STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055858	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rancho Seco Care Center	144 F Street Galt, CA 95632

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 45882 Based on observation, interview, and record review the facility failed to ensure residents' rights to personal privacy and confidentiality of his or her personal medical information, when meal tray tickets were found thrown into the general trash. This had the potential to compromise resident privacy and confidentiality for the 92 residents residing in the facility. Findings: During a concurrent observation and interview on 4/18/24, at 8:25 a.m. with the Dietary Aide (DA) 3 in the kitchen, the DA 3 confirmed tray tickets with resident name and medical record number were in a regular garbage can. The DA 3 stated, this is how we do it. During a concurrent observation and interview on 4/17/24 at 8:27 a.m. with the Dietary Manager (DM), the DM confirmed there were tray tickets with resident protected health information (PHI) in the garbage. The DM stated, [she was] unaware of current practice. The DM confirmed resident name and medical record number are PHI and should not be in regular trash. The DM instructed DA 3 to remove tray tickets in the garbage and place in a shred bin. During a concurrent interview and record review on 4/18/24 at 8:15 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Confidentiality of Personal and Medical Records, dated 2023 was reviewed. The P&P indicated, the facility honors the resident right to secure and confidential personal medical records: #8. Paper .with resident's personal or medical information .will be disposed of in a way that will not compromise resident's personal or medical information. The DON stated tray tickets contained resident names and medical record numbers, which is private and should not be thrown in the regular trash. The tickets should be placed in the shredder.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47197 Based on observation, interview, and record review, the facility failed to ensure two out of 19 sampled residents (Resident 85 and Resident 77) were assisted with nail care as part of their Activities of Daily Living (ADLs- normal daily functions required to meet basic needs) when Resident 85 and Resident 77 had long fingernails with blackish substance underneath the fingernails and had long toenails. These failures had the potential for Resident 85 and Resident 77 to sustain injury and/or for the residents to acquire an infection. Findings: 1a. A review of Resident 85's clinical record indicated Resident 85 was admitted October of 2023 and had diagnoses that included the need for assistance with personal care, muscle weakness, and adult failure to thrive. A review of Resident 85's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/7/24, indicated Resident 85's short-term memory was okay and Resident 85 could independently make decisions regarding tasks of daily life. A review of Resident 85's MDS Functional Abilities and Goals, dated 4/7/24, indicated Resident 85 required setup or clean-up assistance with eating and substantial/maximal assistance with personal hygiene. During a concurrent observation and interview on 4/15/24 at 10:52 a.m. with Resident 85, in Resident 85's room, Resident 85 had long fingernails with blackish substance underneath the fingernails, and long toenails. Resident 85 stated he wanted his fingernails to be clipped and trimmed, and he already told a facility staff before, but facility staff had not clipped his fingernails and toenails yet. During a concurrent observation and interview on 4/15/24 at 10:58 a.m. with Certified Nurse Assistant (CNA) 1, in Resident 85's room, CNA 1 confirmed that Resident 85 had long fingernails with blackish substance underneath the fingernails and had long toenails. CNA 1 stated, These [Resident 85's fingernails] looks long to me .[there's] a little bit of dirt too .These [Resident 85's toenails] looks long too .Anyone can trim his [Resident 85] nails. CNA 1 further stated he would expect Resident 85's fingernails and toenails to be clipped and cleaned. During a concurrent interview and record review on 4/17/24 at 11:22 a.m. with the Desk Nurse (DN), Resident 85's clinical records were reviewed. The DN confirmed that Resident 85 did not refuse hygiene care and had no documented refusals to nail care. The DN stated he would expect Resident 85's fingernails and toenails to be clean and trimmed. The DN further stated having long fingernails could cause skin injury to the resident and the substance underneath the nails was an infection control issue. A review of Resident 85's care plan intervention, initiated 10/23/23, indicated, Resident [Resident 85] will be assisted by staff to meet her [sic] daily ADL needs (.Grooming .). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1b. A review of Resident 77's clinical record indicated Resident 77 was admitted June of 2023 and had diagnoses that included intracranial injury (brain injury), diabetes mellitus (a chronic condition causing too much sugar in the blood which inhibits the body's natural wound-healing capabilities), and cerebral infarction (damage to a part in the brain due to a disrupted blood flow). A review of Resident 77's MDS Cognitive Patterns, dated 3/29/24, indicated Resident 77 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 9 out of 15 which indicated Resident 77 had moderate impairment on cognition. A review of Resident 77's MDS Functional Abilities and Goals, dated 3/29/24, indicated Resident 77 required setup or clean-up assistance with eating and substantial/maximal assistance with personal hygiene. During a concurrent observation and interview on 4/15/24 at 11:02 a.m. with Resident 77, in Resident 77's room, Resident 77 had long fingernails with blackish substance underneath the fingernails, and long toenails. Resident 77 nodded yes when asked if he wanted his nails to get trimmed and cleaned. During a concurrent observation and interview on 4/15/24 at 11:10 a.m. with CNA 1, in Resident 77's room, CNA 1 confirmed that Resident 77 had long fingernails with blackish substance underneath the fingernails and had long toenails. CNA 1 stated he would expect Resident 77's fingernails and toenails to be trimmed and cleaned. During a concurrent interview and record review on 4/17/24 at 11:22 a.m. with the DN, Resident 77's clinical records were reviewed. The DN confirmed that Resident 77 was not refusing hygiene care and had no documented refusals to nail care. The DN stated he would expect Resident 77's fingernails and toenails to be clean and trimmed. A review of Resident 77's Skin