STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055916	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoia Vista	3710 West Tulare Avenue Visalia, CA 93277

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 46958 Based on interview and record review, the facility failed to have accurate informed consent (IC- process that ensures a person is provided the risks and benefits of treatment) for a psychotropic (medication to treat mental disorders) medication for one of six sampled residents (Resident 49). This failure had the potential for Resident 49 not being aware of the risks and benefits of taking psychotropic medications. Findings: During a review of Resident 49's Minimum Data Set (MDS- assessment tool) section C- Cognitive Patterns, dated 10/1/24, the MDS indicated Resident 49's Brief Interview of Mental Status (BIMS, 1-7 Severe cognitive impairment, 8-12 Moderate cognitive impairment, 13-15 Intact cognitive impairment) score was 2. During a review of Resident 49's History and Physical (H&P), dated 9/26/24, the H&P indicated, Due to recent admission and chronic illness and condition change this patient is at increased risk for losing a decision making capacity. During a concurrent interview and record review on 12/4/24 at 10:01 a.m. with Director of Nursing (DON), Resident 49's Facility Verification of Informed Consent (IC), dated 9/26/24 was reviewed. The IC indicated, Resident 49 had signed the IC for Zoloft medication (treat symptoms of depression) 100 mg (milligram) one time a day. DON stated Resident 49 signed his own IC and should have had a BIMS Higher than 2 to sign his IC. During a review of the facility's policy and procedure titled, Informed consent-Psychotherapeutic Medications and Restraint Devices, dated 12/14/17, the P&P indicated, Obtaining informed consent, providing risks/benefits and other related information from the resident and/or resident's representative for use of such medication/devices.d. Determining resident's decision-making capacity.

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42148 Based on observation, interview, and record review, the facility failed to promote care for one of 44 sampled residents (Resident 10) to maintain dignity and respect. This failure had the potential to affect Resident 10's individuality and psychological needs. Findings: During a review of Resident 10's Admission Record (AR), dated 5/1/22, the AR indicated, Resident 10 was admitted on [DATE] with a diagnosis of Schizophrenia (chronic mental illness that affects a person thoughts, feelings, and behavior) and Dementia (decline in mental abilities). During a review of Resident 10's, Minimum Data Set- Section C-Cognitive Patterns (MDS- assessment tool), dated 9/7/24, the MDS-Section C indicated, Resident 10 had a Brief Interview for Mental Status (BIMS, 1-7 Severe cognitive impairment, 8-12 Moderate cognitive impairment, 13-15 Intact cognitive impairment) score of 8. During a review of Resident 10's, MDS- Section GG- Functional Abilities and Goals, dated 9/7/24, The MDS-Section GG indicated, Resident 10 required partial/moderate assistance to shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During an observation on 12/2/24 at 10:48 a.m. in Resident 10's room, the room was cluttered with paper products on Resident 10's bedside table, nightstand, and in every drawer. Resident 10's hair was greasy and disheveled. Resident 10 had a smell of strong urine. During a concurrent observation and interview on 12/3/24 at 9:35 a.m. with Resident 10, in Resident 10's room, Resident 10 was sitting in her wheelchair beside her bed. Resident 10 was confused, her hair was greasy and tangled, the room smelled of strong urine, her clothes appeared dirty, and there were no clothes or shoes in her closet. Resident 10 stated she wanted bath wipes in a women's size. During a concurrent observation and interview on 12/3/24 at 9:44 a.m. with Certified Nursing Assistant (CNA) 32, in Resident 10's room, Resident 10 was wearing the same clothes she had on the prior day, hair was greasy, tangled, and covering her eyes. CNA 32 stated Resident 10 has been smelling like urine for a few days now. Staff will usually just let her do her own personal care. During an observation on 12/4/24 at 10:31 a.m. in Resident 10's room, Resident 10 smelled like urine and continued to have the same clothes on as the last two days. Resident 10 was not wearing any pants, only a brief. Resident 10's hair was greasy and tangled. During an interview on 12/4/24 at 11:22 a.m. with Social Services Designee (SSD), SSD stated Resident 10 likes to do her own personal care and staff let her do her own thing. SSD stated Resident 10 usually has dirty hair and smells like urine, this is just how she is. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/4/24 at 11:38 a.m. with CNA 32, in Resident 10's room, Resident 10 was sitting on the side of her bed with no pants on. Resident 10 smelled of urine. Resident 10 was wearing the same pajama top and vest she had on the last 3 days. Resident 10's hair was greasy and tangled. Resident 10's closet was empty with no clothes. CNA 32 stated, [Resident 10] doesn't have any clothes and doesn't own any. I try to bring her stuff from my car, like a jacket or something, but doesn't have any clothes. She [Resident 10] always smells like urine and has dirty hair. During a concurrent observation and interview on 12/4/24 at 3:06 p.m. with Administrator, in Resident 10's room, Resident 10 was using a clear shopping bag to clean and wipe down her bed. Resident 10 had no pants on and was in the same clothes as 12/2/24. Resident 10 smelled of urine. Administrator stated there were no clothes in resident's closet and stated, every resident should have at least two set of clothes. Administrator stated Resident 10 puts her clothes in plastic bags and staff by accident throws them out with the trash. During a review of Resident 10's, Inventory of Personal Effects (IPE), dated 12/1/21. The IPE indicated, Resident did not have anything of personal use. Only pajama pants. During a review of the facility's policy and procedure (P&P) titled, Resident Personal Belongings, dated January 2024, the P&P indicated, It is the policy of this facility to protect the resident's right to possess personal belongings, such as clothing and furnishings, for their use while in the facility. The facility will ensure that personal belongings and/or possessions are rightfully returned to the resident. 1. All resident possessions, regardless of their apparent value to others, will be treated with respect. 2. The facility wills support the residents right to retain and use personal possessions to promote a homelike environment and maintain their independence. 6. The facility will ensure resident belongings are kept in a neat and orderly fashion and maintained in each resident's room. 7. the facility will exercise reasonable care for the protection of the resident' property from loss or theft. 9. For resident who have no relatives or friends, or few assets, the facility will offer to assist the resident in making his or her room more homelike, if they desire. During a review of the facility's P&P titled, Resident Rights, dated January 2023, the P&P indicated, 4. Respect and dignity. The resident has a right to be treated with respect and dignity, including: a. The right to retain and use personal possessions, including furnishings, and clothing as space permits, c. the right to reside and receive series in the facility with reasonable accommodation of the resident needs and preferences.