in serious medical conditions such as worsening of anxiety, panic episodes, insomnia, irritability, dizziness, headache, and nausea. Findings: During a concurrent observation and interview on 3/3/26 at 11:23 a.m. during initial tour in Resident 31's room, Resident 31 was lying in bed, watching television and talking with another resident in bed next to Resident 31's bed. Resident 31 was appropriately dressed and stated his only concern was the food. Resident 31 stated he felt safe in the facility and staff assisted him with all his care. During a concurrent observation and interview on 3/5/26 at 4:26 p.m. during medication administration in the west wing, Registered Nurse (RN) 1 was observed preparing Resident 31's medication. RN 1 did not administer Resident 31's buspirone. RN 1 stated she did not administer Resident 31's buspirone because it was not available. RN 1 stated she would call the pharmacy after she completed administering medications to all the residents in her wing. RN 1 stated it was the responsibility of licensed nurses to make sure routine medications were available to administer to residents. RN 1 did not answer what could happen to Resident 31 when he did not receive his buspirone. During a review of Resident 31's admission Record (AR-a document containing resident profile information), dated 3/6/26, the AR indicated Resident 31 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), depression (persistent, intense, and long-lasting low mood, loss of interest in activities, and feelings of sadness or worthlessness) and anxiety. During a review of Resident 31's Order Summary Report, dated 3/6/26, the Order Summary Report indicated, .busPIRone [hydrochlorothiazide (HCl)] Oral tablet 7.5 [milligram (MG)-unit of measurement] (Buspirone HCl) Give 1 tablet by mouth two times day for feeling nervous, restless . Order Date: 01/20/2023, Start Date: 01/20/2023 . During an interview on 3/6/26 at 11:15 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated it was the responsibility of all licensed nurses to make sure routine medications were available to administer to residents. LVN 1 stated, We order medications before we run out. LVN 1 stated, The practice was to call pharmacy and Medical Director when a routine medication was not available to administer to resident. During an interview on 3/6/26 at 11:50 a.m. with the Director of Nursing (DON), the DON stated licensed nurses were responsible to make sure medications were available and ready to be administered to residents. The DON stated the practice in the facility was to reorder medications when the last seven days of available medications were left. The DON stated her expectation was for the licensed nurses to call the pharmacy and follow up on medication availability. During an interview on 3/6/26 at 1:15 p.m. with the Administrator (ADM), the ADM stated she was a medical doctor in her country and familiar with medications. The ADM stated Resident 31 not receiving the buspirone medication could lead to an episode of psychosis and delusions. The ADM stated her expectation was for the licensed nurses to order medications before they ran out and call the pharmacy and notify the medical doctor. During a review of facility policy and procedure (P&P) titled, Reordering, Changing, and Discontinuing Medication Orders, dated 12/01/07, the P&P indicated, .Facility should ensure all orders clearly reference the resident's first and last name in full . Non-controlled medications may not be refilled 12 months after the original order . Facilities are encouraged to reorder medications electronically or by fax whenever possible .Reorders can be written and submitted on the pharmacy's Refill Order . During a review of facility P&P titled, Delivery and Receipt of Routine Deliveries, dated 12/01/07, the P&P indicated, . Pharmacy (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Facility should coordinate to determine delivery day(s) and time(s) as soon as possible after the execution of Pharmacy Services Agreement . Upon delivery by pharmacy, facility nurse or other authorized designee . Sign the delivery manifest (may be electronic signature if permitted by Applicable Law), note the time of arrival, and take responsibility for the receipt . During a review of facility policy and procedure (P&P) titled, Pharmacy Services Medication Management, dated 11/17, the P&P indicated, .the facility staff and physician should inform the resident about the risks related to the lack of the medication, and discuss appropriate alternatives, as per the resident care plan. The facility pharmacist is a valuable resource of information about medications including boxed warning or off-label utilization .		