Monitoring: Comprehensive CNA Shower Review, dated 4/13/24, did not indicate an answer on the question if Resident 77 need his toenails cut. The CNA and the Licensed Nurse on duty signed the document on 4/13/24. A review of Resident 77's care plan, initiated 6/26/23, indicated, Resident [Resident 77] requires extensive assistance with ADL self care and performance .personal hygiene .A Review of Resident 77's care plan intervention, initiated 6/26/23, indicated, Resident [Resident 77] will be assisted by staff to meet her [her] daily ADL needs (.Grooming .). During an interview on 4/17/24 at 3:29 p.m. with the Director of Nursing (DON), the DON stated, Expectation is standard, we [facility staff] do ADL care every day, every shift and as needed. I expect their [residents] nails to be clean and trimmed .That's [having long fingernails with blackish substance underneath the fingernails and long toenails] infection control issue, and dignity issue too .We [facility staff] don't want residents to have dirty fingernails. A review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), dated 2/2023, indicated, .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good .grooming and personal .hygiene .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47197 Based on observation, interview, and record review, the facility failed to ensure one out of 19 sampled residents (Resident 72) was provided with appropriate care and services with enteral feeding (also referred to as tube feeding/ feeding tube- the delivery of food and nutrients through a feeding tube directly into the stomach or part of the intestines) when Resident 72's physician's orders for tube feeding and gastrostomy tube (G-tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) site care were not followed. These failures had the potential for Resident 72 to experience complications of enteral feeding such as regurgitation (happens when digestive fluids and undigested contents in the stomach rise into the mouth), accidental aspiration of feeding formula into the lungs, increased blood sugar, skin breakdown problems, and/or infection. Findings: A review of Resident 72's clinical record indicated Resident 72 was admitted September of 2023 and had diagnoses that included cerebral infarction (damage to a part in the brain due to a disrupted blood flow), diabetes mellitus (a chronic condition causing too much sugar in the blood which inhibits the body's natural wound-healing capabilities), and dysphagia (swallowing difficulties). A review of Resident 72's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 3/10/24, indicated Resident 72 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 72 had an intact cognition. A review of Resident 72's MDS Swallowing/Nutritional Status, dated 3/10/24, indicated Resident 72 had feeding tube as a nutritional approach while he was a resident in the facility. During a concurrent observation and interview on 4/15/24 at 9:54 a.m. with Resident 72, in Resident 72's room, Resident 72 was observed lying on bed, awake, and connected to an enteral feeding. Resident 72's enteral feeding was turned on, running at 85 milliliters (ml- unit of measurement) per hour, and was connected to his G-tube. Resident 72's G-tube was inserted on left upper abdomen and had no dressing (a piece of material such as a pad applied to a wound to promote healing and protect it from further harm) applied on the insertion site. Resident 72 confirmed these observations. Resident 72 stated he had the G-tube for about 14 months and staff would leave it without a cover. During a concurrent observation and interview on 4/15/24 at 10:01 a.m. with Licensed Nurse (LN) 1, in Resident 72's room, LN 1 confirmed that Resident 72's enteral feeding was turned on and Resident 72's G-tube insertion site was not covered with a dressing. LN 1 stated, We [facility staff] usually leave it [Resident 72's G-tube insertion site] open to air .we [facility staff] stop it [Resident 72's enteral feeding] at 8 a. m., and turn it back on at 12 noon . A review of Resident 72's active physician's order, started 3/27/24, indicated, Enteral Feed Order every shift Jevity [enteral feeding formula] 1.2 Cal [calories] at 85 cc [cubic centimeter, same measurement as ml] / [per] hour .OFF @ [at] 0800 [8 a.m.] & ON @ 1200 [12 noon] . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 72's active physician's order, started 9/7/23, indicated, GT [G-tube] SITE. Cleanse with NSS [Normal saline solution- a mixture of sodium chloride and water commonly used in cleaning wounds], Pat dry then apply 4 x 4 [4 inches by 4 inches- unit of measurement] gauge [sic] slit dressing .every day shift. During a concurrent interview and record review on 4/17/24 at 11:22 a.m. with the Desk Nurse (DN), Resident 77's clinical records were reviewed. The DN stated, It [Resident 72's enteral feeding] should be turned off at 8 a.m. and back on at 12 noon .It's not acceptable if it's still on at around 10 a.m .He's at risk for regurgitation and aspiration pneumonia [occurs when food or liquid is breathed into the airways or lungs, instead of being swallowed] .The [physician's] order should be followed .We [facility staff] don't want to mess their [residents who are on enteral feeding] stomach, he [Resident 72] could have diarrhea and all of that . The DN further stated. We [facility staff] always have to have a gauze in there [Resident 72's G-tube insertion site] to avoid infection .the risk [of not following the physician's order for G-tube care] is skin breakdown problems. A review of Resident 72's care plan intervention, initiated 9/7/23, indicated, Enteral feedings .as ordered. During an interview on 4/17/24 at 3:29 p.m. with the Director of Nursing (DON), the DON stated he would expect Resident 72's enteral feeding to be stopped at 8 a.m. and for facility staff to always follow the physician's orders for enteral feeding and G-tube wound care. A review of the facility's policy and procedure titled, Care and Treatment of Feedings Tubes, undated, indicated, 1. Feeding tubes will be utilized according to physician orders, which typically include: the kind feeding .duration, mechanism of administration .3. The resident's plan of care will address the use of feeding tube, including strategies to prevent complications .7. Direction for staff on how to provide the following care will be provided: .c. Examination and cleaning of the insertion site in order to identify, lessen, or resolve possible skin irritation and local infection.