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44134 Based on observation, interview and record review, the facility failed to ensure one of 44 sampled resident's (Resident 75) choices were being accommodated to get out of bed daily. This failure resulted in Resident 75 not participating in group activities and had a potential to result in psychosocial harm and a reduction in quality of life. Findings: During a review of Resident 75's Minimum Data Set (MDS, a Resident assessment screening tool), dated 9/27/24, the MDS indicated, in Section GG-Functional Abilities and Goals, Resident 75's lower extremities (hip, knee, ankle and foot) had Impairment on both sides, is dependent with care, and needs the use of a mobility device. During an interview on 12/2/24 at 11:08 a.m. with Resident 75, Resident 75 stated she would like to go to activities, but she was not able to get into a wheelchair because her knees were unable to bend. Resident 75 stated she needed a Geri-Chair (a large, padded chair that reclines and allows people with limited mobility sit comfortably while being transported) but the facility does not always have a Geri-chair available for use. During a review of Resident 75's Activities-Initial Review (A-IR), dated 6/14/24, the A-IR indicated, Does the resident wish to participate in activities while in the home.Yes.Does the resident wish to participate in group activities.yes.Comments.Resident enjoys bingo, nails, coloring.Assistance should be provided to get the resident to an activity.yes.Resident will need to be taken to activities when up. During a review of Resident 75's Activities- Participation Review (A-PR), dated 9/13/24, the A-PR indicated, resident joins group activities 2 out of 5 days a week.resident enjoys socializing with people of choice. During an interview on 12/5/24 at 9:52 a.m. with Interim Director of Activities (IDOA), IDOA stated Resident 75 gets out of bed once or twice a week. IDOA stated when Resident 75 is out of bed she participated in exercises and visited with other residents. During a concurrent interview and record review on 12/5/24 at 9:54 a.m. with IDOA, Resident 75's Activity Attendance Record (AAR), dated December 2024 was reviewed. The AAR indicated, Resident 75 had not participated in any group activities. IDOA stated, It looks like [Resident 75] hasn't been up so far this month. IDOA stated Resident 75 required a Geri-Chair to participate in activities. IDOA stated the facility only had three Geri-chairs. During a concurrent interview and record review on 12/5/24 at 9:58 a.m. with IDOA, Resident 75's AAR, dated November 2024 was reviewed. The AAR indicated Resident 75 did not participate in any group activities the entire month. IDOA stated Resident 75 did not participate in any group activities in November. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/5/24 at 10:05 a.m. with IDOA in the storage room, there were no Geri-Chairs available for use. IDOA stated the Geri-chairs are kept in the storage room, and all were currently being used by residents. IDOA stated one of the Geri-chairs was being used in room [ROOM NUMBER]. During an observation on 12/5/24 at 10:07 a.m. in the 400-unit hallway, a green Geri-chair was in room [ROOM NUMBER] B not in use. During an interview on 12/5/24 at 10:12 a.m. with Resident 75, Resident 75 stated the facility staff ask her daily if she would like to participate in activities. Resident 75 stated she would participate in activities everyday if she had a Geri-chair available for use . Resident 75 stated she liked to get out of her room and talk to other residents. Resident 75 stated she did not go to any group activities in November due to not having a Geri-chair available. During an interview on 12/5/24 at 3:04 p.m. with Director of Nursing (DON), the DON stated the facility had two Geri-chairs that were in use. DON stated the facility did not have a schedule for Geri-chair use between dependent residents. During a review of the facility's policy and procedure (P&P) titled, Resident Self Determination and Participation, dated 1/2024, the P&P indicated, It is the policy of this facility to promote and facilitate a resident's right to self determination through support of resident choice.1. According to federal regulations, the resident has the right to: a. Choose activities, schedules, and providers of healthcare services consistent with his or her interests, assessments and plans of care. b. Interact and participate in community activities with members of the community both inside and outside of the facility; and c. Make choices about aspects of his or her life in the facility that are significant to the resident. During a review of the facility's P&P titled, Accommodation of Needs, dated 1/2024, the P&P indicated, The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individuals needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered.3. Facility staff shall make efforts to reasonably accommodate the needs and preferences of the resident as they make use of their physical environment. 4. Based on individual needs and preferences, the facility will assist the resident in maintaining and/or achieving independent functioning, dignity and well being to the extent possible.

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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** 46958 Based on interview and record review, the facility failed to ensure the Responsible Party (RP) for one of five sampled residents (Resident 22) was notified when Resident 22 had a change of condition and had to be admitted to an acute care hospital setting. This failure resulted in Resident 22's RP being unaware of Resident 22's health status. Findings: During a concurrent interview and record review on 12/4/24 at 11 a.m. with Director of Nursing (DON), Resident 22's Change in Condition Evaluation -V 5.1 (COC), dated 2/27/24 was reviewed. The COC indicated, Stayed [Resident] unresponsive and was took by [Emergency Medical Technician] EMT to [Hospital]. The COC indicated, Resident is own RP. DON stated there was no family notified and family should have been notified. During a concurrent interview and record review on 12/4/24 at 11:08 a.m. with DON, Resident 22's COC, dated 9/5/24 was reviewed. The COC indicated, At time of transfer FSBS [Fasting Blood Sugar] was 100, but patient [Resident] not responding to commands. The COC indicated, Resident is own RP. DON stated there was no family notified and family should have been notified. During a review of the facility's policy and procedure (P&P) titled, Notification of Changes, dated [DATE], the P&P indicated, The facility must inform the resident, consult with resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such condition.4. A transfer or discharge of the resident from the facility.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42148 Based on interview and record review, the facility failed to: 1. Give one of five sampled residents (Resident 192) the Advanced Beneficiary Notice (ABN- a form which gives the resident the choice to continue services under private pay if Medicare does not provide payment) with the appeal contact information. 2. Accurately complete the ABN for one of five sampled residents (Resident 195) when form was left incomplete and Resident 195 signed the form. These failures resulted in Resident 192 and Resident 195 not having the choice to appeal the decision or have knowledge of the costs to continue treatment in the facility. Findings: 1. During a concurrent interview and record review on 12/5/24 at 11:42 a.m. with Admissions Coordinator (AC), Resident 192's, Notice of Medicare Non-Coverage [NOMNC-Notification that Medicare will not pay for your current skilled nursing services] dated 9/11/24 was reviewed. The NOMNC indicated, Pt [Patient] asked to be off therapy [Occupational Therapy] on 9/3/24. Pt family member needed to be notified, [sic] that patient will be placed on RNA [Restorative Nursing Assistance] program. Reached family member on 9/10/24, [sic] that Pt. will be placed on RNA as of 9/11/24 AC stated Resident 192 self discharged from Medicare part A before benefit days were exhausted and remained in the facility. AC stated ABN was not given to Resident 192 and should have been provided in addition to the NOMNC. 