STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055853	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redwood Cove Healthcare Center	1162 S Dora St. Ukiah, CA 95482

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38088 Based on observation, interview and record review, the facility failed to ensure the Resident Rights of 13 Sampled Residents (Resident 200, Resident 16, Resident 28, Resident 164, Resident 264, Resident 22, Resident 5, Resident 42, Resident 14, Resident 53, Resident 38, Resident 30 and Resident 31) were honored, when: 1. Ten Sampled Residents (Resident 200, Resident 16, Resident 28, Resident 164, Resident 264, Resident 22, Resident 5, Resident 42, Resident 14, and Resident 53) reported call light response times of up to two hours. This failure resulted in delay in care and a loss of dignity, when residents were not assisted with timely brief changes when soiled and had the potential to result in incontinent accidents, falls resulting in broken bones, soft tissue injuries, pressure ulcers, psychosocial harm, feelings of despair and depression. 2. The facility did not ensure two sampled Residents (Resident 200, Resident 16) had useable prescription glasses. This failure resulted in the inability of Residents to read, be able to watch television, see what they were eating, or engage in activities that provided them with joy. This failure made the Residents feel like they did not matter and were unimportant to the facility. 3. One Sampled Resident (Resident 28), had not received communication about a request for a room change, resulting in her feeling like she was being ignored and she did not matter. 4. One sampled resident (Resident 28), was not offered or provided a facility phone to make private phone calls. This failure to honor her right to make private phone calls resulted in psychosocial harm from feelings of isolation and increased depression. 5. Two out of two sampled residents' (Resident 14 and Resident 30) urinary catheter drainage bags were not covered with a privacy bag. 6. One sampled resident (Resident 31) was not provided translated documents or translator services during medication administration, activities, nutritional choices and the ability to make decisions about health care. This failure to honor Resident Rights had the potential for depression, psychosocial harm, and result in frustration, miscommunication, misinterpretation of resident's report of symptoms which could lead to misdiagnosis and inappropriate action taken in an emergency situation. Findings: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During an observation on 4/29/24, at 10:58 a.m., at the nurse station, a call light alarm lit up and alarmed on the call light room board. Licensed Nurse N was working at a computer and did not respond to the sound of the resident call light. She did not look up, try to see if there was someone answering the light, or talk on a walkie talkie to tell someone about the call light. During an observation on 4/29/24, at 11 a.m., the call bell for room [ROOM NUMBER] started at 10:57 a.m. The Administrator walked past room [ROOM NUMBER] two times, without stopping to see what the resident's concerns were. The Facilities Manager also walked past room [ROOM NUMBER] twice, with the call bell light still ringing. During an observation on 4/29/24, at 11:03 a.m., a call light in room [ROOM NUMBER] started at 11:03 a.m. One Unlicensed Staff walked past room [ROOM NUMBER] without entering the room to see what the resident's concerns were. During an observation on 4/29/24, at 11:03 a.m., room [ROOM NUMBER]'s call light indicated a resident needed assistance. Three unlicensed staff walked past room [ROOM NUMBER] without stopping. Staff at the nursing station remained seated and did not provide assistance to room [ROOM NUMBER]. At 11:19 a.m. , an unlicensed staff walked into room [ROOM NUMBER], then room [ROOM NUMBER], before answering the Resident call light in room [ROOM NUMBER]. During an interview on 4/29/24, at 12:10 a.m., Resident 38 stated call lights always took a long time for staff to answer. During an observation on 4/29/24 at 12:17 p.m., the call light in room [ROOM NUMBER] went on. Licensed Nurse N, the Administrator, and Unlicensed Staff Q walked past the room without stopping to see what the resident's concern was. During an observation and interview on 4/29/24, at 12:45 p.m. Unlicensed staff Q entered Resident 28's room. Unlicensed Staff Q stated, Honey we need to change your position, lunch will be here soon. When she repositioned Resident 28, Resident 28 shouted, OW OW OW. Unlicensed Staff did not stop, did not ask her if she wanted pain medications, did not offer water, and did not place the call light within reach. The call light was hanging from the bed rail on Resident 28's left side, where her hand had a rolled washcloth in the palm of her left hand, which had a contracture. Resident 28 stated she could not reach her call light. She stated she could not use her left hand. She stated, if she needed help she would either have to wait until they came back or she would have to yell for help. During an observation on 5/1/24, at 7:40 a.m., Resident 28's call light was out of reach, hanging off the bedside railing on Resident 28's left side. During an observation and interview on 5/1/24, at 8:25 a.m., in Resident 28's room, Licensed Staff P stated unlicensed staff should have put the call light in her right hand. During an interview with the Director of Nursing, on 5/1/24, at 10:45 a.m., she stated she expected everyone to answer call lights immediately. She stated, if residents had to wait, it could result in a fall, broken bones, incontinence. She stated the facility Policy and Procedure stated to answer call bells as soon as possible. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/24, at 11 a.m., Licensed Nurse B stated there was enough staff to meet needs of residents. He stated call lights were to be answered by everyone immediately. During an observation on 5/1/24, at 11:03 a.m., Resident 16 stated call lights always take so long. She stated she just needed some help with a new incontinence brief, and when the unlicensed staff came in, she just gave her a new brief and did not help her change her soiled brief. She stated she did it herself. She stated she just wanted some help and it always took so long. She wanted a Depends brief, and the CNA just gave her one and did not assist her with a change. During an interview on 5/1/24, at 11:35 a.m., Resident 5 stated call lights could take a while. They come in and turn off lights but do not come back. During an observation 5/1/24, at 11:40 a.m., Resident 28's call light was not within reach. The call light was hanging off Resident 28's left bed rail. During a phone interview, on 5/2/24, at 11:43 a.m., the Ombudsman stated the residents have said the same things about staff running around, not enough staff to answer call lights. She stated she had informed the Administrator about the residents' concerns. She stated she attended the Resident Council Meetings and they have consistently stated the residents had to wait for a long time for staff to answer call lights which would stay on for at least 30 minutes. She stated the usual amount of time residents stated they had to wait was 30 minutes. During an interview with the Administrator on 5/3/24, at 11:30 a.m., he stated the expectation of all staff was to answer call lights immediately. He stated no one should ever walk past a call light. He stated the facility was not monitoring call light response times, but the facility Policy and Procedure was to answer them as soon as possible. A review of the facility Policy and Procedure, titled CALL LIGHT, not dated, indicated, All personnel will respond to resident requests and needs. Call lights are answered promptly. Call lights are kept within resident's reach. 2. During an observation and interview on 4/29/24, at 11:19 a.m., Resident 16 was laying in her bed, with the curtains pulled shut and no lights on. She was on her back, in a patient gown, not wearing glasses. A bedside table with a paperback book, an embroidery project and an eyeglass case were on her right side. She stated she wore glasses and pointed to her eyeglass case. There were a pair of yellow metal eyeglass frames missing the right lens. Resident 16 stated she did not know if anyone ordered her a new pair of glasses. She stated she told staff about it, and no body had followed-up with her for a while. She stated she could not use them without a lens. She stated it was hard to read for long periods of time or do needlework. She stated she could not watch TV without a lens. She stated she would get headaches trying to do those things without glasses or if she wore the glasses with only one lens. She stated they were useless. During an observation and interview on 4/29/24, at 11:25 a.m., Resident 200 was laying on her bed, with the curtains closed, in a dark area, in a patient gown and did not have eyeglasses on. The television was on without any volume. She stated she used glasses but did not know where they were. She stated she would love to have the volume of the television turned up but would just listen to the television because she could not see it without her glasses. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/29/24 at 12:59 p.m. Unlicensed Staff entered Resident 21's room and set a lunch tray in front of Resident 200. Unlicensed Staff took off the dish lid, cut up the food and left the room without asking Resident 200 if she needed to wear her glasses. During an observation and interview on 4/30/24, at 10:28 a.m., Resident 16 was on her back in bed with the curtain closed and the lights off. Her bedside table held a paperback book and her eye glass case, which contained one pair of bifocal glasses missing one lens . Resident 16 stated, I feel vulnerable and neglected because I don't have my glasses fixed. I can only read for a few minutes before I get a headache. Resident 16 stated she had glasses, but she did not know where they were, and she needed them for reading and watching television. During an observation and interview on 4/30/24, at 1:48 a.m., Resident 200 was laying on her back in bed, her eye closed, not wearing glasses while the television was on. Resident 200 was in her bed with the curtains pulled around the bed, no light on, in a patient gown, with the television on. The television was ceiling mounted, at the foot of Resident 200's bed. She stated she needed glasses and really could not see the television without them. Resident 200's bedside table held personal belongings but there were no eyeglass case or glasses. Resident 200 stated she did not know how long they had been gone. She stated she was lost without them. During an observation and interview on 5/1/24, at 7:58 a.m., Unlicensed Staff Q entered Resident 16 and Resident 200's room to serve breakfast trays. She placed the trays in front of the residents, removed the lids and left the room without an offer to help them put on their glasses. Unlicensed Staff Q stated, part of getting residents ready for breakfast was to make sure they had glasses on so residents could see what they were eating or to help them watch television. She stated she did not know if Resident 16 and Resident 200 needed glasses. She stated she would know the needs of the residents at her morning report. She stated the morning report did not include information that Resident 16 and Resident 200 needed glasses. During an observation and interview on 5/1/24 at 8 a.m., Resident 200 was eating breakfast and not wearing glasses. A brown eye glass case was on her bedside table located next to her closet. She stated she would love to have her glasses, that she had begged for them, and staff never gave them to her. Resident 200 cried when she was handed the eye glass case, and when she opened the eye glass case the eyeglasses were missing one of two prescription lenses. Resident 16 stated she was missing one lens from her glasses and had told the nurses about, but no one ever told her about whether or not she was getting a new pair. Resident 16 stated, All I have is reading and needlework. Without them I cannot read or sew. Resident 200 stated, without her glasses she felt incomplete, and she could not see anything without them. During an observation and interview on 5/1/24 at 8:05 a.m., in the hallway outside of Resident 16 and Resident 200's room, Unlicensed Staff Q stated she did not know Resident 200's glasses were broken. The Social Services Manager walked past and state loudly, What? I never knew that. She told Unlicensed Staff Q If glasses were broken just slip me a note under my door and I would get them fixed. During an interview on 5/1/24, at 8:25 a.m., Licensed Staff DSD stated, If a resident wears glasses staff should offer her glasses before activities or dining. She stated it was undignified and could increase loss of appetite and increase depression. She stated, if staff discovered a resident's eyeglasses were broken, Social Services would have been informed so the glasses could have been repaired. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 5/01/24, at 10 a.m., the Director of Nursing reviewed Resident 16 and Resident 200's care plans, and stated there was nothing in the residents' care plans for vision impairment and the need for prescription eyeglasses. She stated the care plans were not individualized and did not reflect their need for eyeglasses. She stated Resident 16 and Resident 200 were not getting the care they needed. During an interview and record review on 5/1/24, at 11:05 a.m., the Social Services Manager stated she could not locate the Inventory Lists for Resident 16 or Resident 200. She stated, if the resident were admitted to the facility with glasses, it should have been documented on the Inventory List in the medical record. She stated she did not know anything about their glasses, and staff were supposed to tell her when things were broken. She stated staff did not tell her Resident 16 and Resident 200's glasses were broken. A review of a document titled, ADMISSION RECORD, for Resident 16, indicated she was 93-years-old, admitted [DATE], with diagnoses that included Epilepsy (A neurological disorder that results in seizures), Chronic Pain, and Gout (Severe Inflammatory arthritis that impacts a person's joints and results in severe pain and swelling). A review of a document titled, Care Plan, indicated, (Resident 16) had altered visual ability related to: Macular Degeneration. At risk for: may impacts ability to; self-feed, participate in ADL (Activities of Daily Living like eating, brushing teeth, taking care of own needs), Appliances used: Eyeglasses. Date initiated: 8/10/2011. Interventions - Keep glasses within reach as indicated: 8/10/2011 .she is very social to staff /peers. (Resident 16) has multiple activity routines but not limited to: crossword puzzles, word searches, reading romance novels, adult color pages, embroidery projects and visiting with her roommate. A review of a document titled, Inventory of Personal Items, dated 5/9/17, indicated 1 set of Glasses glass case. A review of a document from the Minimum Data Assessment (MDS) (An assessment required upon admission to a nursing facility and periodically to assist the facility in being able to provide the services necessary for a resident to achieve their highest practicable level of functioning), titled, Section B - Hearing, Speech, and Vision, indicated, B1000. Vision Ability to see in adequate light (with glasses or other visual appliances) Adequate - sees fine detail such as regular print in newspapers / books .B1200. Corrective Lenses Yes. Section C - Cognitive Patterns, indicated C0500 BIMS (Brief Interview for Mental Status)(An assessment to determine how mentally intact a person is) Summary Score 12, (0-7 severe impairment, 8-12 moderate impairment, 13-15 cognitively intact). A review of a document titled, ADMISSION RECORD, for Resident 200 indicated she was 93-years-old, admitted [DATE], with diagnoses that included Dementia (A decline in brain functioning, that impacts a person's ability to perform daily activities), Muscle Weakness, and Low Back Pain. A review of a document titled, Care Plan, indicated, VISION CARE PLAN, dated 5/4/21, indicated, Resident 200 had altered visual ability related to: the gaining process. At risk for: pain, and localized irritation. Appliances used: Eyeglasses Interventions If glasses, Prosthetic eye and/or Magnifying glass keep within reach as indicated. Date initiated: 5/4/21. Activities .Resident 200 has identified the following as, 'Very important': reading. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a document titled, Inventory of Personal Items, dated 5/28/21, indicated nothing for, Glasses & Cases. A review of a document from the Minimum Data Assessment (MDS) (An assessment required upon admission to a nursing facility and periodically to assist the facility in being able to provide the services necessary for a resident to achieve their highest practicable level of functioning), titled, Section B - Hearing, Speech, and Vision, indicated, B1000. Vision Ability to see in adequate light (with glasses or other visual appliances) Adequate - sees fine detail such as regular print in newspapers / books .B1200. Corrective Lenses Yes. Section C - Cognitive Patterns, indicated C0500 BIMS (Brief Interview for Mental Status)(An assessment to determine how mental intact a person is) Summary Score 8, (0-7 severe impairment, 8-12 moderate impairment, 13-15 cognitively intact). A review of a facility Policy and Procedure titled, Sensory Impairments - Clinical Protocol, revised March 2018, indicated, The staff will try to minimize complication of sensory impairments; for example, optimize lighting in the resident's room and the hallway, refer for corrective lenses . 3. During a phone interview, on 1/2/24, at 11:43 a.m., the Ombudsman stated she had informed the facility Administrator and Social Services that Resident 28 had requested a room change several times. She stated they would tell her they were, Working on it. She stated she had informed the facility about Resident 28's request for a room change since last year. She stated Resident 28 was cognitively intact enough to know she did not like being against the wall, by the door, in a four-bed room with other residents who make a lot of noise. She stated Resident 28 never saw the outside, and it was not respectful to Resident 28 to not address her request for a room change. During an interview, on 5/1/24, at 9:15 a.m., Resident 3 stated she would tell the nurses if she had any problems, but they would never follow-up with her. She stated it made her feel like she did not matter. During an interview with Unlicensed Staff A, on 5/1/24, at 9:50 a.m., she stated, when a resident had a problem, she would tell the nurse or the Director of Nurses. She stated, if the facility never resolved a resident problem, it might make residents feel like they were not being heard. During an interview and record review on 5/1/24 at 11:10 a.m., the Social Services Manager stated she knew Resident 28 had requested a room change, but there were not any rooms available to move her to. During a review of the Grievance Binder, the Social Service Manager did not find any grievances documented from 2022 to 1/5/24. She stated she never knew Resident 28 wanted a room change or had ever requested the use of a facility phone. During an observation and interview on 5/1/24, at 11:40 a.m., Resident 28 was in a bed directly to the left of the door. The bed was against a small nightstand against the wall. Resident 28 stated she had asked to be moved to another room because the crying and noise from the other residents in the room was very disturbing to her and her sleep. She stated, when staff came in for other resident needs it disturbed her sleep. She stated she had asked the Administrator and the nurses all the time to move to another room, and no one ever come back and told her if she could move. During an interview on 5/1/24, at 12:10 p.m., Unlicensed Staff C stated he did not know Resident 28 wanted to change rooms. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Unlicensed Staff E, on 5/1/24 at 12:25 p.m., she stated, if a resident had an issue, she would tell the nurse. She stated, if a resident wanted to change rooms, she would tell the nurse. She stated she did not know Resident 28 wanted to change rooms. During an interview and record review with the Director of Nursing, on 5/1/24 at 1:30 p.m., she stated she was unsure where the Resident Rights were posted in the facility. She stated all residents got that information when they are admitted , but was not sure if residents ever reviewed it or were educated or reminded during their stay. Resident 28 was not mentally aware enough if she had asked someone for a room change. She stated she could not find documentation in the medical record that Resident 28 or the Ombudsman had requested a room change. She stated she knew Resident 28 wanted to have a room change but stated there were no rooms available. She was unable to locate documentation by the facility of any attempts made to try and make the room change for Resident 28. She stated the census indicated seven open rooms. She stated the open rooms were needed for new admissions. She stated she could not locate documentation Resident 28 had requested a room change or what the facility had done to try and provide her with a room change. She stated Resident 28 had a right to a room change. She stated the observations today made it appear the facility had not provided Resident 28 with those rights. She stated, denial of those rights could have made Resident 28 more depressed and could have made other residents and family members not have confidence in the care the facility provided. Review of a document titled, ADMISSION RECORD, indicated Resident 28 was 79-years-old, admitted on [DATE], with diagnoses that indicated, Hemiplegia (Severe or complete loss of strength or paralysis affecting one side of the body after a stroke) and Hemiparesis (Weakness in one side of the body) Following Cerebral Infarction affecting Left Non-Dominant Side (If you write with your right hand then your left side would be non-dominant), Major Depressive Disorder, (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Insomnia (Inability to sleep), and Primary Osteoarthritis (Cartilage in a joint wears down and results in pain, stiffness and reduced range of motion), Right Shoulder. Review of a document titled, BRIEF INTERVIEW FOR MENTAL STATUS, (A screening tool that uses a 15-point system to evaluate memory and orientation. A score of 13 to 15 indicates that cognition is intact) dated 2/19/2024, indicated a summary score of 15. Review of a document titled, Care Plan, dated 3/27/24, indicated, MOOD CARE PLAN (Resident 28) is at risk for Altered Mood R/T: Depression, Overall Health status. At risk for little interest or pleasure in doing things .Interventions Manage environmental factors to optimize comfort. Review of a facility Policy and Procedure, titled, Resident Rights, dated 2016, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity Communication with and access to people and services, both inside and outside the facility .Be supported by the facility in exercising his or her rights .Voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; have the facility respond to his or her grievances .Share a room with his or her roommate of choice when practicable Inquiries concerning residents' rights should be referred to the Social Services Director. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility P&P titled, Room Change/Roommate Assignment, revised May 2017, indicated, Changes in room or roommate assignment shall be made when the facility deems it necessary or when the resident requests the change. Review of a facility P&P titled, Grievances/Complaints, Filing, revised April 2017, indicated, The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative .A copy of our grievance/complaint procedure is posted on the resident bulleting board The administrator has delegated the responsibility of grievance and/or complaint investigation to the grievance officer who is _____ and can be contacted by _____ The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. a. The administrator, or his or her designee, will make such reports orally within _____ working days of the filing of the grievance or complaint with the facility. b. A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office. 4. During a phone interview, on 1/2/24, at 11:43 a.m., the Ombudsman stated Resident 1 was cognitively intact. She stated Resident 28 had told her she had requested to use a phone to contact friends and family, and no one at the facility would help her get a phone and make a call. She stated Resident 1 had notified her that the facility did not provide a phone she could use. The Ombudsman stated she had never observed Resident 1 using the facility phone. She stated it was undignified for Resident 1 to not be able to call friends or family. During an interview with Unlicensed Staff A, on 5/1/24, at 9:50 a.m., she stated, if the facility never resolved a resident problem, it might make them feel like they were not being heard. During an interview on 5/1/24, at 11 a.m., with Licensed Nurse B, he stated if a resident had a grievance, they would tell the nurse or staff, and they would take care of it. He stated Social Services was told about resident problems too. He stated, if a resident wanted to make a phone call, he would bring them a facility phone. During an interview and record review on 5/1/24 at 11:10 a.m., the Social Services Manager stated she guessed she was in charge of taking care of resident grievances. She stated she never knew Resident 28 had ever requested the use of a facility phone. During an interview with Resident 28 on 5/1/24, at 11:40 a.m., she stated she did not have a phone to call anyone. She stated she asked a lot of staff, and no ever gave her a phone to use. She stated she would ask, and they would never come back to let her make a phone call. She said staying at this facility made her sad, and this place did not feel like a home. During an interview on 5/1/24, at 12:10 p.m., Unlicensed Staff C stated most residents had their own phones, but the facility had phones to give to residents if they wanted to make a phone call. During an interview with the Director of Nursing, on 5/1/24 at 12:55 p.m., she stated there were two phones available for residents to make phone calls. She stated one phone was broken and the other phone was missing. She stated, without the phones, residents might not be able to communicate with friends or families. (continued on next page)

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	055853	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redwood Cove Healthcare Center	1162 S Dora St. Ukiah, CA 95482

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, the Director of Nursing asked Resident 28 if she wanted to use the phone, and Resident 28 stated, Yes. During an interview with the Director of Nursing, on 5/1/24 at 1:30 p.m., she stated the observations today made it appear the facility had not provided Resident 28 with her right to use a phone to make phone calls. She stated there was no facility Policy and Procedure on phone calls and the use of facility phones by residents. She stated, denial of those rights could have made Resident 28 more depressed and could have made other residents and family members not have confidence in the care the facility provided. Review of a facility Policy and Procedure, titled, Resident Rights, dated 2016, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity Communication with and access to people and services, both inside and outside the facility Be supported by the facility in exercising his or her rights. 48660 During an interview on 4/30/24 at 9:11 AM, Resident 264 stated she waited for two hours to have soiled undergarments changed. Resident 264 further stated her bottom was red after two hours, and staff told her it was because she had diarrhea. Resident 264 stated she did not have diarrhea. During an interview on 4/30/24 at 3:27 PM, Resident 22 stated staff did not always come quickly to answer the call light. Sometimes when I needed them 'right now' they didn't show up. I usually had to wait for a change. I was wet most of the time. I had a lot of skin irritation from being wet because they didn't come in enough to change me. I had to sit in a bowel movement occasionally because they did not come in and change me or put me on a bed pan. During an interview on 5/2/24 at 2:05 PM, during the Resident Council Meeting, Residents 5, 42, 14, and 53 stated they had waited a long time for help or care after using their call lights. Resident 5 stated wait times were up to 45 minutes. Resident 5 further stated they all had that problem. Resident 14 stated wait times were up to one hour. 46132 5. A review of Resident 14's face sheet (demographics) indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Hyperlipidemia (HLP, an elevated level of lipids - like cholesterol and triglycerides - in your blood), Dysphagia (swallowing difficulties), and Depression (a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world). Her Minimum Data Sheet Assessment (MDS, a (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 4/11/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 13, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 14's functional status indicated she needed moderate up to maximum assistance when performing her Activities of Daily Living (ADL, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). Resident 14 used a urinary catheter (a tube placed in the body to drain and collect urine from the bladder). A review of Resident 30's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included HLP, Muscle Weakness and Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). His MDS, dated [DATE], BIMS score was 15, indicating intact cognition. Resident 30's functional status indicated he needed up to maximum assistance when performing his ADLs. Resident 30 used a urinary catheter. During a concurrent observation and interview on 4/30/24 at 10:12 a.m., Resident 30 stated staff were not consistently putting a cover on his catheter urinary drainage bag. When asked if he refused to cover his catheter urinary drainage bag, he stated, No. Unlicensed Staff W verified Resident 30's catheter drainage bag was not covered. Unlicensed Staff W stated the catheter drainage bag should be covered, per facility policy, and was important for a resident's dignity. When asked if the catheter drainage bag not being covered meant the facility policy was not followed, Unlicensed Staff V stated, Yes, the facility policy was not followed when the catheter drainage bag was not covered. During a concurrent observation and interview on 4/30/24 at 11:22 a.m., Resident 14 was noted with a catheter urinary drainage bag that was not covered. Resident 14 stated the facility did not consistently provide covers for their c [TRUNCATED]

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. 48660 Based on observation, interview, and record review, the facility failed to ensure residents were aware of and had access to, State Survey Agency contact information. This failure had the potential to interfere with residents' ability to file a complaint with the State Agency and possibly delay an investigation. Findings: During an interview on 4/30/24 at 2:05 PM, during the Resident Council Meeting, Residents 5, 42, 14, 53, and 4 stated they did not know how to file a complaint with the State Agency or where to find contact information. During an interview and observation on 5/2/24 at 4:35 PM, with Licensed Nurse F (LN F), when asked about the posting for residents to file a complaint with the State Agency, LN F pointed to the posting for the Ombudsman. During an interview and observation on 5/2/24 at 4:36 PM, with LN F, the surveyor was escorted to a bulletin board which did not contain State Agency contact information. The LN F stated, Let me ask my supervisor where to find the posting. During an interview and observation on 5/2/24 at 4:38 PM, with LN F, the surveyor was escorted to the end of a hallway in an area away from resident activities and shown a small paper posted on a bulletin board with the State Agency contact information. LN F stated residents usually called the Ombudsman and did not know to ask for State Agency information.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48660 Based on observation, interview, and record review, the facility failed to post the results of the most recent State Survey in a location readily accessible (a place where individuals wishing to examine survey results did not have to ask to see them) to residents, family members, and/or legal representatives of residents. This failure had the potential to prevent access to relevant information that could affect a resident's decision making, quality of care and/or quality of life. Findings: During an interview on 4/30/24 at 2:05 PM, in the Resident Council Meeting, Residents 5, 42, 14, 53, and 4 stated they did not know where to access the results of the State Survey. Residents 5, 42, 14, 53, and 4 stated they wanted to know where the information was located. During an observation on 5/2/24 at 4:30 PM, in the hallway across from the nurse's station, a large white binder with a label, Survey Results, and with a small piece of paper stuck to the binder indicating, 2012 - 2016, was in a binder holder on the wall. During an interview on 5/2/24 at 4:40 PM, the Administrator stated he had given the binder with the results of the most recent survey, dated 2019, to a family for review. The Administrator further stated he did not know the location of the binder. During an interview on 5/2/24 at 4:50 PM, the Administrator stated he found the binder with the most recent State Survey, dated 2019. The Administrator further stated the binder was kept in the Administrator's office. When the Administrator was asked how a resident or a resident's family member viewed the survey results, he stated they requested the binder from him.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure the physician was notified for a significant weight loss (5% in 1 month, 10% in 3 months and 7.5 % in 6 months) for one out of one sampled resident (Resident 25). This failure had the potential to further aggravate and compromise her medical status. Findings: A review of Resident 25's face sheet (demographics) indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Essential Hypertension (occurs when you have abnormally high blood pressure that is not the result of a medical condition), Dysphagia (difficulty swallowing) and Anxiety (a feeling of fear, dread, and uneasiness). Her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 2/12/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 13, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 25's functional status indicated she needed up to maximum assistance from staff when performing her Activities of Daily Living (ADL's, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet). A review of Resident 38's weight log (weight record) indicated she was 120 pounds (#, a unit of weight) on 11/1/23, and 100.2# on 4/21/24, which indicated she lost 19.8 # or 16.5 percent (%, out of 100) weight loss in five months. During an interview on 5/2/24 at 3:53 p.m., Licensed Staff T stated a weight loss of 19.8# in five months was significant and should be reported to the physician. When asked what the risks could be if a resident had significant weight loss and the physician was not notified, Licensed Staff T stated, not reporting a significant weight loss to the physician was a safety risk because the physician would not be able to assess the resident for what was causing the weight loss which could lead to missed interventions that would stop the resident from further weight loss. Licensed Staff T stated this could put the resident at risk for further weight loss. During an interview on 5/2/24 at 4:44 p.m., when asked if a weight loss of 19.8# in five months should be reported to the physician, Unlicensed Staff X stated the resident lost significant weight so it should be reported to the physician. When asked what the risks could be if a resident had significant weight loss and the physician was not notified, Unlicensed Staff X stated it became a safety issue since the resident could continue to lose weight, and there could be something going on in the resident's body that needed to be addressed by the physician. Unlicensed Staff X stated the resident could be at risk for malnutrition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/24 at 4:58 p.m., Licensed Staff F stated the physician should be notified if a resident lost 19.8# in five months. Licensed Staff F stated, losing 19.8# in five months was significant. When asked what the risks could be if a resident had significant weight loss and the physician was not notified, Licensed Staff F stated it would be a safety risk as the physician would not be able to assess the resident for what was causing the weight loss. Licensed Staff F stated this could put the resident at risk for further weight loss and impaired nutrition. During a telephone interview on 5/3/24 at 10:43 a.m., the Medical Director (MD) stated a weight loss of 19.8# in five months was a significant weight loss, and he expected the facility to notify the physician for a significant weight loss. During an interview on 5/3/24 at 11:17 a.m., the nurse consult verified there was no documentation to indicate the physician was notified when Resident 25 lost 19.8# in five months. During an interview on 5/3/24 at 1:29 p.m., the Director of Nursing stated a weight loss of 19.8# in five months was a significant weight loss and should have been reported to the physician. The DON stated staff should notify the physician for significant weight loss so he could assess the resident and find out what could be causing the weight loss. When asked what the risks could be if a resident had significant weight loss and the physician was not notified, the DON stated weight loss could continue to happen. The policy and procedure for weight changes was requested but not provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38088 Based on observations, interview and record review, the facility failed to ensure a safe and sanitary environment for residents, when hand hygiene was not offered to residents before meals, when the hand hygiene P&P was not followed during medication administration, and cross-contamination risks were observed in linen storage and laundry processing areas. Findings: (Reference F 880) During an observation on 4/29/24, at 11:33 a.m., in the housekeeping closet next to Resident room [ROOM NUMBER], the floor, walls, sink and equipment, door and door jamb appeared to have a black, gray residue on all surfaces. The black, gray substance felt greasy to the touch. Under the sink was what appeared to be a calcified, wet, plumbing leak originating from the hopper sink. (See Photos) During an observation on 4/29/24, at 11:34 a.m., the resident Shower Room, located in the hallway across from staffing, had multiple unlabeled razors, lotions, and shampoo sitting on a shower shelf. An insect was on a resident shower seat. The Shower Room closest to the Administrator's office had a sharps disposal box mounted on the wall which had had razors sticking out of the top, had no gloves, and the call light was attached to a plastic glove hanging from the wall. (See Photos) During an observation on 4/29/24, at 12:25 p.m., staff passed lunch trays into rooms [ROOM NUMBERS], and did not offer hand hygiene before meal service. During an observation on 4/29/24, at 2:25 p.m. the Oxygen Storage room had black streaks on floor. During an observation 4/29/24, at 2:30 p.m., the Clean Utility room had gray particulate matter on the counter, in storage bins, and on the floor. The floor had large quantities of dark particulate and gray particulate matter. In a red bin on the counter, which contained resident soaps, and hand lotion, an insect that resembled a cockroach was laying on its back with the legs up. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/29/24, at 2:35 p.m., with the Administrator and Facilities Manager outside the Clean Utility Room, the Facilities Manager stated the room was cleaned daily by Housekeeping staff. He stated it was considered clean, not dirty. Inside the Clean Utility room, the Facilities Manager took a moist paper towel and wiped the floor. Gray and black particulate residue and matter was left on the towel. He stated the room looked like no one had cleaned it. He stated it was supposed to be cleaned daily. He looked in the red bin with the bug, and stated it was a cockroach. He stated there had been reports of spiders. The Administrator stated the facility had a monthly pest control, but there was no facility monitoring process to indicate how many sightings there were of insects or spiders. The Administrator was unable to state how many reports of insects and cockroaches there had been and if the pest control company had been informed or had any suggestions for reduction of pest infestations. The Facilities Manager stated he would use a can of insect spray if someone stated they had seen insects between facility pest management visits. He stated he was not sure if the insect spray was approved for use in healthcare facilities, by the Environmental Protection Agency. The Administrator stated there was no Policy and Procedure for pest and rodent control in the facility. He stated there was no plan on how the facility was to ensure no insects or rodents in the facility. (See Photos) A request was made for the photo of the insect taken by the Administrator. It was not received by the end of survey. During an observation and interview on 5/1/24, at 7:15 a.m., outside the resident Dining Room, Licensed Nurse N and unlicensed staff provided breakfast meal trays to 11 residents in the dining room, without offering hand hygiene. Licensed Nurse N stated, before providing meal trays to residents, to offer hand hygiene. She stated staff offered it. She stated staff had to go to kitchen to get the hand wipes for hand sanitation. An observation of the meal trays that were used by residents and the trash can, did not indicate any disposable hand wipes were used. She stated they had offered, but all the residents refused. She stated the risk to residents who did not engage in hand hygiene, would have been food-borne illness. During an observation on 5/1/24, at 9 a.m., the carpeting near the double doors leading into the kitchen appeared to have a dark gray stained area that was as wide as the hallway and extended to the hallway in front of the Resident dining area. The carpet was stained in all the hallways throughout the length and distance of the hallway from the back entrance of the facility to the front door of the facility and in the hallways leading to all patient rooms. (See Photographs) During an observation on 5/1/24, at 9:05 a.m., the hallway walls appeared to have gray black smudges and streaks on and above the floorboards with exposed plaster and chipped paint throughout the hallway. (See Photographs) During an observation and interview, on 5/1/24, at 9:15 a.m., the bathroom in a resident room had more stained than unstained tiles on the floor. The tile on the floor was chipped and cracked. The walls had exposed plaster, marks, and gray-black marks on all four walls around the floor. The doorways had chipped paint with exposed rust. The base of the toilet had a rough, messy caulk line with rust, brown and gray black stains. Under the hand washing sink was a pile of dirty linen rolled up and placed beside the trash can. The under-sink area had stained tiles that were cracked and chipped. (See photographs). Resident 3 stated the floors looked awful. She stated the bathroom looked terrible. She stated, This is not how my home was. I feel like I am living in a ghetto. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview, on 5/1/24, at 9:34 a.m., the linoleum tiles in the doorway of another resident room were stained and discolored, chipped, and broken. The bathroom floor had fist-sized areas of torn and missing linoleum. The bathroom had rough, messy, and black stained caulking around the base of the toilet. The bathroom area under the sink had trash on the floor and linen thrown on the ground. (See Photographs). Resident 5 stated no one ever cleaned. He stated the stains on the floors and walls made him feel depressed that he was not in his own home. During an observation and interview, on 5/1/24, at 9:45 a.m., the linoleum tile in another resident room was stained, chipped, and cracked. There were dark gray-black marks consistently along the walls. (See Photographs). Resident 6 stated the stained tiles or marks on the wall did not look good, and it would be nice to have things look better. During an interview with Unlicensed Staff A, on 5/1/24, at 9:50 a.m., she stated, if something needed to be repaired, staff were supposed to contact the Facilities Manager. She was unable to state what the infection prevention concerns were for chipped and cracked floor tile, exposed plaster, or chipped paint. During an observation on 5/1/24, at 10 a.m., the resident linen closet in the hallway across from room [ROOM NUMBER] had unfinished plywood on the wire shelves, and had folded linen placed on top of the plywood. The floor of the resident linen closet had chipped, cracked, and stained linoleum tiles. A view of the floor underneath the linen cart showed clear plastic bags with assorted pieces of paper and masks in them and gray dust-like particulate, dirt and strings of gray web-like substance along the floorboards and up the wall. (See Photographs) During an interview and observation with the Facilities Manager, on 5/1/24 at 10:45 a.m., he stated he did not know why chipped paint, rust, exposed plaster, and un-sealed plywood, was an infection issue. He was unable to state if the cleaning solutions used by housekeeping were approved by the infection prevention committee. He stated he oversaw housekeeping and just ordered what the facility told him to order for cleaning solutions or disinfectants. The Facilities Manager stated he had not provided infection prevention in-services for the housekeeping staff. He stated the process for reporting items or areas that needed repair was to write it in the binder at the front desk. A review of a binder titled, Repairs, indicated there were no requests for fixing wheelchair arm rests, bathroom floors, or chipped paint. He stated the housekeeping staff were supposed to report to him when they observed anything that needed to be repaired, painted, or fixed. There were two wheelchairs outside the Human Resources office. (See Photographs) The arm rests were extensively cracked and lifted. He stated he was not aware they needed repair. He stated he thought that physical therapy took care of the wheelchairs. He stated he was unaware that cracked arm rests could not be disinfected and had the potential to irritate the exposed skin on the residents who had very thin, delicate skin and potential bleeding issues from medications. During observations of Resident Rooms 1, 2, 4, and 7, he stated the floors were stained and cracked. He stated the walls had exposed plaster and chipped paint. He stated the floors in the bathrooms were not repaired properly. He stated repairs needed to be done so that the surfaces could be cleaned and appeared in good repair. He stated the bathrooms were, Unsightly and were not cleanable. Regarding the linen closet in the hallway across from room [ROOM NUMBER], the Facilities Manager saw the linen cart with the plywood, and stated he did not know that unsealed plywood could not be disinfected. He stated, Residents could get splinters of wood that were stuck to the linens too. He looked underneath the linen cart and stated, Yeah, that doesn't look like it has been cleaned in a while. He stated the dirt could get onto the linens and possibly cause residents to get sick. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/24, at 11 a.m., with Licensed Nurse B, he stated the stains on the floors were, Pretty bad, could make family and residents think it is dirty. He stated he would call the Facilities Manager for repairs of anything. He stated he never called about the flooring because someone was always cleaning it. He stated he did not know the bathrooms had any infection control issues. During an interview on 5/1/24 at 11:15 a.m., Unlicensed Staff R was unable to state who was responsible for cleaning the Clean Utility room, Housekeeping Closet, the clean and dirty side of the Laundry Room, and the Linen Storage Closets. She stated the Housekeeping Closet looked dirty, and it had a lot of grime, black smudges, and resident toilet paper was stored closed to the dirty sink. (See Photos). During an observation and interview on 5/1/24, at 11:40 a.m., a resident room had a built-in white dresser with three drawers, a countertop and closet doors painted white. There were gray, black scuff marks from the level of the floor up to the second drawer across the front of the drawers and the closet doors. The countertop contained a pair of gray and pink tennis shoes placed on top of a box of gloves and against a stack of white towels. The bathroom of Resident room [ROOM NUMBER] had stained, cracked, and chipped floor tiles. There was exposed plaster behind the toilet. There was chipped paint around the doorway with gray black material around the floor and up the wall. The base of the toilet had a thick, rough, messy line of caulk, and the toilet bowl appeared to have fecal material on the inside. An unidentified bed pan was stuck between the wall and a handrail. Under the sink area there was stained, chipped, and cracked tiles, exposed plaster and chipped paint, and a blanket rolled up and placed under the sink next to the trash can. (See Photographs). Resident 1 stated no one ever came in and cleaned. She stated, when they do come in, they never pick up her things off the floor and put them where she could reach them. She stated, whoever owned this place did not care about whether things were broken or needed painting. She stated the facility was falling apart and looked terrible. She stated it made her feel very sad because she lived in a home that was beautiful, and this was not like a home. During an observation and interview on 5/1/24, at 12:10 p.m., Unlicensed Staff C stated he did not know how to report when wheelchair arm rests needed to be repaired. He stated he had never told anyone about anything that needed to be repaired. He observed the wheelchairs in the Hallway of room [ROOM NUMBER] and stated they look pretty bad. He stated he did not know the arm rests could not be disinfected if the material was cracked. He stated the residents could scratch themselves on the arm rests if they did not have a long-sleeved shirt on. He stated the residents had really thin skin, and they could scratch themselves pretty easily on the cracked arm rests. During an interview on 5/1/24, at 12:10 p.m., the Infection Preventionist stated surfaces needed to be, Intact for cleaning and disinfection to occur. She reviewed facility environmental photographs of the bathrooms, hallway rugs, and wheelchairs and stated, Broken linoleum, wheelchair arm rests, would be at risk for cross contamination if surfaces were in disrepair. She stated, Exposed plaster could not be cleaned or disinfected. She stated the conditions of the bathroom were an infection control concern and had the potential for cross-contamination and potential resident infection risk. During an interview with Unlicensed Staff E, on 5/1/24 at 12:25 p.m., she stated the rugs in the hallway looked really bad. She stated it would not be something she would want to have in her home. She said, It looked dirty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and document review on 5/1/24, at 12:45 p.m., a document titled, Maintenance Log, dated 10/4/(23) to 12/29/23, indicated, 10/4/(23) Toilet leaks water through tiles, requested 10/4 and completed 10/9/23 11/10/23 TOILET OVERFLOW, requested 11/10/23, and completed 11/13/23. The Facilities Manager stated he had reviewed the Maintenance Log from October 2023 to January 2024, and there were no reports from staff about bathroom issues, broken linoleum, chipped paint for Resident Rooms 2, 4, 7, or 23 or wheelchair arm rests that needed to be repaired. He stated his assistant did not know about the Maintenance Log. The Maintenance Log indicated 45 Requests / Repairs and 14 Requests / Repairs were not completed. The Facilities Manager stated he had forgotten to write the completed date. He stated his assistant did not know about the log, and he did not know why staff were not using it. He stated the Maintenance Log was important so staff would communicate issues that needed to be repaired, to him or his assistant. During an interview and observation with the Director of Nursing, on 5/1/24 at 12:55 p.m., she stated she was unaware the wheelchair arm rests were cracked. She stated the condition of the arm rests were an infection control risk for residents because they could not be disinfected. In room [ROOM NUMBER] she observed the bathroom, and stated linen on the floor was not supposed to be in the bathroom. She stated the linen on the floor was an infection control risk to patients. She stated the cracked tiles, rough caulk around the base of the toilet and the exposed plaster could have been an infection control risk for residents from cross-contamination and the spread of infection. During and observation and interview on 5/2/24, at 9 a.m., in the clean laundry area folding room, with Unlicensed Staff S, Infection Preventionist and Facilities Manager, the Facilities Manager stated the outside vents by the dryers were cleaned weekly. Unlicensed Staff S stated she cleaned the countertops used to fold resident linen and clothing, every time she folded laundry, with bleach wipes. She was unable to state how long the surface needed to stay wet to produce bacterial kill to eliminate cross-contamination. No hand hygiene gel or hand hygiene sink was in the room. Unlicensed Staff S stated she used wipes for countertops and hand hygiene. She stated there were none on the countertop because she just threw them away. When asked why there were no empty containers observed in the trash, she stated she just emptied the trash. She used a step ladder to retrieve the last large container of bleach wipes and last remaining small container of hand wipes from the top shelf of a closed cupboard that was attached to the ceiling. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/2/24, at 9:10 a.m., in a room that contained washers, dryers and equipment, a red line ran diagonally from the right side of the doorway between the laundry folding room, to the middle of the room with the washers and dryers. The concrete floor was chipped and had gray particulate matter that looked like lint or dust distributed around the room on equipment, behind equipment, and on the floor. Unlicensed Staff S indicated the red line was dirty on the right side where the washers and bins were, and the left side by the dryers was clean. Behind the washer and dryers, screened vents led to the outside. The vents were heavily encrusted with black, gray particulate that resembled dust, dirt and / or lint. The Facilities Manager stated the vents on the walls, leading outside, were cleaned weekly. He stated it did not look like they had been cleaned. The floors behind the washers and dryers had larger quantities of the same gray particulate matter. Unlicensed Staff S stated she cleaned the lint traps, located under each dryer, at 9:30 a.m. and 1:30 p.m She stated she did not write it down on a log. The lint trap under the dryers had a large sheet of dryer lint in the trap and on the floor. Unlicensed Staff S stated she used a broom to clean the dryer lint traps and walked over the red line to get a broom that was stored on the wall in the, Dirty side of the laundry, then walk back into the, Clean Side, and demonstrated how she cleaned the lint traps. She walked back across the red line and hung up the broom, then walk back into the laundry folding area, without having used hand hygiene. The Infection Preventionist stated she was unaware of the infection prevention practices in the laundry area and having a dirty and clean side. She stated she thought it had the potential for cross-contamination and the spread of infection to residents and staff. The Facilities Manager stated he was not oriented to the infection prevention concerns about clean and dirty in the laundry area. Unlicensed Staff S stated the dirty laundry was sorted on the right side of the red line and transferred into the washing machines. She stated she wore an apron. She pointed to the doorway that separated the laundry folding area from the laundry washer and dryer room, and one sleeveless white plastic apron hanging. She stated it was clean. She stated she used a clean one every time and then threw it away. An observation of the trash can on the right side of the red line did not contain an apron. She stated she had already emptied the trash. There were multiple bottles and buckets of laundry detergent solutions and a large jug of bleach and a mop bucket with solution, which sat between the washer and dryer area of the washer room. Unlicensed Staff S stated she used bleach in the bucket to mop the floors of the entire laundry area. She stated there was no sink in the dirty or clean sides of the laundry area, and she went to the Housekeeping Closet outside the department to get water so she could mop the floors. The Facilities Manager stated he did not know if any of the cleaning solutions or laundry chemicals had been approved for use by the Infection Control Committee. The infection Preventionist stated she did not know if the solutions had been approved for use and were EPA approved. She stated she did not know if the solutions and detergent chemicals were providing the bacterial kill required to prevent the risk of cross-contamination in a laundry process area. The Facilities Manager stated there was no hand hygiene sink in the department, and if staff had to wash hands they would have to leave the department and use the public bathroom outside the area. The Infection Preventionist stated gastrointestinal food-borne illness like C-differential required staff to wash their hands, as alcohol-based hand sanitizers were ineffective. She stated hand hygiene was done before and after putting on and taking off gloves and the apron. Unlicensed Staff S she wore an apron and gloves when she sorted dirty laundry. She stated she did not wear eye protection. Unlicensed Staff S stated, if her face and eyes were splashed with contamination from dirty laundry or laundry chemicals, she would use bottled eye wash to rinse her eyes. She was unable to state how long she had to rinse her eyes. The Facilities Manager was unaware if there was a Policy and Procedure for how long to rinse eyes after a bodily fluid exposure. He was reviewing Safety Data sheets and was unable to locate how long to rinse eyes if bleach splashed into them. He stated one bottle of eye rinse was not enough to rinse eyes after an exposure. He stated staff had the potential to have physical harm to their eyes if they could not rinse their eyes long enough. He stated laundry staff did not know how long to rinse their eyes in case they were exposed. The Facilities Manager stated he did not know when the washers were serviced. He stated he did not know what the washing machines' water temperature was. He stated there were no logs for anything in the laundry area. He stated he thought the water temperature might have been between 140 to 160 degrees Fahrenheit but was not certain. The Infection Preventionist stated she did not know why the water temperature was important for bacterial kill and use of detergent efficacy. She stated she used the Centers for Disease Control (CDC) as a resource for