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47197 Based on observation, interview, and record review, the facility failed to ensure accurate reconciliation and accountability of controlled medications (medications with high potential for abuse or addiction) and medication administration for a census of 92 when: 1. Random controlled medication use audits for Resident 83 and Resident 3 did not reconcile. The medications were signed out of the Controlled Drug Record (CDR, an inventory sheet in the narcotic book that keeps record of the usage of controlled medications) but was not documented on the Medication Administration Record (MAR, a legal document used to record medications given to the residents) on multiple occasions to indicate it was given to Resident 83 and Resident 3; 2. Resident 3's controlled pain medication was not administered in accordance with the physician's order; and, 3. Resident 14's medications were left unattended and unsupervised on her bedside table. These failures had the potential for diversion and/or misuse of controlled medications in the facility, possible under or over medicating Resident 3 and Resident 83, and potential harm to Resident 3, Resident 14, and other residents who could gain access to Resident 14's medications. Findings: 1a. A review of Resident 83's clinical record indicated Resident 83 was admitted October of 2023 and had diagnoses that included fracture (a break in the continuity of a bone) of right lower leg, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and need for assistance with personal care. A review of Resident 83's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 1/17/24, indicated Resident 83 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 11 out of 15 which indicated Resident 83 had moderately impaired cognition. A review of Resident 83's MDS Health Conditions, dated 1/17/24, indicated Resident 83 had received a scheduled pain medication regimen. A review of Resident 83's physician's order, dated 11/16/23, indicated, Norco [a medication for pain which contains a combination of Hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever that increases the effects of hydrocodone] Oral Tablet 10-325 MG [milligrams- unit of measurement] . Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain not to exceed 3 grams [unit of measurement] x [for] 24 hours from all sources. A random audit of Resident 83's MAR and the CDR for Norco, with date range of 3/2024 to 4/2024, indicated nursing staff did not document Norco administration on the MAR when signed out from CDR as follows: 1 tablet on 4/6/24 at 12 noon, 1 tablet on 4/12/24 at 11:41 a.m., and 1 tablet on 4/12/24 at 4 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/17/24 at 11:22 a.m. with the DN (Desk Nurse), Resident 83's CDR and MAR were reviewed. The DN confirmed the finding of Norco being signed out of the CDR but was not accurately documented on the MAR on three occasions. The DN stated, .it [CDR and MAR signatures] should reconcile and match . 1b. A review of Resident 3's clinical record indicated Resident 3 was admitted February of 2024 and had diagnoses that included fibromyalgia (a chronic disorder that causes pain and tenderness throughout the body), fracture of left leg, and need for assistance with personal care. A review of Resident 3's MDS Cognitive Patterns, dated 2/24/24, indicated Resident 3 had a BIMS score of 15 out of 15 which indicated Resident 3 had intact cognition. A review of Resident 3's MDS Health Conditions, dated 2/24/24, indicated Resident 3 had experienced occasional moderate pain or hurting. A review of Resident 3's physician's order, dated 2/20/24, indicated, oxyCODONE HCl [a controlled pain medication] Oral Tablet 15 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 4 hours as needed for severe pain (8-10 [scale rating of pain from 0 to 10]). A random audit of Resident 3's MAR and the CDR for oxycodone, for the month of April 2024, indicated nursing staff did not document oxycodone administration on the MAR when signed out from CDR as follows: 1 tablet on 4/5/24 at 3:30 a.m., 1 tablet on 4/7/24 at 6:05 a.m., 1 tablet on 4/9/24 at 3:53 p.m., 1 tablet on 4/10/24 at 6:10 a.m., 1 tablet on 4/11/24 at 2:30 a.m., 1 tablet on 4/13/24 at 6:08 a.m., and 1 tablet on 4/16/24 at 6:30 a.m. During a concurrent interview and record review on 4/17/24 at 11:22 a.m. with the DN, Resident 3's CDR and MAR were reviewed. The DN confirmed the finding of oxycodone being signed out of the CDR but was not accurately documented on the MAR on seven occasions. The DN stated, The process is you [facility staff] have to sign the CDR then sign the MAR. If not, then the documentation is wrong .It's [signing both CDR and MAR] part of being accountable . [Not accurately signing both CDR and MAR are a] Risk for [controlled substance] diversion . During an interview on 4/17/24 at 3:29 p.m. with the Director of Nursing (DON), the DON stated, Every signature [in the CDR] should match in the MAR. It [CDR and MAR signature] should reconcile .Everything should match .The risk, it's possible diversion of [controlled] medication . A review of the facility's policy and procedure (P&P) titled, Controlled Substances, revised 11/2022, indicated, .2. The system of reconciling the .dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records . A review of the facility's P&P titled, Medication Administration, dated 2023, indicated, .17. Sign MAR after administered .18. If medication is a controlled substance, sign narcotic book. 2. A random review of Resident 3's CDR for oxycodone, for the month of April 2024, indicated nursing staff administered 1 tablet of oxycodone 15 mg on 4/9/24 at 2:10 p.m. and another 1 tablet of oxycodone 15 mg on 4/9/24 at 3:53 p.m. to Resident 3 which were less than two hours apart, not following the order which indicated to give the medication every four hours. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/17/24 at 11:22 a.m. with the DN, Resident 3's CDR for oxycodone, for the month of April 2024 was reviewed. The DN confirmed the finding of oxycodone being administered to Resident 3 less than two hours apart. The DN stated, .the time is too short. The [physician's] order should be followed. [Administering oxycodone too early is a] risk for overdose. It's [oxycodone] a controlled substance and should be administered carefully . During an interview on 4/17/24 at 3:29 p.m. with the DON, the DON stated his expectation is that staff should follow the physician's order of administering oxycodone to Resident 3. A review of the facility's P&P titled, Medication Administration, dated 2023, indicated, Medications are administered by license nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician . 3. A review of Resident 14's clinical record indicated Resident 14 was initially admitted December of 2023 and had diagnoses that included chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), respiratory failure (a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), and need for assistance with personal care. A review of Resident 14's MDS Cognitive Patterns, dated 3/24/24, indicated Resident 14 had a BIMS score of 15 out of 15 which indicated Resident 14 had an intact cognition. A review of Resident 14's MDS Health Conditions, dated 3/24/24, indicated Resident 14 had shortness of breath or trouble breathing when lying flat. A review of Resident 14's active physician's order, started 3/22/24, indicated, Ipratropium-Albuterol Solution [also known as DuoNeb, a medication used to help control the symptoms of lung diseases] 0.5-2.5 (3) MG / [per] 3ML [milliliters- unit of measurement] 3ml inhale orally three times a day for SOB [shortness of breath] or Wheezing [a high-pitched whistling indicating a person may be having breathing problems] related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE .via nebulizer. A review of Resident 14's active physician's order, started 3/22/24, indicated, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally every 4 hours as needed for SOB or Wheezing related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED .via nebulizer. During a concurrent observation and interview on 4/15/24 at 9:45 a.m. with Licensed Nurse (LN) 1, in Resident 14's room, LN 1 confirmed there were two plastic vials of DuoNeb 3 ml left unattended and unsupervised on Resident 14's bedside table. LN 1 stated, .It's [two plastic vials of DuoNeb 3 ml] supposed to be not there [Resident 14's bedside table] . During an interview on 4/17/24 at 3:29 p.m. with the DON, the DON stated, .I expect that no medication is left at bedside at all times . [There's] No patient on this building who is self-medicating .I know sometimes we [facility staff] get careless . A review of the facility's P&P titled, Medication Administration, dated 2023, indicated, .14. Administer medication as ordered .15. Observe resident consumption of medication .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 47197 Based on interview and record review, the facility failed to ensure two out of 19 sampled residents (Resident 3 and Resident 59) did not receive unnecessary narcotic (a controlled substance used to treat pain) pain medication when Resident 3 and resident 59 received narcotic pain medications on multiple occasions which were not in accordance with the physician's order. This failure has the potential for Resident 3 and Resident 59 to overdose (an excessive and dangerous dose of a drug), experience oversedation (excessive state of calmness, relaxation, or sleepiness caused by certain drugs), and/or other side effects of narcotic medication. Findings: 1a. A review of Resident 3's clinical record indicated Resident 3 was admitted February of 2024 and had diagnoses that included fibromyalgia (a chronic disorder that causes pain and tenderness throughout the body), fracture (a break in the continuity of a bone) of left leg, and need for assistance with personal care. A review of Resident 3's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 2/24/24, indicated Resident 3 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 3 had intact cognition. A review of Resident 3's MDS Health Conditions, dated 2/24/24, indicated Resident 3 had experienced occasional moderate pain or hurting. A review of Resident 3's physician's order, dated 2/20/24, indicated, oxyCODONE HCl [a controlled pain medication] Oral Tablet 15 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 4 hours as needed for severe pain (8-10 [pain scale rating from 0 to 10]). A random review of Resident 3's MAR for the month of April 2024, indicated nursing staff administered 1 tablet of oxycodone 15 mg to Resident 3 on the following instances: 4/1/24 at 11:50 a.m. with a pain rating of 7, 4/3/24 at 10:11 a.m. with a pain rating of 4, 4/4/24 at 1:17 a.m. with a pain rating of 6, 4/4/24 at 9:32 a.m. with a pain rating of 4, 4/5/24 at 12:39 p.m. with a pain rating of 4, 4/7/24 at 12:51 p.m. with a pain rating of 7, 4/8/24 at 9:58 a.m. with a pain rating of 4, 4/9/24 at 5:01 a.m. with a pain rating of 0, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/9/24 at 9:57 a.m. with a pain rating of 4, 4/9/24 at 2:09 p.m. with a pain rating of 4, 4/10/24 at 9:58 a.m. with a pain rating of 4, 4/11/24 at 9:45 p.m. with a pain rating of 4, 4/12/24 at 9:18 a.m. with a pain rating of 0, 4/12/24 at 1:36 p.m. with a pain rating of 0, 4/14/24 at 12:29 p.m. with a pain rating of 4, and 4/15/24 at 12:05 p.m. with a pain rating of 0. During a concurrent interview and record review on 4/17/24 at 11:22 a.m. with the Desk Nurse (DN), Resident 3's MAR for the month of April 2024 was reviewed. The DN confirmed the finding of oxycodone 15 mg being administered to Resident 3 on multiple occasions which were not in accordance with the physician's order. The DN stated if Resident 3's pain rating is less than 8, then the oxycodone 15 mg should not be administered. During an interview on 4/17/24 at 3:29 p.m. with the Director of Nursing (DON), the DON stated his expectation is that staff should follow the physician's order of administering oxycodone to Resident 3. 1b. A review of Resident 59's clinical record indicated Resident 59 was admitted March of 2024 and had diagnoses that included bullous pemphigoid (a rare skin condition causing large, fluid-filled blisters), pain in right knee, and need for assistance with personal care. A review of Resident 59's MDS Cognitive Patterns, dated 3/20/24, indicated Resident 59 had a BIMS score of 15 out of 15 which indicated Resident 59 had an intact cognition. A review of Resident 59's MDS Health Conditions, dated 3/20/24, indicated Resident 59 had experienced occasional moderate pain or hurting. A review of Resident 59's physician's order, dated 3/15/24, indicated, Norco [a medication for pain which contains a combination of Hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever that increases the effects of hydrocodone] Oral Tablet 10-325 MG .Give 1 tablet by mouth every 4 hours as needed for as needed for breakthrough pain [a sudden, more intense spike of pain]. A random review of Resident 59's MAR for the month of April 2024, indicated nursing staff administered 1 tablet of Norco 10-325 mg to Resident 59 on the following instances: 4/6/24 at 6:30 a.m. with a pain rating of 0, 4/9/24 at 5:01 a.m. with a pain rating of 0, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/11/24 at 11:54 p.m. with a pain rating of 0, 4/12/24 at 5:36 a.m. with a pain rating of 0, 4/12/24 at 11:54 a.m. with a pain rating of 0, 4/13/24 at 12:40 a.m. with a pain rating of 0, and 4/16/24 