2. During a concurrent interview and record review on 12/5/24 at 11:45 a.m. with AC, Resident 195's, ABN dated 12/8/23 was reviewed. The ABN indicated, G. Options: Check One box: Option 1, Option 2, and Option 3. None of the boxes were checked and left incomplete. Resident 195's signature was at the bottom. AC stated that one of these boxes was required to be checked in order for the form to be considered complete. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage [SNF ABN] (FIABN), (undated), the FIABN indicated, Medicare requires Skilled Nursing Facilities (SNF's) to issue the SNF ABN to Original Medicare, also called fee-for-service (FFS), patients prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is not medically reasonable and necessary; or considered custodial. The SNF ABN provides information to the patient so that S/He can decide whether or not to get the care that may not be paid for by medicare and assume financial responsibility. 2. There are 3 option boxes listed on the SNF ABN with corresponding check boxes. The patient must check only one option box. If the patient is physically unable to make a selection, the SNF may enter the patient's selection at this/their request and indicate on the notice that this was done for the patient. Otherwise, Failure to use this notice or significant alterations of the SNF ABN could result in the notice being invalidated and/or the SNF being held liable for the care in question. 4. Signature and date: the patient or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. If the patient refuses to choose an option and/or refuses to sign the SNF ABN when required, the SNF should annotate the original copy of the SNF ABN indicating the refusal to sign and may list a witness to the refusal. The SNF should consider not furnishing the care.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46958 Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 13 and Resident 22) smoking assessment was completed timely. This failure resulted in residents not being assessed for safety while smoking and had a potential for residents to be burned while smoking. Findings: During a concurrent interview and record review on 12/4/24 at 10:31 a.m. with Director of Nursing (DON), Resident 13's Smoking Safety Evaluation, (undated) was reviewed. Resident 13's admission record indicated, Resident 13 was admitted on [DATE] and there were no quarterly assessments completed after 9/13/23. DON stated Resident 13 should have had smoking assessment completed on 6/5/23, 12/6/23, 3/6/24, 9/6/24 but there were none completed during those dates. During a concurrent interview and record review on 12/4/24 at 10:42 a.m. with DON, Resident 22's Smoking Safety Evaluation, (undated) was reviewed. Resident 22's admission record indicated, Resident 22's initial admitted was 5/1/22 and there were no quarterly assessments completed after 9/13/23. DON stated Resident 22 should have had smoking assessment completed in December 2023, March 2024, June 2024 and there were none completed during those dates. During a review of facility's policy and procedure (P&P) titled, Resident Smoking, dated 6/1/22, the P&P indicated, All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process.6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 46958 Based on interview and record review, the facility failed to accurately complete the annual pre-admission screening assessment and resident review (PASRR-federal requirement to help ensure that individuals are not incorrectly placed in nursing homes or long-term care instead of a psychiatric setting) for two of six sampled residents (Resident 13, Resident 42). This failure had the potential for Resident 13, and Resident 42 to be placed in an inappropriate setting and not receive required services. Findings: During a review of Resident 13's Preadmission Screening Resident Review (PASRR) Level I Screening, dated 10/15/24, the PASRR indicated, Level I positive for SMI [Serious Mental Illness]/negative for ID [Intellectual Disability]/DD [Developmental Disability]/RC [Related Condition]. During an interview on 12/4/24 at 9:27 a.m. with Director of Nursing (DON), DON stated Resident 13 was positive for Level I SMI but there was no Level II PASRR performed on Resident 13. During a review of Resident 42's Preadmission Screening Resident Review (PASRR) Level I Screening, dated 6/23/24, the PASRR indicated, Level I positive for SMI/Negative for ID/DD/RC. During an interview on 12/4/24 at 9:36 a.m. with DON, DON stated Resident 42 was positive for Level I SMI but there was no Level II PASRR performed on Resident 42. DON stated there should have been a level II screening done. During the review of facility's policy and procedure (P&P) titled, Resident Assessment - Coordination with PASARR program, dated January 2024, the P&P indicated, Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission. 5. If a resident who has not screened due to exception above and the resident remains in the facility longer than 30 days: a. The facility mush screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27157 Based on interview and record review the facility failed to obtain a diet order upon admission to the facility for one of one sampled residents (Resident 22). This failure had the potential to resulted in unmet nutritional needs. Findings: During a review of Resident 22's Admission Record (AR), (undated), the AR indicated, Resident 22 was admitted on [DATE]. During a concurrent interview and record review on 12/4/24 at 2:12 p.m. with Director of Nursing (DON) and Assistant Director of Nursing (ADON), Resident 22's Order Summary Report (OSR), dated 11/12/24, was reviewed. The OSR indicated, Diet; Controlled Carb [carbohydrate] diet [to manage diabetes (a blood sugar disorder)] thin pureed [a paste or thick liquid] texture, thin consistency. DON and ADON stated this was Resident 22's first diet order by the facility's physician and was completed four days after admission. During a concurrent interview and record review on 12/4/24 at 2:31 p.m. with ADON, Resident 22's nursing progress notes, dated 11/8/24 to 11/11/24, were reviewed. ADON stated there was no documentation by nursing that Resident 22 had a physician ordered diet upon admission to the facility. ADON stated the nurse should have called the physician to get the diet order. During a review of the facility's policy and procedure (P&P) titled, Admission Orders, dated January 2024, the P&P indicated, Policy: A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide written and/or verbal orders for the residents' immediate care and needs. Policy Explanation and Compliance Guidelines: 1. The written and/or verbal orders should include a minimum: a. Dietary b. Medication orders if indicated c. Routine care orders.The orders should provide information to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. During a review of the facility's P&P titled, Diet Orders, dated 2023, the P&P indicated, Policy: Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department. Procedure: Nursing will send a Diet Order Communication slip to the Food & Nutrition Services Department. 50939

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	055916	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoia Vista	3710 West Tulare Avenue Visalia, CA 93277