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 5/2/24, at 10:55 a.m., the Infection Preventionist stated the CDC was the resource for the facility Infection Control program. She stated she did not know what the facility compliance rate was for hand hygiene compliance. She stated she completed informal visual audits when she had time. She stated the Infection Control program did not have an established goal for hand hygiene compliance. She stated there was no Infection Control Committee that formally met and reviewed the Infection Control program. She stated she did not meet with the Medical Director and had no epidemiological resource person who provided her with support and resources. She stated she had completed the CDC Infection Prevention online training, but was unaware of environmental rounds and risks of infection in laundry processing. She stated the Infection Control program did not have any goals for hand hygiene compliance. Review of a facility Policy and Procedure, titled Resident Rights, dated 2016, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence: Review of a facility Policy and Procedure (P&P) titled, Homelike Environment, reviewed February 2021, indicated, Residents are provided with a safe, clean, comfortable and homelike environment .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment; .c. Inviting colors and decor. Review of a facility P&P titled, Laundry and Bedding, Soiled, revised September 2022, indicated, Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control . Contaminated laundry is bagged or contained at the point of collection (i.e., location where it was used) . Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. Review of a document titled, CDC Guidelines for Environmental Infection Control in Health-Care Facilities 2003, dated 7/2019, page 96, indicated, From a public health and hygiene perspective, arthropod and vertebrate pests should be eradicated from all indoor environments, including health-care facilities Insects should be kept out of all areas of the health-care facility, especially OR's and any area where immunosuppressed patients are located. A pest-control specialist with appropriate credentials can provide a regular insect-control program that is tailored to the needs of the facility and uses approved chemicals and/or physical methods. Review of a document from the CDC titled, Appendix D - Linen and laundry management Best Practices for Environmental Cleaning in Global Healthcare Facilities with Limited Resources, dated 5/4/23, indicated, Best practices for management of clean linen: Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. Each floor/ward should have a designated room for sorting and storing clean linens.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on interviews and record reviews, the facility failed to ensure: 1. Staff were aware of what a Basic Care Plan (BCP, a plan that promotes continuity of care and communication among nursing home staff which should be completed within 48 hours of resident admission and contain the minimum healthcare information necessary to care for resident safely) was and its completion time frame. 2. The BCP was completed for one out of one sampled resident (Resident 216) and completed timely for seven out of eight sampled residents (Residents 10, 14, 20, 30, 31, 216, and 265). These failures had the potential to put residents' safety at risk and for residents not receiving the care they need. Findings: A review of Resident 10's face sheet (demographics) indicated he was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Essential Hypertension (HTN, high blood pressure) and Type 2 Diabetes Mellitus (DM, disease caused by a problem in the way the body regulates and uses sugar as a fuel). His Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 4/1/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 15, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 10's functional status indicated he needed moderate up to maximum assistance when performing his Activities of Daily Living (ADLs, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). His BCP was completed late on 5/12/21. A review of Resident 14's face sheet indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Hyperlipidemia (HLP, an elevated level of lipids - like cholesterol and triglycerides - in your blood), Dysphagia (swallowing difficulties), and Depression (a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world). Her MDS, dated [DATE], BIMS score was 13, indicating intact cognition. Resident 14's functional status indicated she needed moderate to maximum assistance when performing her ADLs. The portions of her BCP completed late on different times were: Nursing Services on 4/25/24, Social Services on 2/23/24, Food and Nutrition Services on 10/17/23, and Activities on 10/12/23. A review of Resident 20's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included HLP, HTN and Schizoaffective disorder (a mental health problem where you experience psychosis - symptoms that happen when a person is disconnected from reality, as well as mood symptoms). His MDS, dated [DATE], BIMS score was 4, indicating severely impaired cognition. Resident 20's functional status indicated he needed supervision up to moderate assistance when performing his ADLs. His BCP was completed late on 3/6/22. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 30's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included HLP, Muscle Weakness and Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). His MDS, dated [DATE], BIMS score was 15, indicating intact cognition. Resident 30's functional status indicated he needed up to maximum assistance when performing his ADLs. His BCP effective date on 3/28/24, was completed late: Nursing services was blank, Rehabilitation Services was completed on 4/25/24, and Activity Services was completed on 4/2/24. A review of Resident 31's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included HTN, Muscle Weakness and Dysphagia. His MDS, dated [DATE], BIMS indicated severe cognitive impairment. Resident 31's functional status indicated he was dependent on staff when performing his ADLs. His BCP was completed late: Nursing services was blank, Social Services, Rehabilitation Services, Food and Nutrition Services were completed on 2/23/24, and Activity Services was completed on 1/12/24. A review of Resident 216's face sheet indicated he was initially admitted to the facility on [DATE]. His diagnoses included HTN, HLP and Dysphagia. His MDS, dated [DATE], BIMS indicated severe cognitive impairment. Resident 216's functional status indicated he needed up to maximum assistance from staff when performing his ADLs. His BCP, dated 1/22/21, was not completed at all. A review of Resident 265's face sheet indicated she was initially admitted to the facility on [DATE]. Her diagnoses included HLP, Dysphagia and Anxiety. Her MDS, dated [DATE], BIMS score was 15, indicating intact cognition. Resident 265's functional status indicated she needed up to moderate assistance from staff when performing her ADLs. Her BCP was completed late on 4/29/24. During an interview on 5/2/24 at 12:21 p.m., Licensed Staff G stated she did not really know what a BCP was. When asked if it was important to create BCP for residents, she stated, Yes. Licensed Staff G stated it was important to make sure staff were taking care of the residents safely. Licensed Staff G stated she did not know the timeframe was for completing a BCP. When asked what could the risk for residents if a BCP was not completed timely, Licensed Staff G stated staff may be providing care to the residents that was not safe. During an interview on 5/2/24 at 12:29 p.m., Licensed Staff F stated a BCP was important to ensure staff were providing appropriate and adequate care for the residents. When asked what the timeframe was for completing a BCP, Licensed Staff F stated within 24 hours. When asked what the risks were for a resident if a BCP was not completed timely, Licensed Staff F stated, if BCP were not completed timely, it could lead to providing inadequate care to the residents. Licensed Staff F stated it was a safety issue. During an interview on 5/2/24 at 3:53 p.m., Licensed Staff T stated she did not know what BCP was and did not know the timeframe for completing a BCP. During an interview on 5/3/24 at 9:37 a.m., the Social Services Director (SSD) stated BCPs help staff to care for residents safely. The SSD stated it was important to create a BCP for residents, so staff knew what the residents needs were. When asked what the risk were for residents if a BCP was not completed timely, the SSD stated staff may not meet the residents' needs. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/3/24 at 12:17 p.m., the DSD stated it was important to create BCPs for residents, so staff knew the basic care they needed to provide for the residents. When asked what the timeframe was for completing a BCP, the DSD stated BCPs should be completed within 48 hours of resident's admission. The DSD stated, if the BCP was not done within 48 hours of admission, the facility policy was not followed. When asked what the risks were for residents if a BCP was not completed timely, the DSD stated staff would not meet residents needs safely. During an interview on 5/3/24 at 1:29 p.m., the Director of Nursing (DON) stated it was important to create BCP for residents so staff were aware of what residents' needs were and to provide safe care to the residents. The DON stated, if the BCP was not completed within 48 hours of residents' admission, then the facility policy was not followed. When asked what the risks were for the residents if a BCP was not completed timely, the DON stated staff may not provide safe care to the residents. A review of the facility's policy and procedure (P&P) titled, Care Plan-Baseline, revised 12/2022, the P&P indicated a baseline plan of care should be developed for each resident within 48 hours of admission.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38088 The facility did not ensure two sampled Residents (Resident 200, Resident 16) had useable prescription glasses. This failure resulted in the inability of Residents to read, be able to watch television, see what they were eating, or engage in activities that provided them joy. This failure made the Residents feel like they did not matter and were unimportant to the facility. Findings: (Cross Reference F550) During an observation and interview on 4/29/24, at 11:19 a.m., Resident 16 was laying in her bed, with the curtains pulled shut and no lights on. She was on her back, in a patient gown, not wearing glasses. A bedside table with a paperback book, an embroidery project and an eyeglass case were on her right side. She stated she wore glasses and pointed to her eyeglass case, which contained a pair of yellow metal eyeglass frames missing the right lens. Resident 16 stated she did not know if anyone ordered her a new pair of glasses. She stated she told staff about it, and no body had followed up with her for a while. She stated she could not use them without a lens. She stated it was hard to read for long periods of time or do needlework. She stated she could not watch TV without a lens. She stated she would get headaches trying to do those things without glasses or if she wore the glasses with only one lens. She stated they were useless. During an observation and interview on 4/29/24, at 11:25 a.m., Resident 200 was laying on her bed, with the curtains closed, in a dark area, in a patient gown and did not have eyeglasses on. The television was on without any volume. She stated she used glasses but did not know where they were. She stated she would love to have the volume of the television turned up but would just listen to the television because she could not see it without her glasses. During an observation and interview on 4/29/24 at 12:59 p.m. Unlicensed Staff Q entered Resident 21's room and set a lunch tray in front of her. Unlicensed Staff Q took off the dish lid, cut up the food and left the room without asking Resident 200 if she needed to wear her glasses. During an observation and interview on 4/30/24, at 10:28 a.m., Resident 16 was on her back in bed with the curtain closed and the lights off. Her bedside table held a paperback book, and her eyeglass case contained one pair of bifocal glasses that was missing one lens . Resident 16 stated, I feel vulnerable and neglected because I don't have my glasses fixed. I can only read for a few minutes before I get a headache. Resident 200 stated she had glasses, but she did not know where they were, and she needed them for reading and watching television. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/30/24, at 1:48 a.m., Resident 16 was still laying on her back in bed, her eye closed, not wearing glasses while the television was on. Resident 200 was in her bed with the curtains pulled around the bed, no light on, in a patient gown, with the television on. The television was ceiling mounted, at the foot of Resident 200's bed. She stated she needed glasses and really could not see the television without them. An observation of Resident 200's bedside table and personal belongings did not indicate an eyeglass case or glasses. Resident 200 stated she did not know how long they had been gone. She stated she was lost without them. During an observation and interview on 5/1/24, at 7:58 a.m., Unlicensed Staff Q entered Resident 16 and Resident 200's room to serve breakfast trays. She placed the trays in front of the residents, removed the lids and left the room without an offer to help them put on their glasses. Unlicensed Staff Q stated part of getting residents ready for breakfast was to make sure they had glasses on so they could see what they were eating or to help them watch television. She stated she did not know if Resident 16 and Resident 200 needed glasses. She stated she would know the needs of the residents at her morning report. She stated the morning report did not include information that Resident 16 and Resident 200 needed glasses. During an observation and interview on 5/1/24 at 8 a.m., Resident 200 was eating breakfast and not wearing glasses. A brown eye glass case was on her bedside table located next to her closet. She stated she would love to have her glasses, that she had begged for them, and staff never gave them to her. Resident 200 cried handed the eyeglass case, and when she opened the eyeglass case the eyeglasses were missing one of two prescription lenses. Resident 16 stated she was missing one lens from her glasses and had told the nurses about, but no one ever told her about whether or not she was getting a new pair. Resident 16 stated All I have is reading and needlework. Without them I cannot read or sew. Resident 200 stated without her glasses she felt incomplete, and she could not see anything without them. During an observation and interview on 5/1/24 at 8:05 a.m., in the hallway outside of Resident 16 and Resident 200's room, Unlicensed Staff Q stated she did not know Resident 200's glasses were broken. The Social Services Manager walked past and state loudly, What? I never knew that. She told Unlicensed Staff Q ,If glasses were broken just slip me a note under my door and I would get them fixed. During an interview on 5/1/24, at 8:25 a.m., Licensed Staff P / DSD stated, If a resident wears glasses staff should offer her glasses before activities or dining. She stated it was undignified and could increase loss of appetite and increase depression. She stated, if staff discovered a resident's eyeglasses were broken, Social Services would have been informed so that the glasses could have been repaired. During an interview and record review on 5/01/24, at 10 a.m., the Director of Nursing reviewed the care plans for Resident 16 and Resident 200, and stated there was nothing in the residents' care plans for vision impairment and the need for prescription eyeglasses. She stated the care plans were not individualized and did not reflect their need for eyeglasses. She stated Resident 16 and Resident 200 were not getting the care they needed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 5/1/24, at 11:05 a.m., the Social Services Manager stated she could not locate the Inventory Lists for Resident 16 or Resident 200. She stated, if the resident were admitted to the facility with glasses, it should have been documented on the Inventory List in the medical record. She stated she did not know anything about their glasses, and staff were supposed to tell her when things were broken. She stated staff did not tell her that Resident 16 and Resident 200's glasses were broken. A review of a document titled, ADMISSION RECORD, for Resident 16, indicated she was 93-years-old, admitted [DATE], with diagnoses that included Epilepsy (A neurological disorder that results in seizures), Chronic Pain, and Gout (Severe Inflammatory arthritis that impacts a person's joints and results in severe pain and swelling). A review of a document titled, Care Plan, indicated, (Resident 16) had altered visual ability related to: Macular Degeneration. At risk for: may impacts ability to; self-feed, participate in ADLs (Activities of Daily Living like eating, brushing teeth, taking care of own needs), Appliances used: Eyeglasses. Date initiated: 8/10/2011. Interventions - Keep glasses within reach as indicated: 8/10/2011 .she is very social to staff /peers. (Resident 16) has multiple activity routines but not limited to: crossword puzzles, word searches, reading romance novels, adult color pages, embroidery projects and visiting with her roommate. A review of a document titled, Inventory of Personal Items, dated 5/9/17, indicated, 1 set of Glasses glass case. A review of a document from the Minimum Data Assessment (MDS) (An assessment required upon admission to a nursing facility and periodically to assist the facility in being able to provide the services necessary for a resident to achieve their highest practicable level of functioning), titled, Section B - Hearing, Speech, and Vision, indicated, B1000. Vision Ability to see in adequate light (with glasses or other visual appliances) Adequate - sees fine detail such as regular print in newspapers / books .B1200. Corrective Lenses Yes .Section C - Cognitive Patterns, indicated C0500 BIMS (Brief Interview for Mental Status)(An assessment to determine how mental intact a person is) Summary Score 12, (0-7 severe impairment, 8-12 moderate impairment, 13-15 cognitively intact). A review of a document titled, ADMISSION RECORD, for Resident 200 indicated she was 93-years-old, admitted [DATE], with diagnoses that included Dementia (A decline in brain functioning, that impacts a person's ability to perform daily activities), Muscle Weakness, and Low Back Pain. A review of a document titled, Care Plan, indicated ,VISION CARE PLAN, dated 5/4/21, indicated Resident 200 had altered visual ability related to: the gaining process. At risk for: pain, and localized irritation. Appliances used: Eyeglasses Interventions If glasses, Prosthetic eye and/or Magnifying glass keep within reach as indicated. Date initiated: 5/4/21 Activities .Resident 200 has identified the following as, 'Very important': reading. A review of a document titled, Inventory of Personal Items, dated 5/28/21, indicated nothing for, Glasses & Cases. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a document from the Minimum Data Assessment (MDS) (An assessment required upon admission to a nursing facility and periodically to assist the facility in being able to provide the services necessary for a resident to achieve their highest practicable level of functioning), titled, Section B - Hearing, Speech, and Vision, indicated, B1000. Vision Ability to see in adequate light (with glasses or other visual appliances) Adequate - sees fine detail such as regular print in newspapers / books .B1200. Corrective Lenses Yes .Section C - Cognitive Patterns, indicated, C0500 BIMS (Brief Interview for Mental Status)(An assessment to determine how mental intact a person is) Summary Score 8, (0-7 severe impairment, 8-12 moderate impairment, 13-15 cognitively intact). A review of a facility Policy and Procedure, titled, Sensory Impairments - Clinical Protocol, revised March 2018, indicated, The staff will try to minimize complication of sensory impairments; for example, optimize lighting in the resident's room and the hallway, refer for corrective lenses .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews and record reviews, for a resident who had a tube feeding (method of feeding that uses the gastrointestinal (GI) tract to deliver nutrition and calories when you cannot eat or drink safely by mouth), the facility failed to: 1. periodically evaluate the amount of feeding being administered for one out one sampled resident (Resident 265), when staff did not know to calculate how much formula was given and how much formula should be left in the feeding bag in a period of time. 2. monitor Resident 265's input and output (I &O, important to help evaluate a person's fluid and electrolyte balance, to suggest various diagnosis, and allows for prompt intervention to correct the imbalance) to ensure she was receiving the calculated amount of tube feeding consistent with practitioner's orders. These failures could put Resident 265 at risk for fluid and electrolyte imbalance (occurs if the body has too much or too little water), dehydration (a condition that results when the body loses more water than it takes in) and malnutrition (getting too little or too much of certain nutrients). Findings: A review of Resident 265's face sheet (demographics) indicated she was initially admitted to the facility on [DATE]. His diagnoses included Hyperlipidemia (HLP, high cholesterol is an excess of lipids or fats in your blood), Dysphagia (difficulty swallowing) and Anxiety (a feeling of fear, dread, and uneasiness). His Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 4/19/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 15, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 265's functional status indicated she needed up to moderate assistance from staff when performing her Activities of Daily Living (ADLs, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). Resident 265 received nutrition through tube feeding. A review of Resident 265's Physician Order Summary indicated a formula feeding to run at 60 centiliters (cc, a unit of measure) for 16 hours, 960 cc volume, 1,728 calories, 78 grams (gr, a unit of measurement used to measure very light object) protein. During an observation on 4/29/24 at 4:29 p.m., Resident 265 was sitting in her wheelchair in the Rehabilitation Therapy room. The tube feeding was running at 60 milliliter (ml, unit of measurement) per hour. The bag indicated it was hung at 4:45 a.m. The feeding tube was running for about 12 hours now. Resident 265 should have received 720 ml of formula by this time, however, there was a little over 500 ml of formula left on the bag. The bag should only have 240 ml of formula left in the bag. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/29/24 at 4:49 p.m., Licensed Nurse H verified Resident 265's formula was hung at 4:45 a.m. Licensed Nurse H verified there was a little over 500 ml of formula remaining in Resident 265's tube feeding bag. When asked if she knew how much formula should be left in Resident 265 at this time, she did not answer. During a concurrent observation and interview on 4/30/24 at 8:37 a.m., Licensed Staff G verified Resident 265's tube feeding formula was hung at 5 a.m., and there was about 900 ml of formula left in the bag. When asked how long Resident 265's tube feeding had been running since it was hung, Licensed Nurse G stated three and a half hours. When asked how much formula Resident 265 should had received from 5 a.m. to 8:37 a.m., she did not answer. When asked what the amount of formula should be left in the bag between 5 a.m. and 8:30 a.m., she did not answer. When asked if the staff were monitoring intake and output for Resident 265, she stated she did not know. During an observation on 5/1/24 at 11:49 a.m., it was noted a 1000 ml of formula was hung at 5 a.m. It indicated that at this time, the tube feeding had been running for about seven hours now, and there was about 750 ml of formula left in the bag. Per calculation, there should only be 540 ml of formula left in the bag. During an interview on 5/1/24 at 2:48 p.m., the Registered Dietician (RD) stated Resident 265's tube feeding order was to run 60 ml for 16 hours and off for eight hours. The RD stated, if the formula was hung at 4:45 a.m., in 12 hours, Resident 265 should have received 720 ml of formula, and there should be about and 240 ml left in the tube feeding bag, not 500 ml. The RD stated she would question this and would ask, Is Resident 265 receiving the amount of tube feeding she was supposed to be receiving? During a concurrent observation and interview on 5/1/24 at 3:00 p.m., the RD verified there was 600 ml of formula left in the tube feeding bag, and Resident 265's tube feeding had been running for ten hours now. The RD stated Resident 265 should have received 600 ml of the formula by now. The RD stated 600 ml of Formula left at this time was more than what was supposed to be left in the bag. During an interview on 5/1/24 at 3:06 p.m., Licensed Staff G stated, if the tube feeding showed there was more formula left in the bag, it probably meant the resident was not receiving the appropriate amount of formula in a given time and could result in impaired nutrition. During an interview on 5/1/24 at 3:18 p.m., Licensed Nurse H stated, if the feeding bag had more formula than it should, it could mean the resident was not receiving the appropriate amount of formula in a given time, which could result in malnutrition. During an interview on 5/2/24 at 11:21 a.m., the Nurse Consultant (NC) stated staff were not monitoring Resident 265's I&O. When asked why, she stated it was because there was no physician order to monitor Resident 265's I&O. When asked why there was an intervention in Resident 265 Dehydration Care Plan, dated 4/17/24, directing staff to monitor Resident 265's I&O, the NC stated it must have been clicked by mistake. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/24 at 12:29 p.m., Licensed Staff F stated it was the facility's policy to ensure residents on tube feeding were placed on I&O monitoring. When asked if staff should be monitoring Resident 265's I&O, he stated, We should be. Licensed Staff F stated I&O monitoring was a nursing intervention and did not require a physician's order. When asked what the risk was if staff were not monitoring I&O, Licensed Staff F stated it could place residents at risk for dehydration, malnutrition and fluid overload. During an interview on 5/02/24 at 3:53 p.m., Licensed Staff T stated all residents who were on tube feedings should have an I&O monitoring. When asked what the risk was if staff were not monitoring I&O, she stated it could place residents at risk for electrolyte imbalance, constipation and impaired nutrition. During a telephone interview on 5/3/24 at 10:43 a.m., when asked if the facility should be monitoring a resident's I&O when they were receiving tube feedings, the Medical Director (MD) stated, absolutely. The MD stated it was important staff knew they were administering the right formula and the residents were receiving the correct amount of formula in a given time. During an interview on 5/3/24 at 11:30 a.m., Licensed Nurse I stated I&O should be monitored for all residents on tube feedings. Licensed Staff I stated I&O monitoring did not need a physician order. When asked what the risk was if staff were not monitoring I&O, Licensed Nurse I stated it could put the resident at risk for malnutrition and weight loss. During an interview on 5/3/24 at 12:17 p.m., the DSD stated staff should be monitoring residents' I&O if they were on tube feedings. During a telephone interview on 5/3/24 at 12:54 p.m., the RD stated staff should be monitoring residents' I&O if they were on tube feedings. A request for I&O monitoring policy was requested but not provided. A review of the facility's policy and procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump, revised 11/2018, the P&P indicated the person performing this procedure should record in residents' medical record the average fluid intake per day. For residents receiving enteral feeding, the National Institute of Health recommend that fluid intake and output be determined every eight hours, on a daily basis.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48660 Based on interview and record review, the facility failed to: 1. Follow its Policy and Procedure for Medication Regimen Review. 2. Ensure staff knew what a glycoprotein-colony stimulating factor (G-CSF, used to increase the number of white blood cells in the blood, which helps your immune system fight infections and heal injuries, in patients receiving anticancer drugs) injection was. 3. Ensure the monthly Medication Regimen Review by the Pharmacist for Resident 14 was thorough and accurate, when the medication G-CSF injection was not listed on Resident 14's current medications, and staff did not notify the pharmacist Resident 14 was receiving G-CSF injection weekly. These failures had the potential to: 1. Cause serious physical and/or psychosocial harm when the facility did not forward pharmacy recommendations to any facility physician for five months, September 2023 through March 2024. 2. Prevent the Pharmacist from identifying an irregularity that might require an urgent action to protect Resident 14. Findings: 1. During an interview and record review on 05/1/24 at 2:35 PM, the Director of Nursing (DON) provided a loose-leaf binder titled, Medication Regimen Review 2023 (MRR), and a loose stack of documents, dated April 2024. The MMR 2023, binder was missing pharmacy review documents from September, October, November, and December 2023. The DON stated she had the MRR for the month of April 2024. The DON stated the recommendations had been reviewed for April 2024, but it was too soon to determine which recommendations had been followed. The DON further stated she did not have the MRR pharmacy review documents for January, February, or March of 2024. During an interview and record review on 5/2/24 at 8:30 AM, the DON stated there was no records documenting action taken by medical or nursing staff on pharmacy recommendations from September 2023 through March 2024. The DON provide a loose stack of documents, dated 11/1/23 through 3/28/24. The documents were titled, Pharmacist's Executive Summary, Medical Director Report, Pharmacist's Recommendation to Prescriber, Pharmacist's Report to Nursing, Resident's Reviewed with No Recommendation, and, Resident's with MRR Activity. All of the documents were signed by the Pharmacist. None of the documents contained a response (agree, disagree, or other), comments, or a signature with a date from the prescriber. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/24 at 11:50 AM, the DON stated the MRR process was the following: The Pharmacist reviewed records monthly and then emailed a summary and recommendations to the DON. The DON printed the recommendations and gave them to the Doctor for review. The process has a snag with the pharmacy, and they are looking to make a change. The DON stated the only thing she had was the pharmacy recommendations. The DON further stated no MMR pharmacy summaries or recommendations had been sent to any facility Doctors from October 2023 through March 2024. The DON stated the documents were in a, holding pattern. The DON also stated the pharmacy review was sent to only one person, the DON. When new orders were obtained from a Doctor following the Pharmacist recommendations, the DON gave the new orders to Medical Records for scanning, they were uploaded to Point Click Care (PCC, an electronic documentation system), and the new orders were given back to the DON to place in the MRR binder. The DON stated the risks for not following the MRR process included adverse drug effects from unmanaged polypharmacy (the simultaneous use of multiple drugs by a single patient, for one or more conditions) and lack of follow-up for dose reduction recommendations. During an interview on 5/2/24 at 2:45 PM, via telephone, the Pharmacy Consultant (PC) stated he reviewed each patient's medications monthly. He sent a report to the facility each month. He stated the process was for the facility to send his report to the Doctor(s). He further stated the format stayed the same every month, and he had no idea if the facility sent the report to the Doctor(s) and whether a response was received. The PC stated he reviewed the patient's medical records the month after he sent recommendations, and he determined whether the Doctor followed his recommendations. He did not receive any direct communication from the Doctor(s) or the DON concerning action taken or not taken. During a record review on 5/3/24, a document titled, Medication Regimen Review Policy and Procedure, revised 3/4/14, indicated in Section F. 1) The MRR comments will be delivered to the DNS (Director of Nursing Services, another term for DON) for timely follow through with the prescriber and/or nursing staff. Section G. indicated, Recommendations are acted upon and documented by the facility staff and/or the prescriber. Section G. 1) indicated, Physician accepts or acts upon suggestion or rejects and provides an explanation for disagreeing. Section G. 3) indicated, The Director of Nursing or designated licensed nurse address and document recommendations that do not require a physician intervention . 46132 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 14's face sheet (demographics) indicated she was initially admitted to the facility on [DATE]. Her diagnoses included Hyperlipidemia (HLP, an elevated level of lipids - like cholesterol and triglycerides - in your blood), Dysphagia (swallowing difficulties), and Depression (a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world). Her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 4/11/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 13, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 14's functional status indicated she needed moderate up to maximum assistance from staff when performing her Activities of Daily Living (ADLs, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). A review of Resident 14's Physician Order Summary did not indicate she was receiving G CSF injection weekly. A review of the electronic medical record indicated there was no MRR completed which included G CSF injections on her medication list nor a care plan for G CSF injection for Resident 14. During an interview on 5/2/24 at 3:53 p.m., Licensed Staff T stated the Pharmacist should know Resident 14 was receiving G CSF injections weekly even if she was receiving this medication from the Oncology Clinic. When asked what the risk could be if the Pharmacist was not able to conduct an accurate Medication Regimen Review (MRR, a thorough evaluation of the medication regimen of a resident, including medications prescribed and over the counter administered by any route with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with a medication) for the Resident 14 while she was receiving G CSF injection, she stated it was a safety issue because the Pharmacist would not be able to review this medication for interaction with other medications and would not know what side effects staff should be monitoring Resident 14 for. When asked if Licensed Staff T knew what medications a negative interaction with G CSF injection could possibly have, she did not answer. When asked if she knew the specific side effect of G CSF injections and what to do in case Resident 14 exhibited a side effect or adverse effect from G CSF injection, Licensed Staff T stated she did not know. During an interview on 5/2/24 at 4:58 p.m., Licensed Staff F thought a G CSF injection was a chemotherapeutic drug. Licensed Staff F stated the expectation was for staff to notify the Pharmacist of all the medications residents were receiving so the Pharmacist could check for drug-to-drug interaction. When asked what the risks could be if the Pharmacist was not able to conduct an accurate MRR for Resident 14 while she was receiving G CSF injections, Licensed Staff F stated the Pharmacist would not be able to conduct a thorough and accurate medication review and could not see if G CSF injections would interact negatively with other medications. When asked if he knew what medications a negative interaction with G CSF injection could possibly have, he did not answer. When asked if he knew the specific side effects of a G CSF injection and what to do in case Resident 14 exhibited side effect or adverse effect from G CSF injection, Licensed Staff F did not answer. During an interview on 5/3/24 at 8:17 a.m., when asked to provide G CSF injection use policy and procedure, Resident 14's MRR which included G CSF injection on her medication list and a care plan for G CSF injection, the Nurse Consultant (NC) stated the facility did not have these items since Resident 14 was receiving G CSF injections from outside which meant the facility was not responsible for ensuring there was G CSF injection use policy and procedure. Resident 14's MRR by the Pharmacist, which included G CSF injection on her medication list was completed, and a care plan was created for G CSF injection usage. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 5/3/24 at 10:36 a.m., the Consultant Pharmacist (CP) stated G CSF was a specialized medication and had specific instruction and precautions. The CP stated it would be beneficial for Resident 14 and staff if he was notified Resident 14 was receiving this medication to ensure he was conducting a thorough and accurate Medication Regimen Review for Resident 14. During a telephone interview on 5/3/24 at 10:43 a.m., the Medical Director (MD) stated he expected the facility to ensure the Pharmacist was aware Resident 14 was receiving G CSF injections, regardless of whether she was receiving it at the facility or from the outside, for residents' safety. The MD stated he expected the staff to ensure Resident 14 was monitored for side effects as well. He stated coordination of care between the facility, the Pharmacist and the Physician was very important. During an interview on 5/3/24 at 1:29 p.m., the Director of Nursing (DON) stated the Pharmacist should be made aware Resident 14 was receiving G CSF injections regardless of whether she was receiving it at the facility or from the outside. The DON stated staff may not know which side effects to look for while Resident 14 was receiving G CSF injection weekly, and that was where the Pharmacist came in- to educate staff and for Resident 14's safety. The facility did not have a documentation to indicate they were monitoring Resident 14 for side effects or adverse effects while she was receiving G CSF injections. The facility did not have a policy and procedure for G CSF medication usage. A review of the facility's policy and procedure (P&P) titled, Consultant Pharmacist Report, revised 3/4/14, the P&P indicated in the MRR: The Pharmacist performs a comprehensive review of each residents MRR at least monthly .the MRR includes evaluating the residents' response to medication therapy to determine the resident maintains the highest practicable level of functioning and prevents or minimize adverse consequences related to medication therapy .the Pharmacist identifies irregularity including prescriber's orders .residents were monitored for cumulative effects of multiple medications .resident is monitored for adverse consequences when there is an addition or deletion of medication .side effects and interactions are evaluated and modifications or alternatives are considered.