at 11:39 a.m. with a pain rating of 0. During a concurrent interview and record review on 4/17/24 at 11:22 a.m. with the DN, Resident 59's MAR for the month of April 2024 was reviewed. The DN confirmed the finding of Norco 10-325 mg being administered to Resident 59 on seven occasions which were not in accordance with the physician's order. The DN stated, .Her [Resident 59] Norco for breakthrough pain, in between other [pain medication] dosage, if she [Resident 59] still has pain, it [Norco 10-325 mg] would be given. If [Resident 59's] pain is zero, it [Norco 10-325 mg] should not be given [to Resident 59] .It's [administering pain medication to Resident 59 which is not in accordance with the physician's order] a risk for overdose. During an interview on 4/17/24 at 3:29 p.m. with the DON, the DON stated, .If [Resident 59's] pain is zero, that means there's no pain, then it [Norco 10-325 mg] should not be given to the resident [Resident 59] . A review of the facility's P&P titled, Medication Administration, dated 2023, indicated, Medications are administered by license nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47197 Based on observation, interview, and record review, the facility failed to ensure medications and supplies were properly labeled and properly stored in accordance with the facility's policies and procedures, and accepted professional principles for a census of 92 when: 1. A total of 22 loose pills were found in medication cart A and medication cart B; and, 2. An opened Tuberculin purified protein derivative (PPD) (used in a skin test to help diagnose a contagious lung infection called tuberculosis infection) vial (a glass container used for holding liquid medicines) was found stored in the medication refrigerator without an opened date label. These failures had the potential for diversion of the loose medications, and for residents to receive medication that was expired or with unsafe or reduced potency. Findings: 1. During a concurrent observation and interview on [DATE] at 8:56 a.m. with Licensed Nurse (LN) 2, of medication cart B, five loose pills were found inside the second-right drawer of medication cart B. LN 2 confirmed the observation. LN 2 stated she would not know what medication, dosage of the pill, or for which resident this medication was prescribed. LN 2 further stated, .It's [loose pills] not supposed to be there [medication cart] .A lot of risk .wrong patient . During a concurrent observation and interview on [DATE] at 10:23 a.m. with LN 4, of medication cart A, 15 loose pills were found inside the second-right drawer and two loose pills were found inside the third-right drawer of medication cart A. LN 4 confirmed the observation. LN 4 stated, It's [loose pills] supposed to not be there [medication cart] . [The risk is] Infection control and residents are at risk to use it [loose pills]. During an interview on [DATE] at 3:29 p.m. with the DON, the DON stated, Those things [loose pills] are suppose not to be there [inside medication carts]. All nurses are supposed to make their [medication] carts clean .It's [loose pills] a risk for running out of medication, diversion, and resident safety. A review of the facility's policy and procedure (P&P) titled, Medication Labelling and Storage, revised , d+[DATE], indicated, 1. Medications and biologicals are stored in the packaging, containers, or other dispensing system in which they are received .2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on [DATE] at 10:44 a.m., with the Desk Nurse (DN), in front station medication room, an opened 1 ml (milliliters- unit of measurement) vial of PPD was found stored in the medication refrigerator without an opened date label. The DN confirmed the observation. The DN stated, It [vial of PPD] should be labeled when opened. We [facility staff] usually discard them [opened vial of PPD] for a maximum of a month .It's [labelling PPD vial with opened date] infection control and to know when to discard it [opened vial of PPD]. During an interview on [DATE] at 3:29 p.m. with the DON, the DON stated, It [opened vial of PPD with no opened date label] wasn't supposed to be there [inside the medication refrigerator]. It [opened vial of PPD] was supposed to be labeled. A review of the facility's policy and procedure (P&P) titled, Medication Labelling and Storage, revised , d+[DATE], indicated, 5. Multi-dose vials that have been opened or accessed (e.g. [for example], needle punctured) are dated and discarded within 28 days .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45882 Based on observation, interview, and record review the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for residents who received facility prepared foods for a total census of 92 when: 1.Food items were unlabeled and undated; 2.Expired items were found in dry storage room; 3.Dry storage areas temperatures were not monitored; 4.There was no thermometer in the open-door fridge and freezer; 5. The walk-in freezer was found with; a. food items that were unlabeled, undated and appeared freezer burned, b. temperature was not maintained at the required level, ice buildup on door rim and the gasket (a seal stripping around the edge of freezer door that provides an airtight seal, prevents warm air from entering the cold interior) was misshapen. 6. Certified Nursing Assistant (CNA 3) touched Resident 4's butter knife blade with his bare hands; and 7. Director of Staff Development (DSD) touched the inner part of the salad bowl's rim for Resident 30, Resident 49, Resident 4, Resident 32 and Resident 38. These failures had the potential to lead to food-borne illnesses. Findings: 1.During a concurrent observation and interview on [DATE] at 9:20 a.m. with the Dietary Manager (DM) in the kitchen, there were undated and opened containers containing items identified as basil leaves, oregano leaves, whole bay leaves and ground black pepper, and an unlabeled and undated opened bag of bread rolls. The DM stated the containers and bag should be labeled and dated so the staff knew when items were opened and when they expired. During a review of the facility's policy and procedure (P&P) titled, Storage of Food Supplies, dated RDS for Healthcare, Inc. 2020, the P&P indicated, Dry food items which have been opened .will be .labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Food and Drug Administration (FDA) Food Code 2022, ,d+[DATE].17 (A) (B) (C) (D) which discussed required food labeling and dating, the food code indicated, The day the original container is opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date . with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. 