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42148 Based on observation, interview, and record review, the facility failed to ensure one of four residents (Resident 10) was given the appropriate care and services to improve hearing and communication. This failure resulted in Resident 10 not having her communication needs met. Findings: During a review of Resident 10's Admission Record (AR), dated 5/1/22, the AR indicated, Resident 10 was admitted on [DATE]. During a concurrent interview and observation on 12/3/24 at 9:37 a.m. with Resident 10 in Resident 10's room, Resident 10 was having a hard time hearing and required this surveyor to get close to her ear and speak loud and clear for her to understand. Resident 10 stated, I wish I had some hearing aids so I could hear you better. During an interview on 12/4/24 at 3:16 p.m. with Resident 10 and Social Service Designee (SSD), Resident 10 stated I can't hear, and I think my ears need to be cleaned out. I would like some hearing aids. SSD stated, she was not sure if Audiology (hearing specialist) Services had been used for Resident 10 and agreed that Resident 10 was hard of hearing. During an interview on 12/5/24 at 9:47 a.m. with SSD, SSD stated Resident 10 has never had a hearing test at the facility. During an interview on 12/5/24 at 10:13 a.m. with SSD and Resident 10, SSD asked Resident 10 What did you eat for breakfast and what kind of music do you listen to? Resident 10 repeatedly stated, I can't hear you, I need my ears cleaned out. During the facility's policy and procedure (P&P) titled, Hearing and Vision Services, dated January 2024, the P&P indicated, It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. 3. The social worker/social service designee is responsible for assisting resident, and their families, in locating and utilizing any available resources for the provision of the vision and hearing services the resident needs. 5. Employees will assist the resident with the use of any devices or adaptive equipment needed to maintain vision or hearing.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 27157 Based on observation, interview and record review, the facility failed to document the quantity consumed of a nutrition beverage supplement ordered to address significant weight loss for one of one sampled residents (Resident 22) ensuring the accuracy of nutrition assessments and ability to monitor effectiveness. This failure had the potential to ineffectively evaluate and delay timely revision of nutrition interventions needed to meet residents' nutrition needs. Findings: During a concurrent observation and interview on 12/2/24 at 12:56 p.m. with Certified Nursing Assistant (CNA) 9 and Resident 22 in Resident 22's room, Resident 22 had an unopened four (4) ounce (oz.) carton of chocolate flavored sugar free health shake (to increase calorie and protein intake) on her lunch meal tray. LN 1 translated in Spanish to Resident 22 to ask if she liked the health shake. Resident 22 stated she does not drink the health shake because she does not like it at all, even if it was a different flavor. Resident 22 stated she feels bad about her weight loss because it occurred too fast and that she lost twenty pounds not long ago. During an interview on 12/3/24 at 10:13 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 used an electronic device located on the wall in hallway 400 to show where CNAs were trained to document quantity consumed of a health shake. CNA 1 was asked to show the documentation for the quantity consumed of the health shake for Resident 22 for lunch on 12/2/24. CNA 1 reviewed Resident 22's documented meal and fluid intake using the electronic device that displayed Effective Date: 12/2/24; 14:59 [2:59 p.m.], CNA 1 stated it was blank, nothing was entered. CNA 1 showed the screen titled Document Fluid Intake Ml's [milliliters; unit of volume for liquids], and CNA 1 stated the total cc [cubic centimeter; unit of volume] of fluid from any fluids located on the meal tray would be indicated as a total number of cc fluids consumed, and not itemized such as water, coffee, juice or health shake, for example. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/3/24 at 2:56 p.m. with the Registered Dietitian (RD), Resident 22's Nutrition Evaluation (NE), dated 11/14/24 was reviewed. The NE indicated, Resident experienced a significant wt [weight] change r/t [related to] recent hospitalization .Will add no sugar house nutritional supplement TID [three times a day] with meal. M/E [monitor/evaluate] PO [by mouth] intake. RD stated resident [Resident 22] told her she feels too skinny and wants to gain weight. RD was asked how she monitors po intake of the sugar free health shake supplements. RD reviewed Resident 22's electronic health record (EHR) and under the Tasks tab reviewed ADLs [activities for daily living], under Amount Eaten, and RD stated those percent meal eaten is from her diet order of CCHO [consistent carbohydrate] puree diet and did not include the health shake. RD reviewed an entry of 480 cc of fluid and stated that was the total amount of fluids consumed for a meal. RD stated to tell you the truth I am not sure what fluids that could be. RD stated for an accurate nutrition assessment, she would need to have the ability to quantify the calories a resident consumes and compare to a resident's daily assessed needs to develop a care plan to meet a gap in nutritional needs, when necessary. RD stated since the facility does not document quantity consumed of nutrition supplements, she was not able to have accurate nutrition assessments. Further, RD stated she was unaware Resident 22 was not drinking the health shakes routinely, which in part is due to the facility's lack of documentation of quantity consumed, for effective monitoring and to offer an alternative nutrition intervention for Resident 22, in a timely manner before a negative outcome occurred such as potential weight loss. During a concurrent interview and record review on 12/4/24 at 1:51 p.m., Resident 22's Medication Administration Record (MAR), dated November 2024 was reviewed. The MAR indicated the Health Shake TID with a check mark and nursing initials for each of the meals, there was no documentation of quantity consumed. ADON stated the check mark next to the health shake order indicated the health shake was provided, and stated the facility lacked a system to document quantity consumed. During a concurrent interview and record review on 12/4/24 at 2:00 p.m., Resident 22's ADL's under Amount Eaten, dated 12/2/24 was reviewed. ADON stated the documentation showed Resident 22 refused breakfast and lunch, and dinner was left blank. ADON stated under Document Fluid Intake Ml's, dated 12/2/24, there was documentation of 750 cc fluid consumed for one shift. ADON stated she would not be able to know whether the 750-cc fluid consumed included a health shake. ADON stated the facility should be documenting quantity consumed of the health shake (or any nutrition intervention provided to increase calories and/or protein) for the ability to monitor for effectiveness. During a review of the facility's policy and procedure (P&P) titled, NUTRITIONAL SCREENING/ASSESSMENTS/RESIDENT CARE PLANNING, dated 2023, the P&P indicated, POLICY: The resident's nutritional status and nutritional needs will be assessed. A nutritional program specific to the resident's needs will be planned and implemented, and then reassessed periodically for progress. 50939