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Redwood Cove Healthcare Center	1162 S Dora St. Ukiah, CA 95482

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48660 Based on observation and interview, the facility failed to properly label insulin pens (insulin delivery device that comes preloaded with insulin, including premixed insulin's) with resident information, when insulin pens were labeled on the outer plastic storage bag or on the cap of the pen instead of the shaft (the section of the pen that contains the insulin storage container). This failure had the potential to: 1. Expose residents to infectious agents if the insulin pens were used by more than one resident. 2. Cause serious adverse effects if a resident was given a dose and/or type of insulin prescribed for another resident. Findings: During an observation and interview on 5/1/24 at 8 AM, Licensed Nurse G (LN G) prepared and administered insulin to Resident 1 using an insulin pen. LN G stated the insulin pen was obtained from the E Kit (Emergency Medication Supply for use when resident medications were not available) and did not come labeled with resident identifying information. LN G filled in the label with Resident 1's identifying information. During an observation and interview on 5/1/24 at 8:10 AM, LN G prepared and administered insulin to Resident 267. LN G stated the insulin pen was obtained from the E Kit medication supply. The insulin pen was improperly labeled on the cap of the insulin pen and not the shaft. During an interview on 5/1/24 at 8:30 AM, the Director of Nursing (DON) stated the insulin label with resident identifying information should have been on the shaft of the insulin pen and not on the cap. During an observation on 5/1/24 at 9:58 AM, of Medication Cart for Hallway Two, three insulin pens were improperly labeled. One insulin pen was labeled on the outer plastic storage bag, one insulin pen was labeled with a sticker on the cap of the insulin pen, and one insulin pen was labeled with a black marker on the cap of the insulin pen. The Institute for Safe Medical Practices (ISMP) has defined strict best practices for labeling. To protect patient safety, a label must feature two forms of patient identification, such as name and medical record number, proper storage condition information, proper drug ID information and proper expiration date.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 46132 Based on interview and record review, the facility failed to ensure it designated a person to serve as the Director of Food and Nutrition Services who was certified, when the Registered Dietician (RD) was not employed full-time. This failure indicated the facility did not meet the Federal guidelines and did not follow the job description, when hiring a Dietary Manager (DM). During an interview on 4/29/24 at 10:01 a.m., the Dietary Manager (DM) stated she was not a Certified Dietary Manager. The DM stated the Registered Dietician (RD) only came in once every week on Wednesdays. The DM stated she did not receive consistent in-services and training's from the RD. During an interview on 4/30/24 at 3 p.m., the DM stated she was not a Certified DM. The DM also stated she was not a graduate of a Dietetic Technician Training Program approved by Academy of Nutrition and Dietetics (AND, an organization of dietetic professionals committed to improving the nation's health). The DM stated she also did not receive six hours of Title 22 (State regulations on health and safety standards for licensed care facilities) training, was not a graduate of a College Degree Program with major studies in food or nutrition, nor did she have any military equivalent. The RD stated she was not a graduate of a State Dietetic Approved Program. The DM stated the RD was contractual staff, was not hired full time and only came to the facility on ce a week on Wednesdays. When asked what her tasks were, she stated she oversaw the kitchen and the Dietary Department. When asked what the risks for residents were if the facility hired a non-certified Dietary Manager, the DM was did not answer. When asked if she met the requirements as stated on the job description for a Dietary Manager, she stated she did not know. During an interview on 5/1/24 at 2:33 p.m., the RD verified she was contractual staff who came in the facility once a week. The RD stated she was not a full-time RD for the facility. During an interview on 5/2/24 at 3:45 p.m., a request was made to the Human Resources Department (HRD) to provide a copy of the DM's file, but it was not provided. A review of the facility's job description for DM, prepared by the HRD, dated 1/2019, the job description indicated under qualification, A DM must be a graduate of an approved DM's course that meet the State regulations (set of rules and regulations that govern a particular state) and Federal regulations (a set of requirements issued by a federal government agency to implement laws passed by Congress).

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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. 46132 Based on observation, interviews and record reviews, the facility failed to ensure the development of a plant-based menu. This failure had the potential for residents to not meet the Recommended Daily Intake (RDI, the average daily dietary intake level that is sufficient to meet the nutrient requirements of nearly all (97-98 per cent) healthy individuals in a particular life stage and gender group) for certain nutrients like protein or vitamins,which could further compromise their medical status. During a concurrent observation and interview 5/1/24 at 7:23 a.m., the Dietary Manager (DM) stated the facility did not have a plant-based menu. The DM stated she asked their vendor and was told they did not have any plant-based menu being offered at this time, but they would be releasing a plant-based menu soon. The DM stated, if the facility had a resident on a vegan diet, they would just use the food items they currently had in the building to substitute. The DM checked the freezer and found a Ziploc labeled Veggie burger which had no information on the dietary content, such as calories or protein, of the patties. When asked if the resident on a vegan diet requested a veggie burger now, how could they be sure they were receiving adequate nutrition if there were no indications on the nutrient contents per burger, the DM did not answer. The DM stated it was important to ensure the facility had a plant-based menu to ensure the residents were receiving varied meals and they were receiving adequate nutrition. The DM stated, if the facility did not have a plant-based menu it could result in malnutrition, calorie deficit, and residents not getting adequate proteins in their diet, which could result in residents getting sick. The DM stated it was not the cook's responsibility to calculate protein and nutrients per meal, so having a plant-based menu and recipes to follow could help ensure residents were receiving adequate nutrition. During an interview on 5/1/24 at 7:36 a.m., [NAME] 1 stated the facility did not have a plant-based menu, and stated it would be helpful if the facility had one. [NAME] 1 stated, following the plant-based menu and recipes, ensured resident were receiving varied plant-based meals and ensured residents were receiving adequate nutrition. [NAME] 1 stated, not having a plant-based menu could be a safety issue and could result in residents' weight loss and not receiving the nutrients they needed to get better. During an interview on 5/1/24 at 8:34 a.m., Dietary Aide 1, who spoke and understood little English, was assisted by the DM during the interview. Dietary Aide 1 stated the facility did not have a plant-based menu. Dietary Aide 1 stated it was important for the facility to have a plant-based menu to ensure the residents were receiving adequate nutrition. Dietary Aide 1 stated, not having a plant-based menu and recipes could result in weight loss. During an interview on 5/1/24 at 9 a.m., Dietary Aide 2 stated the facility did not have a plant-based menu. Dietary Aide 2 stated it was important to have a plant-based menu to ensure residents on vegan diets received adequate and appropriate nutrition. Dietary Aide 2 stated, if the facility did not have a plant-based menu and recipes, it could result in residents' malnutrition, weight loss and residents getting sicker. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 2:40 p.m., the Registered Dietician (RD) verified the facility did not have a plant-based menu. The RD stated, having a plant-based menu with recipes for staff to follow, could be beneficial for the residents on vegan diets. The RD stated, having a plant-based menu would ensure residents on vegan diets were receiving adequate nutrition, such as micronutrients and protein in their diet. The facility did not have a policy and procedure on plant-based menus. A review of the facility's policy and procedure (P&P), titled, Menus, revised 10/2017, the P&P indicated, Menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy . menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences) .menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal.

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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** 46132 Based on observations, interviews and record reviews, the facility failed to ensure food was palatable, and served at temperatures in accordance with resident preferences, for four out of five sampled residents (Residents 5, 14, 42 and 53), and the food temperature was not taken prior to serving to one out of 5 sampled residents (Resident 47). These failures could result in residents not eating the food served, which could result in weight loss and further compromise their medical status. Not taking the food temperature prior to serving to the resident could result in accidents such as burns. Findings: A review of Resident 14's face sheet (demographics) indicated she was admitted to the facility on [DATE], with a diagnoses of Dysphagia (swallowing difficulties), Hyperlipidemia (HLP, abnormally high levels of fats (lipids) in the blood) and Essential Hypertension (HTN, high blood pressure). Resident 14 reported she had Breast Cancer (Cancer that forms in tissues of the breast) which was being treated outside the facility. A review of her Minimum Data Sheet Assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 4/11/24, Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents) score was 13, indicating intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 14's functional status indicated she needed maximum assistance when performing her Activities of Daily Living (ADLs, activities related to personal care which include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet) such as bathing, dressing and putting on/removing footwear. A review of Resident 5's MDS assessment, dated 3/19/24, indicated she had a BIMS score of 13, indicating intact cognition. Her diagnoses include Heart Failure (HF, occurs when the heart muscle doesn't pump blood as well as it should), HTN and Diabetes Mellitus (DM, a chronic (long-lasting) health condition that affects how your body turns food into energy). A review of Resident 42's MDS assessment, dated 2/17/24, indicated she made decisions that were consistent and reasonable. Her diagnoses include Anxiety (a feeling of fear, dread, and uneasiness) and Schizophrenia (a chronic, severe mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality). A review of Resident 53's MDS assessment, dated 2/18/24, indicated she had a BIMS score of 15, indicating intact cognition. Her diagnoses include Asthma (a chronic condition that inflames and narrows the airways in the lungs) and Respiratory Failure (RF, a serious condition that makes it hard for you to breathe on your own). During an interview on 4/30/24 at 2:38 p.m., Residents 5, 14, 42 and 53, stated hot foods were served cold and had no taste. Residents 5, 14, 42 and 53, stated vegetables were overcooked, mushy and had no taste. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/1/24 at 7:06 a.m., [NAME] 1 was noted to warm up three cups of liquid meals for Resident 47, in the microwave for one minute and 30 seconds. [NAME] 1 did not take the food temperature prior to putting it on Resident 47's tray. When asked if she should take the food temperature prior to putting it on Resident 47's tray, she did not answer. During a concurrent observation and interview on 5/01/24 at 8:02 a.m., the Dietary Manager (DM) took the temperature of the food included in the test tray. The temperature results were as follows: Pureed eggs temperature was 136.5, pureed pancake temperature was 107, sausage temperature was 128.4, and the pancake temperature was 139.6. Upon tasting these food items, it was noted they were slightly cold in temperature, and the pureed egg and pancake had thick consistency and it tasted pasty, floury and doughy. The DM also tasted the food items and stated the pureed egg and pancake was slightly thickened in texture and tasted pasty and floury. When asked if the pureed eggs and the pureed pancake should be this thick in texture, tasted pasty and floury and the pancake tough and chewy, she stated, No. The DM stated this could be due to the cook adding thickener on these items. The DM stated the pancake was difficult to slice, and residents could have a hard time eating the pancake. During an interview on 5/1/24 at 2:40 p.m., the Registered Dietician (RD) stated staff should take the temperature of the food items warmed in the microwave, prior to serving it to the residents, to ensure residents' safety from accidents and burns. The RD stated food items' temperature should be in a range that was safe for the residents consumption. The RD stated, if food was not palatable and the temperature was not in range, residents may not eat the food, which could result in weight loss and impaired nutrition. During an interview on 5/2/24 at 10:20 a.m., the DM stated the test tray food temperatures for pureed at 136. 5, pureed pancake temperature of 107, the sausage temperature of 128.4, the pancake temperature of 139. 6, during test tray, was not appropriate and did not meet the food temperature guidelines. The DM stated, serving food that did not have the right temperature could cause food-borne illness. The DM also stated, if food were not served at a right temperature, it could lead to residents not eating the food which could result in weight loss or malnutrition. During an interview on 5/2/24 at 10:50 a.m., the DM stated, if food items were placed in the microwave to warm it, staff should have taken the temperature before placing it on the resident's meal tray, to ensure resident safety from burns or accidents and to ensure the resident did not get sick from food-borne illness. During an observation on 5/2/24 at 10:55 a.m., the DM made another batch of pureed eggs. She stated she would use two-thirds (2/3, an amount that is two out of three equal parts of it) cups of eggs which was equal to three eggs and would add one-forth (1/4, an amount that is one out of four equal parts of it) cup of milk. The DM stated, per their pureed eggs menu, they were allowed to use between 1/3 to 3/4 cups of milk. The DM stated the pureed eggs she prepared appeared very lumpy so she had to put them back in the blender. The DM was noted to add milk in the blender. When asked how much milk she added on the pureed eggs, the DM stated she added a splash of milk which resulted in the pureed eggs appearing watery with some clumps. When asked what a splash of milk meant, she did not answer. She stated she should not have added more milk. A review of recipe titled, Pureed eggs, indicated puree should reach a consistency slightly softer than whipped topping. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on the facility's policy and procedure (P&P) titled, Food Preparation and Service, revised 11/2022, the P&P indicated, Food and Nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling services .the following internal cooking temperatures/times for specific foods are reached to kill or sufficiently inactivate pathogenic microorganism, 155 degrees for eggs held for service, mechanically tenderized meat .previously cooked food is reheated to an internal temperature of 165 for at least 15 seconds before holding for hot service .mechanically altered hot foods prepared for modified consistency diet remains above 135 degrees during preparation or they are reheated to 165 degrees for at least 15 seconds.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observation and interviews, the facility failed to ensure food items in the refrigerator, freezer and dry pantry area were opened- and discard-dated and expired food items were discarded. These failures led to unsafe and unsanitary storage of food. These failures were also a safety risk that could lead to accidental ingestion of expired food items that could result in food-borne illness (an illness that comes from eating contaminated food). Findings: During a concurrent observation and interview on [DATE] at 9:49 a.m., the dry pantry was noted with cooking oil that was halfway used and an opened two-way chocolate mix that did not have a discard date. Refrigerator 1 had an opened bottle of 100% lemon juice and teriyaki sauce that had no open and discard-by date. The Dietary Manager (DM) stated these items should be opened- and discard-dated. The DM stated all food items in the kitchen should be opened- and discard-dated. During an interview on [DATE] at 10:01 a.m., the DM stated food items in the kitchen should have an open- and discard-by date so staff knew when food items were to be discarded and expired food items could be discarded. The DM stated it was for resident's safety to prevent food-borne illness. During a concurrent observation and interview on [DATE] at 7:23 a.m., there was a Ziploc labeled veggie burger on the freezer that was open-dated but had no discard date. The DM stated this should have a discard-by date so staff knew when to discard these veggie patties, for resident's safety. The DM stated, if food items did not have a discard-by date, it could result in resident's receiving food items that were already expired, which could result in residents getting sick. During an interview on [DATE] at 8:52 a.m., Dietary Aide 1, who understood little English, was assisted by the DM during the interview. Dietary Aide 1 stated food items should be opened and discard-dated for patient safety. Dietary Aide 1 stated it was a safety risk, and residents could get sick if food items in the kitchen were not opened- and discard-dated. During an interview on [DATE] at 8:54 a.m., [NAME] 1 stated all food items in the refrigerator and the dry pantry should be opened- and discard-dated to ensure residents were not consuming expired food items. [NAME] 1 stated, if food items were not opened- or discard-dated, it could result in residents receiving expired food items, which was a safety issue because it could lead to residents getting sick with diarrhea (loose, watery stools three or more times a day). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 8:56 a.m., Dietary Aide 2 stated food items from the kitchen should always be opened- and discard-dated for resident's safety. Dietary Aide 2 stated this was done to ensure residents were not receiving items that were expired. Dietary Aide 2 stated, if food items were not opened- or discard-dated, it could lead to residents receiving expired food items which could make them sick. Dietary Aide 2 verified the following items did not have a discard-by date: Baking Soda, peanut butter, and chicken bouillon. Dietary Aide 2 stated these items were supposed to have a discard-by date for safety, to decrease risk of residents ingesting expired food items that could make them sick, such as diarrhea and vomiting. Dietary Aide 2 verified the box of opened Sodium Bicarbonate (when used for baking, it produces a chemical reaction that helps batter expand or rise in a hot oven) expired on [DATE], and should have been discarded to decrease the risk of staff accidentally using it. During an interview on [DATE] at 2:29 p.m., the Registered Dietician stated the food items in the kitchen should always be opened- and discard-dated to ensure residents did not consume food items that were expired, thus preventing food-borne illness such as salmonella (a group of bacteria that can cause diarrhea in humans) and listeria (a food-borne bacterial illness that can be very serious for people older than 65 and people with weakened immune system-body's defense against infections). The United States Department of Agriculture (USDA, a branch of government that works to increase food security) Food Safety and Inspection Services (FSIS, a science-based national system to ensure food safety and food defense) indicated microorganisms, such as molds, yeasts, and bacteria, can multiply and cause food to spoil, and date-marking was a process the food was discarded before these bacteria could cause food-borne illness. The policy for food storage and labeling was requested but not provided.