2. During a concurrent observation and interview on [DATE] at 9:31 a.m. with the DM in pantry two, the DM confirmed four containers of white cooking wine, three containers of red cooking wine and a container of Zesty Orange Sauce were expired [per manufactures date]. The DM further confirmed, the expired items should be removed from the shelf and should not be served to residents. During a review of the facility's P&P titled, Storage of Food Supplies, dated RDS for Healthcare, Inc. 2020, the P&P indicated, no food will be kept longer that the expiration date on the product. 3.During a concurrent observation and interview on [DATE] at 9:30 a.m. with the DM, the DM confirmed there was no thermometer present in pantry one or two. The DM stated there should be a thermometer in each pantry to ensure food is maintained at a safe temperature. The DM further stated if the pantry is too hot or too cold .food items [quality] can be affected. During a review of the facility's P&P titled, Storage of Food Supplies, dated RDs for Healthcare, Inc. 2020, the P&P indicated, Thermometers should be placed in all storage areas and checked frequently. 4. During a concurrent observation and interview on [DATE] at 9:35 a.m. with the DM at the front open-door fridge and freezer, the DM confirmed the open-door fridge and freezer were monitored by the built in thermometer system. The DM stated each unit had only one thermometer for monitoring temperatures. During a concurrent interview and record review on [DATE] at 9:40 a.m. with DM, the facility P&P titled, titled, Procedure for Freezer Storage, dated RDs for Healthcare, Inc. 2018 was reviewed. The P&P indicated 2. Each freezer must have two thermometers that are easily visible. The DM confirmed there should be two thermometers for each open-door fridge and freezer to monitor inside temperatures for food safety. During a review of the facility P&P titled, Procedure for Freezer Storage, dated RDs for Healthcare, Inc. 2018, the P&P indicated 2. Each freezer must have two thermometers that are easily visible. During a review of the facility P&P titled, Procedure for Refrigerated Storage, dated RDs for Healthcare, Inc. 2019, the P&P indicated, 2. Two thermometers, placed to be easily visible for checking, should be inside all . reach-in refrigerators .the second thermometer is a check against the first thermometer for accuracy. 5.a. During a concurrent observation and interview on [DATE] at 9:47 a.m. with the DM in the walk-in freezer, there were two sealed packages, one containing pink meat like item and one sealed package with whitish yellow cubed items that were unlabeled and appear to have freezer burn. The DM acknowledged the freezer burn and stated the items were not labeled with item name, open date and use by date. The DM stated the items should be thrown away and not served due to freezer burn and no labeling [item name, date, time]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Procedure for Refrigerated Storage, dated RDs for Healthcare, Inc. 2019, the P&P indicated, 13. Individual packages of .frozen food taken from the original packing box need to be labeled and dated. Freezer burn may occur before that and reduce the maximum shelf life. Food that has been freezer burned must be discarded. During a review of the facility P&P titled, Procedure for Freezer Storage, dated RDs for Healthcare, Inc. 2018, the P&P indicated, 6. All frozen food should be labeled and dated. 5.b. During a concurrent observation and interview on [DATE] at 9:47 a.m. with the DM in the walk- in freezer, the DM confirmed the inside thermometer read four degrees Fahrenheit (F, a scale of temperature). During a subsequent observation and interview on [DATE] at 1:06 p.m. with the DM by the walk-in freezer, the DM confirmed inside thermometer indicated six degrees F, there was ice buildup on the freezer door rim and the gasket was misshapen on both the left and right edges of the freezer door. The DM further states, maintenance is working on it .they know gasket is broken and [are] ordering parts. During an interview on [DATE] at 12:40 p.m. with Maintenance Director (MD), the MD confirmed the walk-in freezer gasket was broken. MD stated, freezer temps [temperatures] should be zero [degrees F]m we thought it should be below 10 [degrees F] .the gasket is broken on freezer, we are working on it .parts are expensive, and we are getting quotes. During a confirming interview and record review on [DATE] at 9:40 a.m. with DM, the facility's P&P titled, Procedure for Freezer Storage, dated RDs for Healthcare, Inc. 2018 was reviewed. The P&P indicated: 1. The freezer should be maintained at a temperature of 0 [degree] F or lower and 7. Freezer doors are to close tightly. The DM confirmed the freezer temperature should be zero [or less] per facility policy. According to the Food and Drug Administration (FDA) 2017 Food Code section ,d+[DATE].11 on Preventing Food and Ingredient Contamination, The freezer equipment should be designed and maintained to keep foods in the frozen state. Also found in the FDA Food Code 2017, section ,d+[DATE].11 on Good Repair and Proper Adjustment indicated: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts ,d+[DATE] and ,d+[DATE]. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (https://www.fda.gov/media/110822/download) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During a concurrent observation and interview in the dining room on [DATE] at 11:53 a.m., Resident 4 asked CNA 3 to help her open the packet of dressing for her salad. CNA 3 agreed, handled the butter knife blade with his bare hands and used it to open the salad dressing packet. When done, he returned the butter knife to Resident 4 to use. When asked, CNA 3 confirmed he touched the butter knife blade with his bare hands. CNA 3 stated, I'm supposed to hold the knife by the handles, and not by the blade to keep it clean. 