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46958 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was scheduled and on duty eight hours a day, seven days a week. This failure had the potential for resident care to be negatively impacted. Findings: During a concurrent interview and record review on 12/5/24 at 2:28 p.m. with Human Resource Payroll Manager (HR), facility's staff schedule dated November 2024 were reviewed. The staff scheduled indicated, on 11/9/24, 11/23/24, and 11/24/24 there was no RN for 8 hours a day. HR stated there was no RN present in the building for 8 hours a day on these days. During a review of the facility's policy and procedure (P&P) titled, Nursing Services-Registered Nurse (RN), dated [DATE], the P&P indicated, The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46958 Based on interview and record review, the facility failed to ensure Performance Evaluation (PE-a process to give employees feedback on their job performance) for three of eight sampled employees (Certified Nursing Assistance [CNA] 54, CNA 88, Terminated [T]CNA) were completed. This failure had the potential for staff not being aware of their need improvement in certain areas, which could affect patient care. Findings: During a concurrent interview and record review on 12/5/24 at 11:30 a.m. with Human Resources Payroll (HR), CNA 54's PE was reviewed. CNA 54 was hired on 6/22/21 and there were no PEs found in her file. HR stated no PE was done. During a concurrent interview and record review on 12/5/24 at 11:40 a.m. with HR, CNA 54's PE was reviewed. CNA 54 was hired on 4/5/22 and there were no PEs found in her file. HR stated no PE was done. During a concurrent interview and record review on 12/5/24 at 11:50 a.m. with HR, TCNA PE was reviewed. TCNA was hired on 6/11/23 and there were no PEs found in her file. HR stated no PE was done. During a review of the facility's policy and procedure titled, Evaluation Process, dated [DATE], the P&P indicated, a. At the end of each month, the Human Resource department with notify the Department Manager of evaluations due for the following month. The Manager or Supervisor is to notify the employee of the evaluation at least one week prior to employee's evaluation due date.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 44134 Based on observation, interview, and record review, the facility failed to ensure medication error rate was five percent or less when five medication errors were observed out of 43 medication administration opportunities, which yielded a medication error rate of 11.63 percent. These failures had the potential for residents to not receive the therapeutic effects of the medications. Findings: During an observation on 12/3/24 at 9:20 a.m. in the 100-unit hallway, Licensed Vocational Nurse (LVN) 3 was preparing Resident 32's morning medications. LVN 3 crushed one tablet of chewable aspirin (lowers risk of heart attack, or blood clots) 81 milligram (mg), one tablet docusate sodium (stool softener) 100 mg, one tablet of metformin (helps lower blood sugar) 500 mg, two tablets of Keppra (used to treat seizures) 500 mg, and one tablet of Januvia (helps lower blood sugars) 100 mg and mixed them into a plastic medicine cup of pudding. During an observation on 12/3/24 at 9:40 a.m. in Resident 32's room, LVN 3 orally administered Resident 32's medications that had been crushed and mixed with pudding. During an interview on 12/4/24 at 1:55 p.m. with LVN 3, LVN 3 stated he had administered all of Resident 32's medications orally during the morning medication pass on 12/3/24. During a concurrent interview and record review on 12/4/24 at 1:56 p.m. with LVN 3, Resident 32's Order Summary Report (OSR), dated 12/1/24 was reviewed. The OSR indicated, Aspirin Tablet Chewable 81 mg Give 1 tablet via [by] G-Tube [gastrostomy tube, a surgically placed tube that provides direct route for delivering nutrients, fluids and medication to the stomach] one time a day. LVN 1 stated Resident 32's aspirin should have been given by G-tube. During a concurrent interview and record review on 12/4/24 at 1:57 p.m. with LVN 3, Resident 32's Order Summary Report (OSR), dated 12/1/24 was reviewed. The OSR indicated, Docusate Sodium Oral Tablet 100 MG (Docusate Sodium) Give 1 tablet via G-Tube one time a day. LVN 3 stated the docusate was ordered to give by g-tube and he should have administered it that way. During a concurrent interview and record review on 12/4/24 at 1:58 p.m. with LVN 3, Resident 32's Order Summary Report (OSR), dated 12/1/24 was reviewed. The OSR indicated, MetFORMIN Tablet 500 MG Give 1 tablet via G-Tube three times a day. LVN 3 stated Resident 32's metformin should have been administered by g-tube. During a concurrent interview and record review on 12/4/24 at 1:59 p.m. with LVN 3, Resident 32's Order Summary Report (OSR), dated 12/1/24 was reviewed. The OSR indicated, Keppra Tablet 500 MG. Give 2 tablet via G-Tube two times a day. LVN 3 stated Resident 32's Keppra should have been given by g-tube. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/4/24 at 2 p.m. with LVN 3, Resident 32's Order Summary Report (OSR), dated 12/1/24 was reviewed. The OSR indicated, Januvia Oral Tablet 100 MG.Give 1 tablet via G-Tube one time a day. LVN 3 stated Resident 32's Januvia should have been administered by g-tube. LVN 3 stated he should have checked the order and called the physician to change the route of administration prior to giving Resident 32's medication orally. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 1/2024, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. 10. Ensure that the six rights of medication administration are followed.d. Right route.12. Compare medication source with MAR [medication administration record] to verify resident name, medication name, form, dose, route, and time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44134 Based on observation, interview, and record review, one of four sampled Licensed Vocational Nurses (LVN 2) failed to: 1. Ensure a controlled medication was not accessible to staff and residents during medication pass. 2. Ensure a controlled medication was properly disposed of. These failures had the potential to result in diversion of a controlled medication. Findings: 1. During a concurrent observation and interview on [DATE] at 8:26 a.m. with LVN 2 in Resident 189's room, LVN 2 dropped a plastic medication cup containing Resident 189's Vitamin B12 (vitamins that help keep blood and nerve cells healthy) 1000 milligram (mg), Docusate (stool softener) 100 mg, Eliquis (blood thinner used to prevent and treat blood clots) 5 mg, Neurontin (used to treat seizures and nerve pain) 100 mg, Reglan (used for stomach and esophageal problems; nausea, vomiting, and heartburn) 5 mg, Jardiance (used to improve blood sugar levels in patients with diabetes) 10 mg, Prilosec (used to treat stomach acid) 20 mg, Iron (supplement used to prevent low iron levels in the blood) 325 mg, Tramadol (a controlled substance opioid used to treat moderate to severe pain) 50 mg on the bed. LVN 2 picked up all nine tablets and stated the dropped medications will need to be wasted. LVN 2 stated she needed a witness to sign off on her wasted Tramadol 50 mg. During an observation on [DATE] at 8:32 a.m. in the hallway, LVN 2 had placed the plastic medicine cup containing Tramadol 50 mg tablet and 8 other dropped tablets on top of the medication cart. LVN 2 walked away from the medication cart and entered Resident 189's room. During an interview on [DATE] at 8:34 a.m. with LVN 2, in the hallway, LVN 2 stated the medication should not have been left on top of the cart when she walked into Resident 189's room. LVN 2 stated she should have locked all medications inside of the medication cart until she was able to waste the Tramadol 50 mg with another licensed nurse. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated ,d+[DATE], the P&P indicated, It is the policy of this facility to ensure all medications housed on our premise will be stored in the pharmacy and or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security.During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview on [DATE] at 8:26 a.m. with LVN 2 in Resident 189's room, LVN 2 dropped a plastic medication cup containing Resident 189's Vitamin B12 (vitamins that help keep blood and nerve cells healthy) 1000 milligram (mg), Docusate (stool softener) 100 mg, Eliquis (blood thinner used to prevent and treat blood clots) 5 mg, Neurontin (used to treat seizures and nerve pain) 100 mg, Reglan (used for stomach and esophageal problems; nausea, vomiting, and heartburn) 5 mg, Jardiance (used to improve blood sugar levels in patients with diabetes) 10 mg, Prilosec (used to treat stomach acid) 20 mg, Iron (supplement used to prevent low iron levels in the blood) 325 mg, Tramadol (a controlled substance opioid used to treat moderate to severe pain) 50 mg on the bed. LVN 2 picked up all nine tablets and stated all the dropped medications will need to be wasted. LVN 2 stated she will need a witness to sign off on her wasted Tramadol 50 mg. During a concurrent observation and interview on [DATE] at 8:45 a.m. with LVN 2 in Medication room [ROOM NUMBER], LVN 3 witnessed LVN 2 dispose of Tramadol 50 mg that had been dropped in Resident 189's room. LVN 2 emptied the plastic medicine cup containing all 9 tablets into a black plastic container labeled Hazardous Waste Container. The wasted medications were not crushed, and there were no solvent or solutions added to the medications to destroy the tablets. LVN 2 stated this was the container that was designated for all wasted medications. During an interview on [DATE] at 11:13 a.m. with LVN 2, LVN 2 stated narcotics are disposed of in the black container in the medication room with a witness. During an interview on [DATE] with Director of Nursing (DON), DON stated disposal of a single controlled medication can be done by a licensed nurse with the witness of another licensed nurse. DON stated controlled medications/narcotics should be disposed of in a drug buster liquid. DON stated the black bins located in the medication rooms are not appropriate for controlled medication/narcotic disposal. During an interview on [DATE] at 3:38 p.m. with Assistant Director of Nursing (ADON), ADON stated all controlled medications/narcotics should be brought to the DONs office to be destroyed later with the pharmacist. ADON stated controlled medications/narcotics should not have been disposed of in the black waste containers. ADON stated the black waste containers are for all other medications like inhalers. During a review of the facility's policy and procedure (P&P) titled, Destruction of Unused Drugs, dated , d+[DATE], the P&P indicated, All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations.1. Drugs will be destroyed of in a manner that renders the drug unfit for human consumption.4. The actual destruction of drugs conducted by our facility must be witnessed by the consultant pharmacist and one of the following individuals: a. An agent of the State Board of Pharmacy; b. The facility Administrator; or c. The Director of Nursing Services.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 27157 Based on observation, interview, and record review, the facility failed to ensure there was adequate communication to and from the Dietary Manager and RD for proper guidance to ensure food safety when a one of two sampled refrigerator unit (Refrigerator 1) that was not in good working condition remained in use to store TCS foods (Time Temperature Control for Safety - food that requires time-temperature control to prevent the growth of bacteria.) This failure had the potential to result in residents nutritional need not being met in safe manner. Findings: During an observation on 12/2/24 at 9:57 a.m. in the kitchen, there was a reach in refrigerator (Refrigerator 1) located in the middle of the kitchen next to trayline area and cook station (stove range). The inside of refrigerator 1 did not feel cold. Refrigerator 1 had an internal thermometer indicated 38 degrees F (Fahrenheit) with two individual sized yogurt containers, unopened, three cartons of butter milk, several trays of individually served containers of pudding, and 12 gallon containers of milk on the right hand side of the reach in refrigerator. During a concurrent interview and record review on 12/2/24 at 9:58 a.m. with Lead [NAME] (LC) 2, Refrigerator 1's Temperature Monitoring Log (TML) dated November 2024 was reviewed. The TML indicated, on 12/2/24, a question mark was documented instead of a temperature reading. LC 2 stated there was a problem with the Refrigerator 1. LC 2 stated he put a question mark on the temperature monitoring log, because he was not sure what the correct temperature was. LC 2 stated he identified a problem with unit 1 refrigerator on 11/29/24 and reported it to Plant Operations Manager (POM) on the same day. During a concurrent observation and interview on 12/2/24 at 9:58 a.m. with LC 2 in the kitchen, LC 2 removed 2 containers of pudding from Refrigerator 1 and obtained the internal temperature of two of the pudding cups. LC 2 stated one cup was 50.1 degrees F, and the other cup was 52 degrees F. LC 2 stated the pudding had been in Refrigerator 1 since yesterday, and had not been removed, and the tray of pudding cups was labeled with a preparation date of 12/1/24. During an interview on 12/2/24 at 11:07 a.m. with POM, POM stated an outside service company assessed Refrigerator 1 and stated the compressor needed to be replaced. POM stated the Dietary Manager (DM) was not at the facility on 11/29/24. POM stated he informed the Administrator that Unit 1 needed a compressor. During a review of the facility's Service Invoice (SI), dated 11/29/24, the SI indicated, Found the compressor over amping. Checked all start components and they are good. Compressor is windings are bad. No Supply Houses are open today because of Thanksgiving. (continued on next page)

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	055916	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoia Vista	3710 West Tulare Avenue Visalia, CA 93277

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/2/24 at 4:02 p.m. with Administrator, Administrator stated she received a text from POM, which indicated Refrigerator 1 needed a new compressor. Administrator stated she had not called the DM nor the Registered Dietitian (RD) to inform them of the situation to ensure oversight of food safety by the credentialed, qualified persons responsible for the food and nutrition department. During a telephone interview on 12/02/24 at 4:05 p.m. with RD, in the presence of Administrator, the RD stated no one had communicated to her that Refrigerator 1 needed a replacement compressor and she was unaware TCS foods continued to be stored in Refrigerator 1. During a concurrent observation and interview on 12/02/24 at 03:27 p.m. with LC 1, in the kitchen, Refrigerator 1 contained TCS foods such as a tray with cups of milk, several gallons of milk, carton of buttermilk, produce and jello. An internal thermometer located in Refrigerator 1 indicated 55 degrees F. LC 1 stated Administrator told them to throw out the food in Refrigerator 1 about 20 minutes ago. LC 1 was asked why food was still in Refrigerator 1, and LC 1 stated the pudding cups [that were in the temperature danger zone] were moved to another reach-in refrigerator that was working properly to be served as snacks to the residents. LC 1 stated she has not had time to throw out the rest of the food per Administrator direction. According to the United States Department of Agriculture (USDA), The Danger Zone is the temperature range between 40 degrees F and 140 degrees F in which bacteria can grow rapidly. During an interview on 12/05/24 at 9:47 a.m. with DM, DM stated he was not aware that Refrigerator 1 needed a replacement compressor until he received a phone call from facility informing him on 12/1/24. DM stated that via a phone call he told the kitchen staff to remove the food from Refrigerator 1. DM stated he was unsure if food was removed, and unable to explain why food was located in Refrigerator 1 on 12/2/24. DM stated the cook position at the facility was expected to take a lead role in the kitchen and has been trained to call the DM with any questions. During an interview on 12/5/24 at 11 a.m. with DM and RD, both DM and RD stated there lacked adequate communication from the facility to them and from them to ensure food safety was maintained when a broken piece of equipment need repair on Refrigerator 1. Refrigerator 1 continued to be used to store TCS foods that should have been maintained with an internal temperature of 41 degrees F, or less, and were not. During a review of the Food and Drug Administration (FDA) Food Code Annex, dated 2022, the FDA Food Code indicated FDA continues to recommend that cold food storage for time/temperature control for safety foods (TCS), and ready to-eat foods are stored at a maximum temperature of 41 F. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, Correct temperatures for the storage and handling of foods are used. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's job description (JD) titled Dietitian, dated 2003, the JD indicated, Purpose of Your Job Position: The primary purpose of your job position is to plan, organize, develop and direct the overall operation of the Food Services Department in accordance with current federal, state, and local standards, guidelines, and regulations that governing our facility, and as may be directed by the Administrator, to assure that quality nutritional services are being provided on a daily basis and that the food services department is maintained in a clean. safe, and sanitary manner. 50939