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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** 38088 Based on observation, interview and record review, the facility failed to ensure an effective Infection Control Program when: 1. Dirty and stained carpeting, broken floor surfaces, cracked wheelchair arm rests, exposed wall plaster, rust, and chipped paint were observed in patient care areas. 2. Cross-contamination risks were observed in Laundry Processing and storage areas, Clean Utility Room, and resident Ice Storage Room. 3. Vaccination rates of staff and Residents and Hand Hygiene compliance was not monitored. These failures had the potential for resident infection, potential death from cross-contamination and infection, and psychosocial harm Findings: (Reference F 584) 1. During an observation on 4/29/24, at 11:33 a.m. the Housekeeping Closet, next to Resident room [ROOM NUMBER], revealed the floor, walls, sink and equipment, door and door jamb had black, gray residue on all surfaces. The black, gray substance felt greasy to the touch. Under the sink there appeared to be a calcified, wet, plumbing leak originating from the hopper sink. (See Photos) During an observation on 4/29/24, at 11:34 a.m., the resident Shower Room, located in the hallway across from staffing, had multiple unlabeled razors, lotions, and shampoo sitting on a shower shelf. An insect was on a resident shower seat. The Shower Room, closest to the Administrator's office, had a sharps' disposal box mounted on the wall, contained razors sticking out of the top, there were no gloves, and the call light was attached to a plastic glove hanging from the wall. (See Photos) During an observation on 4/29/24, at 12:25 p.m., staff passed lunch trays into rooms [ROOM NUMBERS], and did not offer hand hygiene before meal service. During an observation on 4/29/24, at 2:25 p.m. the Oxygen Storage room was had black streaks on floor. During an observation 4/29/24, at 2:30 p.m., the Clean Utility Room had gray particulate matter on the counter, in storage bins, and on the floor. The floor had large quantities of dark particulate and gray particulate matter. A red bin, on the counter, contained resident soaps and hand lotion. An insect, resembling a cockroach, was laying on its back with the legs up. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/1/24, at 9 a.m., the carpeting near the double doors leading into the kitchen appeared to have a dark, gray stained area, as wide the hallway and extended to the hallway in front of the Resident dining area. There was stained carpet in all the hallways throughout the length and distance of the hallway, from the back entrance of the facility to the front door of the facility and in the hallways leading to all patient rooms. (See Photographs) During an observation on 5/1/24, at 9:05 a.m., the hallway walls appeared to have gray-black smudges and streaks on them, and above the floorboards was exposed plaster and chipped paint throughout the hallway. (See Photographs) During an observation and interview, on 5/1/24, at 9:15 a.m., the bathroom in a resident room had more stained than unstained tiles on the floor. The tiles on the floor were chipped and cracked. The walls had exposed plaster, marks, and gray-black marks on all four walls around the floor. The doorways had chipped paint with exposed rust. The base of the toilet had a rough, messy caulk line of rust, brown and gray-black stains. Beneath the hand washing sink there was a pile of dirty linen rolled up and placed beside the trash can. This area had stained tiles that were cracked and chipped. (See photographs) Resident 3 stated the floors looked awful. She stated the bathroom looked terrible. She stated, This is not how my home was. She stated, I feel like I am living in a ghetto. During an observation and interview, on 5/1/24, at 9:34 a.m., the linoleum tiles in the doorway of another resident room were stained and discolored, chipped, and broken. The bathroom in this room had linoleum with fist-sized areas of torn and missing linoleum. The bathroom had rough, messy, and black stained caulking around the base of the toilet. The area under the sink had trash on the floor and linen thrown on the ground. (See Photographs) Resident 5 stated no one ever cleaned. He stated the stains on the floors and walls made him feel depressed that he was not in his own home. During an observation and interview, on 5/1/24, at 9:45 a.m., the linoleum tile in another resident room was stained, chipped, and cracked. The walls had dark gray-black marks. (See Photographs) Resident 6 stated the stained tiles or marks on the wall did not look good, and it would be nice to have things look better. During an interview with Unlicensed Staff A, on 5/1/24, at 9:50 a.m., she stated, if something needed to be repaired, staff were supposed to contact the Facilities Manager. She was unable to state what the infection prevention concerns were for chipped and cracked floor tile, exposed plaster, or chipped paint. During an observation on 5/1/24, at 10 a.m., the resident Linen Closet in the hallway across from room [ROOM NUMBER], had unfinished plywood on the wire shelves and had folded linen placed on top of the plywood. The floor of the resident Linen Closet had chipped, cracked, and stained linoleum tiles. The floor underneath the linen cart had clear plastic bags, with assorted pieces of paper and masks in them, and gray dust-like particulate and dirt and strings of gray web-like substance along the floorboards and up the wall. (See Photographs) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation with the Facilities Manager, on 5/1/24 at 10:45 a.m., he stated he did not know why chipped paint, rust, exposed plaster, and un-sealed plywood, was an infection issue. He was unable to state if the cleaning solutions used by housekeeping were approved by the Infection Prevention Committee. He stated he oversaw housekeeping and just ordered what the facility told him to order for cleaning solutions or disinfectants. The Facilities Manager stated he had not provided infection prevention in-services for the housekeeping staff. He stated the process for reporting items or areas that needed repair, was to write it in the binder at the front desk. A review of a binder titled, Repairs, indicated there were no requests for fixing wheelchair arm rests, bathroom floors, or chipped paint. He stated the housekeeping staff were supposed to report to him when they observed anything that needed to be repaired, painted, or fixed. There were two wheelchairs outside the Human Resources office. (See Photographs) The arm rests were extensively cracked and lifted. He stated he was not aware they needed repair. He stated he thought that Physical Therapy took care of the wheelchairs. He stated he was unaware that cracked arm rests could not be disinfected and had the potential to irritate the exposed skin on residents who had very thin delicate skin and potential bleeding issues, from medications. During an observation of Resident Rooms 1, 2, 4, and 7, he stated the floors were stained and cracked. He stated the walls had exposed plaster and chipped paint. He stated the floors in the bathrooms were not repaired properly. He stated repairs needed to be done so the surfaces could be cleaned and appeared in good repair. He stated the bathrooms were, Unsightly and were not cleanable. Regarding the Linen Closet in the hallway across from room [ROOM NUMBER], the Facilities Manager observed the linen cart with the plywood, and stated he did not know that unsealed plywood could not be disinfected. He stated, Residents could get splinters of wood that were stuck to the linens too. He observed underneath the linen cart and stated, Yeah, that doesn't look like it has been cleaned in a while. He stated the dirt could get onto the linens and possibly cause residents to get sick. During an interview on 5/1/24, at 11 a.m., with Licensed Nurse B, he stated the stains on the floors were, Pretty bad, could make family and residents think it is dirty. He stated he would call the Facilities Manager for repairs of anything. He stated he never called about the flooring because someone was always cleaning it. He stated he did not know the bathrooms had any infection control issues. During an observation and interview on 5/1/24, at 11:40 a.m., a resident room had a built-in white dresser with three drawers, a countertop and closet doors painted white. There were gray, black scuff marks from the level of the floor up to the second drawer, across the front of the drawers and the closet doors. The countertop contained a pair of gray and pink tennis shoes that were placed on top of a box of gloves and against a stack of white towels. The bathroom had stained, cracked, and chipped floor tiles around the entire bathroom. There was exposed plaster behind the toilet. There was chipped paint around the doorway with gray-black material around the floor and up the wall. The base of the toilet had a thick, rough, messy line of caulk, and the toilet bowl appeared to have fecal material on the inside. An unidentified bed pan was stuck between the wall and a handrail. The area under the sink had stained, chipped, and cracked tiles, exposed plaster and chipped paint. There was a blanket rolled up and placed under the sink next to the trash can. (See Photographs) Resident 1 stated no one ever came in and cleaned. She stated, when they did come in, they never picked up her things off the floor and put them where she could reach them. She stated, whoever owned this place did not care if things were broken or needed painting. She stated the facility was falling apart and looked terrible. She stated it made her feel very sad because she had lived in a home that was beautiful and, this was not like a home. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/1/24, at 12:10 p.m., Unlicensed Staff C stated he did not know how to report when wheelchair arm rests needed to be repaired. He stated he had never told anyone about anything that needed to be repaired. He observed the wheelchairs in the hallway, and stated they looked pretty bad. He stated he did not know the arm rests could not be disinfected if the material was cracked. He stated the residents could scratch themselves on the arm rests if they did not have a long-sleeved shirt on. He stated the residents had really thin skin, and they could scratch themselves pretty easily on the cracked arm rests. During an interview on 5/1/24, at 12:10 p.m., the Infection Preventionist stated surfaces needed to be, Intact for cleaning and disinfection to occur. She reviewed the facility environmental photographs of the bathrooms, hallway rugs, and wheelchairs and stated, Broken linoleum, wheelchair arm rests, would be at risk for cross-contamination if surfaces were in disrepair. She stated, Exposed plaster could not be cleaned or disinfected. She stated the conditions of the bathroom were an infection control concern and had the potential for cross-contamination and potential resident infection risk. During an interview with Unlicensed Staff E, on 5/1/24 at 12:25 p.m., she stated the rugs in the hallway looked really bad. She stated it would not be something she would want to have in her home. She said, It looked dirty. During an interview and document review on 5/1/24, at 12:45 p.m., a document titled, Maintenance Log, dated 10/4/(23) to 12/29/23, indicated, 10/4/(23) Toilet leaks water through tiles, requested 10/4 and completed 10/9/23. 11/10/23 TOILET OVERFLOW, requested 11/10/23, and completed 11/13/23. The Facilities Manager stated he had reviewed the Maintenance Log from October 2023 to January 2024, and there were no reports from staff about bathroom issues, broken linoleum, chipped paint, or wheelchair arm rests that needed to be repaired for Resident Rooms 2, 4, 7, or 23. He stated his assistant did not know about the Maintenance Log. The Maintenance Log indicated 45 Requests / Repairs and 14 Requests / Repairs were not completed. The Facilities Manager stated he forgot to write completed dates. He stated his assistant did not know about the log, and he did not know why staff were not using it. He stated the Maintenance Log was important so staff would communicate issues that needed to be repaired, to him or his assistant. During an interview and observation with the Director of Nursing, on 5/1/24 at 12:55 p.m., she stated she was unaware the wheelchair arm rests were cracked. She stated the condition of the arm rests were an infection control risk for residents because they could not be disinfected. In room [ROOM NUMBER] she observed the bathroom, and stated linen on the floor was not supposed to be in the bathroom. She stated the linen on the floor was an infection control risk to patients. She stated the cracked tiles, rough caulk around the base of the toilet, and the exposed plaster could have been an infection control risk for residents from cross-contamination and the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation and interview on 4/29/24, at 2:35 p.m., with the Administrator and Facilities Manager, outside the Clean Utility Room, the Facilities Manager stated the room was cleaned daily by housekeeping staff. He stated it was considered clean, not dirty. Inside the Clean Utility room, the Facilities Manager took a moist paper towel and wiped the floor. Gray and black particulate residue and matter was left on the towel. He stated the room looked like no one had cleaned it. He stated it was supposed to be cleaned daily. He looked in the red bin with the cockroach, and stated it was a cockroach. He stated there had been reports of spiders. The Administrator stated the facility had a monthly pest control, but there was no facility monitoring process to indicate how many sightings of insects or spiders there were. The Administrator was unable to state how many reports of insects and cockroaches there had been and if the pest control company had been informed or had any suggestions for reduction of pest infestations. The Facilities Manager stated he would use a can of insect spray if someone stated they had seen insects between facility pest management visits. He stated he was not sure if the insect spray was approved for use in healthcare facilities, by the Environmental Protection Agency. The Administrator stated there was no Policy and Procedure for pest and rodent control in the facility. He stated there was no plan on how the facility was to ensure there were no insects or rodents in the facility. (See Photos) A request was made for the photo of the insect taken by the Administrator. It was not received by the end of survey. During an observation and interview on 5/1/24, at 7:15 a.m., outside the resident Dining Room, Licensed Nurse N and unlicensed staff provided breakfast meal trays to 11 residents in the Dining Room without offering hand hygiene. Licensed Nurse N stated, before providing meal trays to residents, to offer hand hygiene. She stated the staff offered it during this observation. She stated staff had to go to kitchen to get the hand wipes for hand sanitation. The meal trays, used by residents and the trash can, did not show any disposable hand wipes were used during this observation. She stated they had offered but all the residents refused. She stated the risk to residents who did not engage in hand hygiene, would have been food-borne illness. During an interview on 5/1/24 at 11:15 a.m., Unlicensed Staff R was unable to stated who was responsible for cleaning the Clean Utility Room, Housekeeping Closet, the clean and dirty side of the Laundry Room, and the Linen Storage Closets. She stated the Housekeeping Closet looked dirty, and it had a lot of grime, black smudges, and resident toilet paper was stored closed to the dirty sink. (Se Photos) During and observation and interview on 5/2/24, at 9 a.m., in the clean laundry area folding room, with Unlicensed Staff S, the Infection Preventionist and the Facilities Manager, the Facilities Manager stated the outside vents by the dryers were cleaned weekly. Unlicensed Staff S stated she cleaned the countertops, used to fold resident linen and clothing, every time she folded laundry, with bleach wipes. She was unable to state how long the surface needed to stay wet to produce bacterial kill to eliminate cross-contamination. There was no hand hygiene gel or hand hygiene sink. Unlicensed Staff S stated she used wipes for countertops and hand hygiene. She stated there were none on the countertop because she just threw them away. When asked why there were no empty containers in the trash, she stated she just emptied the trash. She used a step ladder to retrieve the last large container of bleach wipes and last remaining small container of hand wipes, from the top shelf of a closed cupboard attached to the ceiling. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/2/24, at 9:10 a.m., in a room that contained washers, dryers and equipment, a red line ran diagonally from the right side of the doorway between the laundry folding room, to the middle of the room with the washers and dryers. The concrete floor was chipped and had gray particulate matter, resembling lint or dust, distributed around the room on equipment, behind equipment, and on the floor. Unlicensed Staff S stated indicated the red line was dirty, on the right side where the washers and bins were, and the left side, by the dryers, was clean. Behind the washer and dryers, screened vents led to the outside. The vents were heavily encrusted with black, gray particulate resembling dust, dirt and / or lint. The Facilities Manager stated the vents on the walls leading outside, were cleaned weekly. He stated it did not look like they had been cleaned. The floors behind the washers and dryers had larger quantities of the same gray particulate matter. Unlicensed Staff S stated she cleaned the lint traps, located under each dryer, at 9:30 a.m. and 1:30 p.m She stated she did not write it down on a log. The lint trap under the dryers had a large sheet of dryer lint in the trap and on the floor. Unlicensed Staff S stated she used a broom to clean the dryer lint traps, and walked over the red line to get a broom, stored on the wall on the, Dirty side of the laundry, walked back into the, Clean Side, and demonstrated how she cleaned the lint traps. She then walked back across the red line and hung up the broom, then walk back into the laundry folding area, without using hand hygiene. The Infection Preventionist stated she was unaware of the infection prevention practices in the laundry area and having a dirty and clean side. She stated she thought it had the potential for cross-contamination and the spread of infection to residents and staff. The Facilities Manager stated he was not oriented to the infection prevention concerns about clean and dirty in the laundry area. Unlicensed Staff S stated the dirty laundry was sorted on the right side of the red line and transferred into the washing machines. She stated she wore an apron. She pointed to the doorway that separated the laundry folding area from the laundry washer and dryer room, where one sleeveless white plastic apron hanging. She stated it was clean. She stated she used a clean one every time and then threw it away. The trash can on the right side of the red line did not contain an apron. She stated she had already emptied the trash. There were multiple bottles and buckets of laundry detergent solutions and a large jug of bleach and a mop bucket with solution, placed between the washer and dryer area. Unlicensed Staff S stated she used bleach in the bucket to mop the floors of the entire laundry area. She stated there was no sink in the dirty or clean sides of the laundry area, and she went to the Housekeeping Closet outside the Department to get water so she could mop the floors. The Facilities Manager stated he did not know if any of the cleaning solutions or laundry chemicals had been approved for use by the Infection Control Committee. The Infection Preventionist stated she did not know if the solutions had been approved for use and were EPA approved. She stated she did not know if the solutions and detergent chemicals were providing the bacterial kill required to prevent the risk of cross-contamination in the laundry process area. The Facilities Manager stated there was no hand hygiene sink in the Department, and if staff had to wash hands, they would have to leave the Department and use the public bathroom outside the area. The Infection Preventionist stated gastrointestinal food-borne illness like C-differential, required staff to wash their hands, as alcohol based hand sanitizers were ineffective. She stated hand hygiene was done before and after putting on and taking off gloves and the apron. Unlicensed Staff S stated she wore an apron and gloves when she sorted dirty laundry. She stated she did not wear eye protection. Unlicensed Staff S stated, if her face and eyes were splashed with contamination from dirty laundry or laundry chemicals, she would use bottled eye wash to rinse her eyes. She was unable to state how long she had to rinse her eyes. The Facilities Manager was unaware if there was a Policy and Procedure for how long to rinse eyes after a bodily fluid exposure. He reviewed the Safety Data Sheets and was unable to locate how long to rinse eyes if bleach splashed into eyes. He stated one bottle of eye rinse was not enough to rinse eyes after an exposure. He stated staff had the potential to have physical harm to their eyes if they could not rinse their eyes for long enough. He stated laundry staff did not know how long to rinse their eyes in case they were exposed. The Facilities Manager stated he did not know when the washers were serviced. He stated he did not know what the water temperature was of the washing machines. He stated there were no logs for anything in the laundry area. He stated he thought the water temperature might have been between 140 to 160 degrees Fahrenheit but was not certain. The Infection Preventionist stated she did not know why the water temperature was important for bacterial kill and use of detergent efficacy. She stated she used the Centers for Disease Control (CDC) as a