7. During an observation in the dining room on [DATE] at 12:05 p.m., the DSD delivered Resident 30's meal tray to her table, removed the lid of the potato salad bowl and served her meal. As she moved the bowl from the meal tray to her table, the DSD touched the inner part of the bowl's rim with her thumb. After setting up Resident 30's food, she told her to enjoy her meal. During an observation in the dining room on [DATE] at 12:10 p.m., Resident 49 was having a conversation with the other residents when the DSD delivered her meal. The DSD removed the lid of the potato salad bowl and set up her dishes to her liking. As the DSD moved the bowl from the meal tray to her table, she touched the inner part of the bowl's rim with her thumb. During an observation in the dining room on [DATE] at 12:16 p.m., the DSD delivered Resident 4's meal tray to her table, removed the lid of the potato salad bowl and served her meal. As she moved the bowl from the meal tray to her table, DSD touched the inner part of the bowl's rim with her thumb. During an observation in the dining room on [DATE] at 12:21 p.m., the DSD delivered Resident 32's meal tray, removed the lid of the bowl and as she moves the bowl from the meal tray to her table, the DSD touched the inner part of the bowl's rim with her thumb. When done, she asked Resident 32 if she needed anything else. During an observation on [DATE] at 12:27 p.m., Resident 38 self-propelled himself to the dining room and positioned himself in one of the resident's tables. The DSD asked him if he wanted to eat so she could deliver his meal tray. She removed the lid of the potato salad bowl and as she moved the bowl from the meal tray to his table, the DSD touched the inner part of the bowl's rim with her thumb. During an interview on [DATE] at 12:35 p.m., the DSD acknowledged her thumb touched the inner part of the salad bowl's rim and stated, I should have not touched the inner rim of the bowl because it's not sanitary and it's an infection control issue. During an interview on [DATE] at 10:05 a.m., with the Infection Preventionist (IP), the IP stated, The staff should hold the butter knife by the handles for infection control reason, they should not touch the part of the utensils that come in contact with the food. She further stated the staff are not supposed to touch with their bare hands the inside opening of the bowls used by the residents. The IP also added, her expectation from the staff is to practice infection control all the time to prevent cross contamination. During a review of the facility's policy and procedure titled, SANITATION, dated 2018, indicated, .Cups and glasses are to be grasped firmly in the middle when picking them up or by the handle .Silverware must always be held by the handles; the eating portion which comes in contact with the food must never be touched .

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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** 47197 Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 92 residents when: 1. Resident 14's nebulizer (device used to deliver medicine to lungs) facemasks and tubing was not changed within seven days; 2. A shared blood pressure monitor was not cleaned and sanitized in between resident's use; 3. Non-pharmaceutical items were found stored in medication cart D and front station IV (intravenous-administration through a vein) cart with pharmaceutical products; and, 4. Uncovered linen cart contained clean personal clothes of the residents. These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure of Resident 14 to germs, and may cause infection among residents, staff, and visitors. Findings: 1. A review of Resident 14's clinical record indicated Resident 14 was initially admitted December of 2023 and had diagnoses that included chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), respiratory failure (a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), and need for assistance with personal care. A review of Resident 14's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 3/24/24, indicated Resident 14 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 14 had intact cognition. A review of Resident 14's MDS Health Conditions, dated 3/24/24, indicated Resident 14 had shortness of breath or trouble breathing when lying flat. During a concurrent observation and interview on 4/15/24 at 9:20 a.m. with Certified Nurse Assistant (CNA) 2, in Resident 14's room, CNA 2 confirmed that Resident 14 had a nebulizer machine on bed side connected to a nebulizer facemask and tubing which was labelled 4/7/24 and was ready to be used. A review of Resident 14's active physician's order, started 3/22/24, indicated, Ipratropium-Albuterol Solution [also known as DuoNeb, a medication used to help control the symptoms of lung diseases] 0.5-2.5 (3) MG [milligrams- unit of measurement] / [per] 3ML [milliliters- unit of measurement] 3ml inhale orally three times a day for SOB [shortness of breath] or Wheezing [a high-pitched whistling indicating a person may be having breathing problems] related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE .via nebulizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 14's active physician's order, started 3/22/24, indicated, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally every 4 hours as needed for SOB or Wheezing related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED .via nebulizer. A review of Resident 14's Medication Administration Record (MAR, a legal document used to record medications given to the residents), for the month of April 2024, indicated Resident 14 last received her DuoNeb medication via nebulizer on 4/15/24 at 8 a.m. During an interview on 4/17/24 at 3:29 p.m. with the Director of Nursing (DON), the DON stated, They [Resident's nebulizer facemask and tubing] should be changed every 7 days, or as ordered [by the physician], or as needed .That's [not changing nebulizer facemask and tubing every 7 days] an infection control and safety issue. A review of the facility's policy and procedure (P&P) titled, Nebulizer Therapy, dated 2023, indicated, Care of the Equipment .8. Change the nebulizer tubing every seven days . 2. During a medication administration observation which started on 4/16/24 at 8:56 a.m. with Licensed Nurse (LN) 2, in hall B, LN 2 was observed checking a resident's blood pressure using an electric wrist blood pressure monitor. After which, LN 2 placed the wrist blood pressure monitor on top of medication cart B without cleaning it and proceeded on administering medications to the resident. After the administration of medication to the resident, LN 2 grabbed the unsanitized electric wrist blood pressure monitor on top of the medication cart B and went on to check the blood pressure of the next resident. During a concurrent observation and interview on 4/16/24 at 9:40 a.m. with LN 2, in hall B, LN 2 confirmed that she did not clean and sanitized the shared electric wrist blood pressure monitor before using it to the next resident. LN 2 stated, It's [not cleaning and sanitizing shared blood pressure equipment in between resident's use] my mistake .It's [not cleaning and sanitizing shared blood pressure equipment in between resident's use] infection control issue .The germs from the first resident can transfer to second resident or to me . During an interview on 4/17/24 at 3:29 p.m. with the DON, the DON stated he would expect staff to clean shared resident care items such as blood pressure equipment in between resident's use. The DON further stated that not cleaning shared resident equipment in between resident's use is an infection control problem. A review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 10/2018, indicated, d. Reusable items are cleaned and disinfected or sterilized between residents (e. g. [for example], .durable medical equipment). 