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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. 50939 Based on observation, interview, and record review, the facility failed to follow the meal tray ticket and/or planned menu for two out of three sampled residents (Resident 62 and Resident 83). This failure had the potential for Resident 62 and Resident 83's nutritional goals not being met. Findings: During a concurrent observation and interview on 12/3/24 at 12:10 p.m. with the Registered Dietitian (RD) in the kitchen, Resident 62's lunch meal tray was placed onto a meal delivery cart and Meal Tray Ticket (MTT) indicated large portions. There was only one slice of garlic bread on the meal tray. RD stated two slices of garlic bread should have been served per the planned menu for large portion diet. During a review of Resident 62's Physician Diet Order (PDO), dated 7/12/24, the PDO indicated, Resident 62 had large portion for diet order type. During a concurrent observation and interview on 12/3/24 at 12:15 p.m. with the RD in the kitchen, Resident 83's MTT under standing orders indicated 4 oz [ounce], 2% [percent] milk. RD stated Resident 83's meal tray did not have the 4 oz, 2% milk. During a review of Resident 83's MTT, dated 12/4/24, the MTT indicated, Resident 83 had 4 fl [fluid] oz Milk 2% under standing orders. During a review of the facility's P&P titled, Diet Orders, dated 2023, the P&P indicated, Policy: Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department. Procedure: Nursing will send a Diet Order Communication slip to the Food & Nutrition Services Department. 27157

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 27157 50939 Based on observation, interview, and record review, the facility failed to ensure the therapeutic diet was served in accordance with the diet order for one of three sampled residents (Resident 22). This failure had the potential for Resident 22 to choke. Findings: During an observation and record review on 12/2/24 at 12:56 p.m. in Resident 22's room, Resident 22's meal tray consisted of corn bread and chili (regular texture). Resident 22's meal ticket diet order indicated regular texture, CCHO (Consistent, constant, or controlled carbohydrate), thin liquid was crossed out and replaced with a handwritten notation of puree. During a review of Resident 22's Physician's Diet Order (POD) dated 12/2/24, the POD indicated, Resident 22 had puree as the diet texture order. During a concurrent interview and record review on 12/3/24 at 3:25 p.m. with Registered Dietitian (RD), RD reviewed a photo picture of Resident 22's lunch meal tray ticket dated 12/2/24. Resident 22's lunch meal tray ticket indicated diet order regular texture, CCHO, thin liquid was crossed out and replaced with a handwritten notation of puree. RD stated Resident 22 had two meal tray ticket's on file. RD stated one meal tray ticket indicated a regular textured diet and the second meal tray ticket indicated a puree diet. RD stated Resident 22 had a diet order for pureed texture. RD stated Resident 22 was not provided the correct physician ordered therapeutic diet of pureed texture. During a review of the facility's policy and procedure (P&P) titled, Diet Orders, dated 2023, the P&P indicated, Policy: Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department. Procedure: Nursing will send a Diet Order Communication slip to the Food & Nutrition Services Department.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50939 Based on observation, interview, and record review the facility failed to ensure proper storage, preparation, and distribution of food was in accordance with professional standards for food service safety when: 1. Kitchen had unsanitary food preparation conditions. 2. Facility only had non pasteurized eggs available for use. 3. Certified Nursing Assistant (CNA) 81 walked an uncovered salad to a resident's room down the hallway. 4. Did not ensure cold food storage refrigerator maintained a minimum temperature of 41 degrees. These failures had the potential for residents in the facility to develop foodborne illnesses. Findings: 1. During a concurrent observation and interview on 12/2/24 at 3:41 p.m. with Lead [NAME] (LC) 1 in the kitchen, there was an extensive amount of dry old egg debris on the stove range area. LC 1 stated it was dried up leftover egg from the morning breakfast. During an observation on 12/3/24 at 9:56 a.m. in the kitchen, there was a # (number) 8 scooper that had dry old food debris on it and was stored inside of the clean utensil drawer. During a concurrent interview and record review on 12/5/24 at 9:45 a.m. with Dietary Manager (DM), a photo of the facility's # (number) 8 scooper that had dry old food debris on it, stored inside of the clean utensil drawer was reviewed. DM stated that the dirty # (number) 8 scooper should not have been stored with the clean utensils. DM stated that was unsanitary. During a review of the facility's Policy and Procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, 11. All utensils . shall be kept clean. During a review of the facility's Policy and Procedure (P&P) titled, Food Safety Requirements, dated 2/23, the P&P indicated, 6. All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination. 2. During an observation on 12/2/24 at 9:48 a.m. in Refrigerator 1 there was a case of shelled eggs that were not labeled as being pasteurized on the box, nor did the shell eggs have a P stamped on them. During a concurrent observation and interview on 12/3/24 at 9:11 a.m. with LC 2 in the kitchen, LC 2 stated the observed eggs were not pasteurized. LC 2 stated the facility was supposed to use pasteurized eggs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/5/24 at 9:45 a.m. with Dietary Manager (DM), DM stated the facility was supposed to use pasteurized eggs and the current supply of eggs were not pasteurized and should be. During a review of the facility's Food and Service Invoice (FSI), dated 11/30/24, the FSI indicated, the facility's 115 dozen supply of eggs was not pasteurized. During a review of Resident 17 and Resident 21's Meal Tray Tickets, dated 12/4/24, the MTT indicated Resident 17 and Resident 21 had 2 x 1 serving Eggs (Over easy). During a review of the facility's Policy and Procedure (P&P) titled, Food Preparation, dated 2023, the P&P indicated, Pasteurized eggs are to be used for all purposes. 