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility P&P titled, Laundry and Bedding, Soiled, revised September 2022, indicated, Soiled laundry/bedding shall be handled, transported and process according to best practices for infection prevention and control Contaminated laundry is bagged or contained at the point of collection (i.e., location where it was used) Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. Review of a document titled, CDC Guidelines for Environmental Infection Control in Health-Care Facilities 2003, dated 7/2019, page 96, indicated, From a public health and hygiene perspective, arthropod and vertebrate pests should be eradicated from all indoor environments, including health-care facilities .Insects should be kept out of all areas of the health-care facility, especially ORs and any area where immunosuppressed patients are located. A pest-control specialist with appropriate credentials can provide a regular insect-control program that is tailored to the needs of the facility and uses approved chemicals and/or physical methods. Review of a document titled, Healthcare Personnel Vaccination Recommendations, indicated, CDC Vaccines and recommendations in brief, Hepatitis B - If previously unvaccinated, give a 2-dose (Heplisav-B) or 3-dose (Engerix-[NAME] Recombivax HB) series. Give intramuscularly (IM). For HCP who perform tasks that may involve exposure to blood or body fluids, obtain anti-HBs serologic testing 1-2 months after dose #2 (for Heplisav-B) or dose #3 (for Engerix-B or Recombivax HB).nfluenza - Give 1 dose of influenza vaccine annually. Inactivated injectable vaccine is given IM. Live attenuated influenza vaccine (LAIV) is given intranasally.MMR - For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957, see below. Give subcutaneously (Subcut). Varicella (chickenpox) - For HCP who have no serologic proof of immunity, prior vaccination, or diagnosis or verification of a history of varicella or herpes zoster(shingles) by a healthcare provider, give 2 doses of varicella vaccine, 4 weeks apart. Give Subcut. Tetanus, diphtheria, pertussis - Give 1 dose of Tdap as soon as feasible to all HCP who have not received Tdap previously and to pregnant HCP with each pregnancy.low). Give Td or Tdap boosters every [AGE] years thereafter. Give IM. Meningococcal - Give both MenACWY and MenB to microbiologists who are routinely exposed to isolates of Neisseria meningitidis. As long as risk continues: boost with MenB after 1 year, then every 2-3 years thereafter; boost with MenACWY every 5 years. Give MenACWY and MenB IM. Review of a document from the CDC titled, Appendix D - Linen and laundry management Best Practices for Environmental Cleaning in Global Healthcare Facilities with Limited Resources, dated 5/4/23, indicated, Best practices for management of clean linen: Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. Each floor/ward should have a designated room for sorting and storing clean linens. 48660 3. b. During an observation on 5/1/24 at 7:30 AM, in the hallway outside Resident room [ROOM NUMBER]B, Licensed Nurse G (LN G) did not perform hand hygiene before entering the room to check blood pressure, or after leaving the room. During an observation on 5/1/24 at 7:40 AM, in the hallway outside Resident room [ROOM NUMBER]B, LN G did not perform hand hygiene before entering the room to administer inhaler treatments, or after leaving the room. (continued on next page)

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	055853	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redwood Cove Healthcare Center	1162 S Dora St. Ukiah, CA 95482

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 5/1/24 at 9:58 AM, in the hallway in front of the Nurse's Station, Medication Cart #2 had three medication drawers with visible paper debris, hair, and five loose medication pills. One drawer in the medication cart had a sticky substance at the bottom of the drawer and a medication bottle where a pink substance dripped on the cap and down the side of the bottle. Licensed Nurse H (LN H) verified the debris, hair, and loose pills in three drawers, the sticky substance on the bottom of one drawer, and the medication bottle with a pink substance dripping on the cap and down the side of the bottle. During an observation on 5/1/24 at 11:25 AM, in the hallway outside Resident room [ROOM NUMBER]B, LN G did not perform hand hygiene before putting on gloves to administer enteral medications. During an observation on 5/1/24 at 11:35 AM, in the hallway outside Resident room [ROOM NUMBER]B, LN G did not perform hand hygiene after removing gloves to re-pour a medication after one medication was spilled. During an observation on 5/1/24 at 4 PM, in the hallway outside Resident room [ROOM NUMBER]B, Licensed Nurse I (LN I) did not perform hand hygiene before entering the room to administer medications. During an observation on 5/1/24 at 4:10 PM, in the hallway outside Resident room [ROOM NUMBER]A, LN 1 did not perform hand hygiene before entering the room to administer medications. During an observation on 5/1/24 at 4:25 PM, in the hallway outside Resident room [ROOM NUMBER]A, LN H did not perform hand hygiene before entering the room to administer medications. During an observation on 5/1/24 at 4:30 PM, in the hallway outside Resident room [ROOM NUMBER]B, LN H did not perform hand hygiene before putting on gloves to perform a blood sugar check on the resident. During an interview on 5/2/24 at 10:55 AM, Licensed Nurse J (LN J), stated nursing staff was trained upon hire, annually, and as needed, on hand hygiene. The standard for nursing staff was to perform hand hygiene before entering a resident room, when leaving a resident room, before putting on gloves, and after taking off gloves. A record review of a document titled, Administration of Medication Policy and Procedure, not dated, indicated, Wash hands before and after each administration of medication. A record review of a document titled, Handwashing/Hand Hygiene, dated with revision as October 2023, indicated, All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. The document also listed the following indications for hand hygiene: Immediately before touching a resident, .after touching a resident, after touching the resident's environment ., and immediately a [TRUNCATED]

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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. 46132 Based on observation, interviews and record reviews, the facility failed to ensure the kitchen walls were in good repair, when cracks and holes in the walls were noted during rounds, and the dish washing sink counter was rusty. These failures could result in rodents and pests accessing the kitchen area through these cracks and holes, which could put residents at risk for harmful diseases. The rusty kitchen sink counter created a breeding ground for bacteria as it could not be disinfected and cleaned thoroughly, which could be a safety risk. Findings: During an observation on 4/29/24 at 9:58 a.m., the wall underneath the dish washing sink, near the dish sanitizing machine, was cracked and had a hole, the floor was dirty with whitish material build up, the area under the sink was noted with cobwebs. The metal sheet wall by the dish washing area had holes. The wall by the door leading towards the hallway had a hole, and the dishwashing sink counter was rusty. During a concurrent observation and interview on 5/1/24 at 7:23 a.m., the Dietary Manager verified the sheet metal wall by the dish washing sink had holes, the bottom of the wall near the door leading to the hallway had a hole, the wall underneath the dishwashing sink had cracks and a hole, the dish washing sink counter was rusty, and the walls underneath the dish washing sink were noted with blackish-tinged material. The DM stated the walls should not have holes and cracks, because these could be an entry way for pests and cockroaches. The DM stated these pests and cockroaches could contaminate the food, food items, the cooking area and the utensils, which was a safety issue and an infection control issue. The DM stated pests and cockroaches could bring illness, and residents could get sick, such as nausea, vomiting and diarrhea. The DM stated the kitchen should not have a rusty dish washing sink counter, for safety issues and for infection control. A pest was seen crawling underneath the dishwashing sink, the DM identified it as a small cockroach. The DM stated this was not the first time they saw a cockroach in the kitchen, and stated this was an ongoing issue. During an interview on 5/1/24 at 7:35 a.m., [NAME] 2 stated the sheet metal wall by the dish washing sink should not have holes, the bottom of the wall near the door leading to the hallway should not have a hole, the wall underneath the dishwashing sink should not have holes and cracks, the dish washing sink counter should not be rusty, and the walls underneath the dish washing sink should not be noted with blackish-tinged material. [NAME] 1 stated the walls should not have walls or openings or cracks because pests, vermin or cockroaches could enter the kitchen area and contaminate the food or items for residents' consumption. [NAME] 1 stated, if vermin, pests, or cockroaches had access to the kitchen, residents could get sick. [NAME] 1 stated the dishwashing sink counter should also be free from rust as these was an infection control issue and a safety hazard. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/1/24 at 7:40 a.m., Dietary Aide 2 verified the sheet metal wall by the dish washing sink had holes, the bottom of the wall near the door leading to the hallway had a hole, the wall underneath the dishwashing sink had a hole or cracks, the dish washing sink counter was rusty, and the walls underneath the sink were noted with blackish-tinged material. Dietary Aide 2 stated the walls should not have holes or cracks, because these could be entry ways for vermin, pests or cockroaches and was a big safety and infection control issue. Dietary Aide 2 stated if pests, cockroaches, or vermin had access to the kitchen area, these pests and cockroaches could contaminate food, the food items, the cooking area and the utensils. Dietary Aide 2 stated residents could get sick or have gastrointestinal (GI, a pathway by which food enters the body and solid wastes are expelled) illness, such as diarrhea and vomiting. Dietary Aide 2 stated the dishwashing sink counter area should be free from rust for safety and infection control purposes. During a concurrent observation and interview on 5/1/24 at 8:17 a.m., the Maintenance Assistant (MA) verified the sheet metal wall by the dish washing sink had holes, the bottom of the wall near the door leading to the hallway had a hole, the wall underneath the dishwashing sink had a hole and cracks, the dish washing sink counter was rusty and the walls underneath the dishwashing sink were noted with blackish-tinged material. The MA stated the holes on the walls should be covered so there could be no way for cockroaches and pests to enter the kitchen area. The MA stated it was a safety issue and contamination issue because pests and cockroaches were known to bring illness such as vomiting and diarrhea. The MA stated the dishwashing sink counter area should not be rusty for safety and to prevent contamination. The MA stated he recommended to the Maintenance Director to change the entire dishwashing sink because, it was rusty. During an interview on 5/1/24 at 2:15 p.m., the Maintenance Director stated he was aware of the issues with holes and cracks in the kitchen walls and the rust on the dishwashing sink counter. The Maintenance Director stated it was not acceptable for walls in the kitchen to have holes and cracks and for the dishwashing sink counter to be rusty, for safety reasons and for infection control, as pests could come through the walls in the kitchen area and could cause cross-contamination of residents' food which could result in residents getting sick, such as vomiting and other stomach illness. During an interview on 5/1/24 at 2:33 p.m., the Registered Dietician (RD) stated there should be no holes, cracks and opening in the walls in the kitchen area because pests could enter the kitchen through these openings. The RD also stated the dishwashing sink counter should be free from rust because of infection control issues, as there was no way to clean a rusty dishwashing sink thoroughly. A review of the facility's policy and procedure (P&P) titled, Supervision, Maintenance Services, revised 5/2008, the P&P indicated the Maintenance Director was responsible for scheduling preventive maintenance service.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 46132 Based on observation and interviews, the facility failed to maintain an effective pest control program to ensure the facility was free of pests or cockroaches, when a cockroach was seen crawling underneath the dish washing sink. This failure could lead to transfer of harmful bacteria to humans and could cause Salmonella (a group of bacteria that can cause diarrhea-3 or more loose, watery stool in a day, in humans), Leptospirosis (an infectious disease that damages the liver and kidneys), Typhoid Fever (a life-threatening infection that causes diarrhea and fever) and Cholera (an infectious disease that causes severe watery diarrhea). During a concurrent observation and interview on 5/1/24 at 7:23 a.m., a brownish-colored pest was crawling underneath the dishwashing sink area, which the Dietary Manager (DM) identified as a small cockroach. The DM stated this was not the first time they saw a cockroach in the kitchen area. The DM stated this was an ongoing issue. The DM stated pests and cockroaches could bring illness, and residents could get sick, such as Nausea (the condition of feeling sick and the feeling that you are going to vomit), Vomiting and Diarrhea. During an interview on 5/1/24 at 7:35 a.m. [NAME] 1 stated the kitchen had issues with cockroaches. [NAME] 1 stated it was not the first time a cockroach was seen in the kitchen. [NAME] 1 stated this was a safety, infection, and sanitation issue as it was in the kitchen where residents' food was prepared for their consumption. [NAME] 1 stated the kitchen area should be free from pests and cockroaches because of the risk for contamination and residents getting sick with diarrhea, vomiting and poisoning. During a concurrent observation and interview on 5/1/24 at 7:40 a.m., Dietary Aide 2 verified there was another cockroach on the wall by the dishwashing sink area. Dietary Aide 2 stated this was not the first time the kitchen was noted with cockroaches. Dietary Aide 2 stated this was an ongoing issue. Dietary Aide 2 stated, having cockroaches in the kitchen area was a big safety and infection control issue. Dietary Aide 2 stated, if a pest or cockroaches had access to the kitchen area, these pests or cockroaches could contaminate food items, the cooking area, and the utensils. Dietary Aide 2 stated residents could get sick or have gastrointestinal (GI, pathway by which food enters the body and solid wastes are expelled) illness, such as diarrhea or vomiting. During an interview on 5/1/24 at 8:23 a.m., the Maintenance Assistant stated the kitchen had issues with cockroaches, and he had been spraying pesticide in the kitchen area to get rid of the cockroaches. The Maintenance Assistant also stated a pest control company came once a month to help get rid of the cockroaches in the facility. When asked if these measures were effective in eliminating the cockroach issue in the kitchen, he stated, No. When asked if he knew where these cockroaches were coming from, the Maintenance Assistant stated it was probably from the holes, openings or cracks in the walls in the kitchen area. During a concurrent observation on 5/1/24 at 11:36 a.m., the DM verified another small cockroach was seen underneath the dishwashing sink. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/24 at 2 p.m., the Maintenance Director stated the facility had issues with pest control. The Maintenance Director stated the facility had been using a pest spray and a trap to kill the cockroaches. When asked what the pest control management was, he did not answer. He stated the pest control company came once a month to spray the facility to get rid of the pests and cockroaches. When asked what the facility was doing in between these monthly treatments, the Maintenance Director stated they did not really have any schedule or program they stuck to in between these treatments. The Maintenance Director stated what they did was spray the area with pesticides and kill the cockroach on contact. When asked if the pesticides they were using was Environmental Protection Agency (EPA, an agency of the United States federal government whose mission is to protect human and environmental health) registered, he did not answer. When asked if the facility was successful in eliminating cockroaches in the facility with the use of their pesticide, the Maintenance Director stated, No. When asked if the facility should be using a pesticide that was EPA registered, to be sure it was safe to use in the facility and effective in eliminating cockroaches, the Maintenance Director stated, Yes. When asked whether he knew where the cockroach was coming from, the Maintenance Director stated it could be from the holes or openings in the walls. During an interview on 5/1/24 at 2:40 p.m., the Registered Dietician (RD) stated cockroaches in the kitchen was a big concern. The RD stated cockroaches were not supposed to be in the kitchen, period. The RD stated cockroaches could bring disease and illness and could make residents sick from Salmonella and Leptospirosis. During an interview on 5/1/24 at 2:20 p.m., the Administrator stated the facility was using a cockroach spray that was EPA exempt FIFRA 25(B) (meant the certification was done by the manufacturer only). When asked if the facility should be using an EPA registered pest control spray, the Administrator did not answer. When asked if it was important the pesticide facility was using was EPA registered, the Administrator did not answer. During an interview on 5/1/24 at 4:45 p.m., the Nurse Consultant (NC) stated the facility did not have a pest control program. The NC also stated the facility did not have a policy for pest control management. During an interview on 5/2/24 at 8:54 a.m., when asked if the facility should be using an EPA registered pesticide, the Maintenance Director did not answer. When asked whether the facility had a pest control program which included the facility inspection and monitoring, identification of pests and where they were coming from, implementation of the pest control techniques, regular follow-up by the facility, whether treatments were ineffective or successful, the Maintenance Director stated, No. When asked if their pest control measure at this time were effective, the Maintenance Director did not answer. When asked if the pesticide the facility was using was effective in controlling pests, the Maintenance Director stated, Somewhat. When asked if the presence of pests or cockroaches in the facility and the kitchen area was acceptable, he stated, No. When asked what the risk was for residents if there were cockroaches in the kitchen area, the Maintenance Director stated residents could get diseases from cockroaches. The facility did not have a policy and procedure for pest control management. The facility did not have a pest control program.