3. During a concurrent observation and interview on 4/15/24 at 3:21 p.m. with LN 3, of medication cart D, a black computer mouse, an approximately 4 inch- silver nail clipper, and an approximately 6 inch-white nail file were found stored on the right top drawer of medication cart D, next to four prescribed resident eye drops. LN 3 confirmed the observation. LN 3 stated, I'm not sure about those [non-pharmaceutical items stored next to pharmaceutical products]. Those [Non-pharmaceutical items] are not supposed to be in there [medication cart D drawer] because of infection control. It's [Non-pharmaceutical items] supposed to be in a separate container . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055858	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rancho Seco Care Center	144 F Street Galt, CA 95632

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/16/24 at 10:44 a.m. with the Desk Nurse (DN), of front station IV cart, an approximately 3 feet-white electronic tablet charger was found stored on the top drawer, on top of IV tubing and supplies. The DN confirmed the observation. The DN stated, It's not okay that it's [electronic tablet charger] there [on top of IV tubing and supplies] because of infection control . During an interview on 4/17/24 at 3:29 p.m. with the DON, the DON stated, Those [Non-pharmaceutical items] things are not supposed to be there [medication cart and IV cart]. That's why it's called medication cart [for a reason] .The risk [of non-pharmaceutical items stored in medication cart D and front station IV cart with pharmaceutical products] is infection control issues. A review of the facility's P&P titled, Medication Labelling and Storage, revised 02/2018, indicated, Medication Storage . 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. During a concurrent observation and interview on 4/15/24 at 1:10 p.m., the uncovered linen cart contained clean personal clothes was observed parked at the hallway outside of room [ROOM NUMBER]. Housekeeping/laundry staff (LS 1) confirmed the linen cart was not covered when she delivered clean personal clothes to the residents. LS 1 further stated the linen cart should be covered to prevent contamination. During an interview on 4/16/24 at 3:45 p.m., with the Maintenance Director/Housekeeping Supervisor (MD/HS), MD/HS stated linen carts with clean personal clothes must be covered at all the time. LS 1 should practice infection control by pulling out clothes to be delivered from the linen cart, cover the clean clothes again to protect it from dust and soil. MD/HS further stated this practice will also avoid other residents from randomly pulling out clothes from the linen cart. During a review of the facility's policy and procedure titled, Handling Clean Linen, undated, indicated, .4. Clean linens must be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter-facility loading, transport and unloading, such as: .b. Placing clean linen in a properly cleaned cart and covering the cart with disposable material or a properly cleaned reusable textile material that can be secured to the cart .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45882 Based on observation, interview and record review, the facility failed to maintain the walk-in freezer in safe operating condition when ice buildup was noted on the door rim and the gasket (a seal stripping around the edge of freezer door that provides an airtight seal, prevents warm air from entering the cold interior) was found to be misshapen. This had the potential to affect the safety and quality of the food served for the residents eating facility prepared meals. Findings: During a concurrent observation and interview on 4/16/24 at 1:06 p.m. with the Dietary Manager (DM) by the walk-in freezer, the DM confirmed there was ice buildup on the walk-in freezer door rim and the gasket was misshapen on both the upper left and right edges [corners] of the freezer door. The DM stated, maintenance is working on it .they know gasket is broken and [are] ordering parts. During an interview on 4/17/24 at 12:40 p.m. with Maintenance Director (MD), the MD confirmed the walk-in freezer gasket was broken and ice buildup on the door rim. MD stated, .gasket is broken on freezer, we are working on it .parts are expensive, and we are getting quotes. During an interview on 4/18/24 at 9:40 a.m. with the DM, the DM confirmed a broken walk-in freezer can cause freezer burn .freezer burned food should not be served to residents . [freezer burned food] can cause food borne illnesses .should be thrown away. During a review of facility provided manual for the freezer, titled, [NAME] Walk-In Installation & Operation Manual, dated September 2017, the manual indicated on page 32 . Inspect the door .and sweep gasket monthly for ease of operation .any damaged hardware should be replaced immediately to prevent permanent damage to the door. Review of the website Commercial Equipment Service, (https://commercialequipmentserviceinc.com > 2021/07) indicated: One of the most common issues that occurs in commercial freezers is an excessive buildup of ice. Over time, icing can reduce the efficiency of the system, and potentially compromise the freshness and quality of the food due to the elevated moisture content in the unit .In most cases, ice buildup in a freezer is a result of a combination of warm, humid air in the cold environment of the freezer.If left unaddressed, the ice buildup caused by the above issues can damage freezer components, drastically increase operating costs and utility expenses and reduce the lifespan of your commercial freezer. Review of the United States Food and Drug (FDA) Food Code 2022 section 4-501.11 for Good Repair and Proper Adjustment indicated (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Also found in the FDA Food Code 2017, section 4-501.11 on Good Repair and Proper Adjustment indicated: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (https://www.fda.gov/media/110822/download) Review of the United States Food and Drug (FDA) Food Code 2022 section 4-501.11 for Good Repair and Proper Adjustment indicated (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. Also found in the FDA Food Code 2017, section 4-501.11 on Good Repair and Proper Adjustment indicated: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (https://www.fda.gov/media/110822/download)