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and review of facility documents, the facility failed to ensure the Dietary Manager (DM) received frequently scheduled consultation from the Registered Dietitian (RD). Failure to have the RD provide frequent oversight and consultation with the DM of food and nutrition services can result in a lack of the RD identifying system issues regarding menus and recipes not being followed, food not in the proper form, and lack of competent staff and ensuring development of a prompt action plan to resolve the issues for the health and safety of the 66 residents admitted to the facility. Cross Reference F802, F803, F804, F805. Findings: During a series of observations and interviews that identified multiple failures to deliver food and nutrition services safely and effectively on 3/3/26 through 3/5/26 indicated the facility RD lacked familiarity with the food and nutrition service operation in relation to: a. During an observation on 3/3/26 at 12:01 p.m. of the lunch meal service, in the meal cart, Resident 15's lunch meal ticket showed a renal, consistent carbohydrate diet, regular texture and thin liquids with a scoop plate as the adaptive equipment. During a further review of Resident 15's meal ticket at the same time, indicated three ounces of pot roast, 1/2 cup white rice, 1/2 cup mixed vegetables. It was observed on Resident 15's lunch tray there was a scoop plate with three ounces of pot roast, 1/2 cup of mashed potatoes, and 1/2 cup mixed vegetables. During an observation with concurrent interview with the Food Service Worker (FSW) 1 when the kitchen meal cart was about to leave the kitchen on 3/3/26 at 12:13 p.m., FSW 1 observed Resident 15's lunch tray and meal ticket and confirmed the tray had the incorrect food item. FSW 1 stated the tray needed the rice and not the mashed potatoes. At the same time, the Dietary Manager (DM) confirmed that yes this was incorrect and needed the rice instead of the mashed potatoes. Cross Reference F803.b. During an observation of the lunch meal test tray for a puree and regular diet in the presence of the Dietary Manager (DM) on 3/5/26 at 12:46 p.m., on the nursing unit once all the trays were passed to the residents. The puree and regular food items tasted by the surveyors and the DM as well as the DM took temperatures of the foods at this time. The puree asparagus had multiple strings and thin pieces throughout the portion on the plate. During a concurrent interview with the DM, DM acknowledged the strings in the puree asparagus and stated they should not be there. During an interview with the Food Service Worker (FSW) 1 on 3/5/26 at 12:59 p.m., FSW 1 stated she uses frozen asparagus, cooks for 30 minutes then will add the broth to thin to the appropriate consistency. FSW 1 stated she is looking at the back of the spoon and to have the food stick to it. FSW 1 stated she has trouble with having strands when she makes the pureed asparagus. During an interview with the DM on 3/05/2026 at 11:47 a.m., DM stated she would expect staff to test for consistency for International Dysphagia Diet Standardization Initiative (IDDSI). During a review of the facility document titled Standards of Professional Practice: Diet Guide for the IDDSI for Level 4: Pureed Food, undated, indicated foods are to be smooth, and lump-free, not firm or sticky, requires no chewing or bolus formation, fall off the spoon as an intact spoonful, and hold shape on a plate. During a review of the facility recipe titled PU4 Asparagus with Red Pepper (fzn), indicated to measure desired number of servings into food processor. Blend until smooth. Use Fork Drip Test & Spoon Tilt Test to confirm texture is within IDDSI Level 4 specifications. Cross Reference F805.c. During an observation of the lunch meal preparation on 3/4/26 at 10:06 a.m., FSW 2 placed 60, three ounce chicken enchiladas from a box into a full-size hotel pans. Then she poured red enchilada sauce over the enchiladas. Next FSW 2 grabbed three handfuls of shredded mozzarella cheese out of the bag and sprinkled on top of each hotel pan. Then she did the same with shredded cheddar cheese. During a concurrent interview at this time, FSW 2 stated she just tries to cover the enchiladas with sauce so they are soft and then she stated she puts cheese on top. FSW 2 stated she just guesses what quantity of cheese to place on the food. During a review of the facility recipe titled BVH Chicken (continued on next page)		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Enchiladas