3. During a concurrent observation and interview on 12/2/24 at 12:45 p.m. with CNA 81 in the hallway, CNA 81 walked past the nurse's station, room [ROOM NUMBER] and room [ROOM NUMBER] carrying a meal tray that contained an uncovered salad and dressing. CNA 81 stated she took the food tray with the uncovered salad & uncovered salad dressing to room [ROOM NUMBER]B. During an interview on 12/5/24 at 2:24 p.m. with Director of Nursing (DON), DON stated he expected the residents food meal trays to remain covered during delivery to the resident rooms. During a review of the facility's Policy and Procedure (P&P) titled, Food Safety Requirements, dated 2/23, the P&P indicated, a. Covering all foods when traveling a distance [i.e., down a hallway, to a different unit or floor]. 4. During an observation on 12/2/24 at 9:57 a.m. in the kitchen, the inside of Refrigerator 1 did not feel cold. Refrigerator 1 had two individual sized yogurt containers, unopened, four cartons of butter milk, several trays of individually served containers of pudding, and 12 cartons of milk. During a concurrent interview and record review on 12/2/24 at 9:58 a.m. with LC 2, the Refrigerator 1 Temperature Monitoring Log (TML) dated November 2024 was reviewed. The TML indicated, on 12/2/24, no documented temperature check. LC 2 stated there is a problem with Refrigerator 1 and it did not feel cold. During a concurrent observation and interview on 12/2/24 at 9:58 a.m. with LC 2 in the kitchen, LC 2 obtained the internal temperature of two of the pudding cups that were placed in plastic serving containers by staff. LC 2 stated it was 50.1 degrees F, and the other one was 52 degrees F. During an interview on 12/2/24 at 11:07 a.m. with Plant Operations Manager (POM), POM stated the compressor needed to be replaced for Refrigerator 1. During an interview on 12/2/24 at 4:02 p.m. with Administrator, Administrator stated she received a text from POM who told her the unit 1 refrigerator needed a new compressor. During a review of the facility's Service Invoice (SI), dated 11/29/24, the SI indicated, Found the compressor over amping. Checked all start components and they are good. Compressor is windings are bad. No Supply Houses are open today because of Thanksgiving. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 12/02/24 at 3:27 p.m. in the kitchen, with LC 1 Refrigerator 1 internal thermometer indicated 55 degrees F. According to the United States Department of Agriculture (USDA), The Danger Zone is the temperature range between 40 degrees F and 140 degrees F in which bacteria can grow rapidly. During a review of the facility's Policy and Procedure (P&P) titled, Food Safety Requirements, dated 2/23, the P&P indicated, Practices to maintain safe refrigerated storage include: i. Monitoring food temperature and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation. During a review of the Food and Drug Administration (FDA) Food Code Annex, dated 2022, the FDA Food Code indicated FDA continues to recommend that cold food storage for time/temperature control for safety foods (TCS), and ready to-eat foods are stored at a maximum temperature of 41 F. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, Correct temperatures for the storage and handling of foods are used. 27157

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 27157 50939 Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) titled, FOOD FOR RESIDENTS FROM OUTSIDE SOURCES for one of one resident designated refrigerator (RDR). This failure resulted in undated and unlabeled food and had the potential for food contamination. Findings: During a concurrent observation and interview on 12/3/24 at 10:27 a.m. with Certified Nursing Assistant (CNA) 81 in the employee break room, the RDR had undated and unlabeled foil covered plated food items stored inside. CNA 81 stated all food stored inside the RDR should have been dated and labeled with the residents name. During an interview on 12/3/24 at 9:23 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated the food stored in the RDR for residents should have the resident name and the date the food item was received. During a review of the facility's P&P titled, FOOD FOR RESIDENTS FROM OUTSIDE SOURCES, dated 2023, the P&P indicated, 5. Prepared foods, beverages, or perishable food that requires refrigeration, can be stored for the resident in the facility. resident's personal refrigerator.unopened, refrigerated or frozen items will be disposed of by the expiration date on the container. If opened, the food must be sealed, dated to the date opened and disposed of in 2 days after opening.

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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. 42148 Based on observation, interview, and record review, the facility failed to ensure five of eight sampled residents (Resident 82, Resident 79, Resident 238, Resident 239, Resident 241) with indwelling devices (device inserted into the body) had Enhanced Barrier Precautions (infection control intervention designed to reduce transmission of bacteria) in place. This failure had the potential to cause infection and adverse outcomes. Findings: During an observation on 12/2/24 at 10:58 a.m. in Resident 82's room, Resident 82 had an indwelling Foley catheter (collection bag with tubing going into resident's bladder) hanging from the side of her bed. During an observation on 12/3/24 at 9:52 a.m. in Resident 82's room, Resident 82 was not on Enhanced Barrier Precautions. No signage or Personal Protective Equipment (PPE-gown, gloves, mask, goggles) cart seen. During an interview on 12/4/24 at 8:52 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated she was unaware if a resident with an indwelling device should be on Enhanced Barrier Precautions. During an interview on 12/4/24 at 8:54 a.m. with LVN 4, LVN 4 stated, Resident 79, Resident 82, Resident 238, Resident 239, and Resident 241 should be on Enhanced Barrier Precautions since they had various dwelling devices and stated these residents did not have any signage or PPE carts outside of their rooms and should have these in place to indicate to staff these residents are on Enhanced Barrier Precautions. During a concurrent observation and interview on 12/4/24 at 9:43 a.m. with Certified Nursing Assistant (CNA) 73 in Resident 79's room, Resident 79 had a Dialysis Catheter (indwelling device used for dialysis- process used to remove waste and extra fluid from the blood when the kidneys are unable to function properly) to his right upper chest. CNA 73 stated she did not know if Resident 79 should be on enhanced barrier precautions and did not see any signage stating that he was. During a review of Resident 82's, Order Summary Report (OSR), dated 10/17/24, the OSR indicated, Foley catheter care every shift and check for signs and symptoms of infection or bleeding. During a review of Resident 79's, OSR, dated 12/5/24, the OSR indicated, Dialysis access site: Check right upper chest upon return from dialysis, then every shift for s/s [signs and symptoms] of infection or bleeding. During a review of Resident 238's, OSR, dated 12/1/24, the OSR indicated, Foley Catheter care every shift. Observe for s/s of complication such as infection, obstruction, or when closed system is compromised. During a review of Resident 239's, OSR, dated 9/27/24, the OSR indicated, Foley Catheter care every shift. Observe for s/s of complication such as infection or bleeding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 241's, OSR, dated 11/17/24, the OSR indicated, Foley Catheter care every shift. Observe for s/s of complications such as infection, obstruction, or when closed system is compromised. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated January 2024, the P&P indicated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). 1. Prompt recognition of need: a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. 2. B. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes. hemodialysis catheters. even if the resident is not known to be infected or colonized with a MDRO. 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. B. PPE for enhanced barrier precautions is only necessary when performing high contact care activities.