for 110 servings, indicated to dilute three cans of enchilada sauce with water and vegetable base to cover bottom of hotel pans with sauce before adding enchiladas and then to top with sauce. It indicated to top with seven pounds of shredded [NAME] jack cheese and seven pounds of shredded cheddar cheese. FSW 2 did not mix the water and vegetable base with the enchilada sauce. It was unclear how much cheese should be used for the approximate 60 servings for the facility. During a review of the facility recipe titled Enchilada Chicken [3] for 50 servings, indicated to mix water, tomato paste and seasonings together in a saucepan, heat then pour over enchiladas. Then to cover with 10.5 ounces of shredded mozzarella cheese. It was unclear how much cheese should be used for the approximate 60 servings for the facility. During a review of the personnel file for FSW 2 indicated the date of hire was 8/26/25 and there was no documentation of the job competency for FSW 2. During a concurrent interview with the Director of Staff Development (DSD) on 3/5/26 at 9:01 AM, DSD stated after one year there will be an evaluation for the employee. The DSD stated the Dietary Manager (DM) is responsible for department training and they had no record of any competency or training for the department but thought maybe the DM would have that. During a interview with the DM on 3/5/26 at 9:41 a.m., the DM stated when she has hired staff she will give them one week of training and then determines when they can work solo. DM stated she was not sure what was done in the past since she has been here since the end of December. DM stated she has been trying to locate if there was any documentation of staff competencies for any kitchen staff. DM stated she had only done a couple of in-services for kitchen staff since she started and was trying to locate any from the past manager. During the course of the survey, there was no documentation provided for any kitchen in-services regarding following menus, recipes or food consistencies, or kitchen staff competencies. Cross Reference F802.d. During a review of the lunch meal on 3/5/26, indicated Marinated pork loin, parslid potatoes, and red pepper asparagus was to be served for the following diets: Regular, Consistent Carbohydrate Diet (CCD), Heart Healthy (Cardiac), soft and bite sized diets. During a concurrent lunch meal test tray observation and interview on 3/5/26 at 12:46 p.m. with the Dietary Manager (DM) in 100 East Wing Hallway. The temperatures of the food were taken, and the regular and puree test tray were sampled. The regular and pureed asparagus tasted bland and lacked flavor. The DM acknowledged the asparagus lacked flavor and tasted bland. During an interview on 3/5/26 at 12:59 p.m. with FSW 1 and the DM, FSW 1 stated she was unable to recall the quantity of items used to flavor the asparagus. FSW 1 stated she eyeballed the salt and pepper to taste and used margarine. FSW 1 stated the quantity of items put on the asparagus was not measured. FSW 1 stated the asparagus was a frozen product and she did not want to use oven since the facility had one working oven. FSW 1 stated the asparagus was prepared on the stove for about 30 minutes and then put it on the steam table at 11am. FSW 1 stated she liked to start tray line or meal service around 11:40 a.m. or 11:45 a.m. FSW 1 stated the outcome of the asparagus could be due to the length of time it was cooked. The DM stated food should not be on the steam table longer than 30 minutes. Cross Reference F804. During an interview with the RD on 3/05/2026 at 10:58 a.m., the RD stated she started working at the facility on 12/26/25 and had a site visit at the facility in January to meet the team and did kitchen inspection as well as a test tray. The RD stated she is based out of Washington State and works 8 hours per week remotely. RD stated she was onsite on 1/6 and 1/7/26. RD stated she will be conducting quarterly site visits to do sanitation inspection and test tray. RD stated when she was at the facility, she checked labels and dates, cleanliness, storage room, observe tray line and observe the kitchen staff wear hairnets and then conducted a test tray. RD stated she will send results to DM and administrator. RD stated she did not recall observing any food production but did a trayline (lunch meal service) observation to watch their flow. RD stated her expectation was that staff follow menus and match the meal ticket with the food items on the tray. RD stated she was not sure when she was onsite if she watched food production or the staff using recipes. RD stated most times the recipe books are out but was not sure if this building was one that did that. RD stated the DM might know if they are doing the tests for food consistency and it was her (continued on next page)		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation for IDDSI does require testing of foods. RD stated she will come on site and do the kitchen audit on a quarterly basis. RD stated the DM has her email and phone and can reach out when she needs things. RD stated the DM and her both started at the facility around the same time. RD stated she has not done in-services or not scheduled that do routinely. RD stated she does not have any formal or documentation to show her frequently scheduled consultation to the DM. During a review of the RD job description, dated and electronically signed 9/4/25, indicated essential functions for Dietary Services was to provide oversight and ensures compliance with the provision of quality food services and nutritional care to residents, serve as a resource to the facilities.in-service education, perform standard reviews and nutrition and food service audits in the facility, act as a resource for the dietary services so that food services department is maintained in a clean, safe and sanitary manner, and to plan, organize, develop and direct.in accordance with current federal, state, and local standards, guidelines and regulators that govern the facility. It indicated under Continuing Education to assist in the orientation and training of other staff. During a review of the RD audit titled Kitchen/Food Service Operation dated 1/7/26, indicated the audit was for kitchen tour observations to identify any issues that may lead to food borne illness and if foods are prepared and stored under sanitary conditions. There was only one question that asked if food was prepared under sanitary conditions and in a manner that conserved nutritive value, flavor and appearance. The form had check marks indicating for a yes. There were no comments on the form. There was a test tray form dated 1/6/26 for lunch, however it did not show what type of diet was checked and tested. While the form identifies food temperatures, handling, accuracy, it does not indicate an area or question to ensure food is the proper consistency for the type of diet. There were other RD audits from the previous RD dated 9/18/25 and 11/28/25 that were more in-depth however only had a S to indicate satisfactory and the only comment was major improvements. During a review of the facility policy and procedures titled Food and Nutrition Services Qualified Dietary Staff, dated 7/18, indicated the facility will employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of food and nutrition services. It indicated if the RD is not employed full-time, the facility will designate a director of food and nutrition services (DM) who will receive frequently scheduled consultation from a RD.		

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interviews, and review of facility documents, the facility failed to ensure menus were followed for a renal diet for one sampled resident (Resident 15) during the lunch meal service on Tuesday, March 3, 2026. This failure had the potential to result in the resident exceeding the micronutrients in the physician's prescribed therapeutic diet order which may compromise the nutritional and medical status of the resident. During an observation of the lunch meal service on 3/3/26 at 12:01 p.m., in the meal cart, a concurrent review of Resident 15's lunch meal ticket showed a renal, consistent carbohydrate diet, regular texture and thin liquids with a scoop plate as the adaptive equipment. During a further review of Resident 15's meal ticket at the same time, indicated three ounces of pot roast, 1/2 cup white rice, 1/2 cup mixed vegetables. It was observed on Resident 15's lunch tray there was a scoop plate with three ounces of pot roast, 1/2 cup of mashed potatoes, and 1/2 cup mixed vegetables. During an observation with concurrent interview with the Food Service Worker (FSW) 1 when the kitchen meal cart was about to leave the kitchen on 3/3/26 at 12:13 p.m., FSW 1 observed Resident 15's lunch tray and meal ticket and confirmed the tray had the incorrect food item. FSW 1 stated the tray needed the rice and not the mashed potatoes. At the same time, the Dietary Manager (DM) confirmed that yes this was incorrect and needed the rice instead of the mashed potatoes. During a review of the facility policy and procedures titled Food and Nutrition Services Menus and Therapeutic Diets, dated 7/18, indicated, The facility will follow menus.		