STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055922	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Health Care Center	1850 East 8th Street Davis, CA 95616

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 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. 34328 Based on observation, interview and record review the facility failed to obtain informed consent (the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention) on the use of psychotropic medication (drugs that affect a person's mental state) from the resident's Responsible Party (RP, a person designated to make decisions for the resident who is unable to make decisions for himself) for one resident (Resident 73) of 30 sampled residents. This failure decreased the facility's potential to ensure residents and RPs were aware of the risks, benefits, and alternatives of treatment offered to them. Findings: A review of Resident 73's admission record indicated admission to the facility April 2022 with diagnoses which included hemiplegia (complete paralysis of one side of the body) and hemiparesis (partial paralysis of one side of the body) affecting the right side, dementia (the impaired ability to remember, think, or make decisions) with psychotic disturbance, anxiety disorder (a feeling of fear, dread, and uneasiness), personality disorder (patterns of thinking, feeling, and behaving which is different from the expectations of culture which causes distress or problems functioning), and major depressive disorder (a persistent feeling of sadness). Resident 73's admission record also indicated the son was the RP for healthcare decisions and the daughter was the RP for financial decisions. A review of Resident 73's physician's order dated 5/24/22 indicated, .MD determines that Resident DOES NOT [sic] the Mental Capacity to make Healthcare decisions as per History & Physical or Transfer orders or preferred intensity of care. During an initial tour of the facility on 5/21/24, Resident 73 was observed in bed and receiving oxygen via nasal cannula (a tube used to deliver oxygen to the nose) from an oxygen concentrator (a machine that pulls oxygen from the surrounding air). Resident 73 was arousable, had a flat affect (speech in a dull, flat voice and facial expressions may not change), and was confused as to time and place. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 73's Medication Administration Record (MAR), dated May 2024, indicated Resident 73 was prescribed quetiapine (a medication used to treat major depressive disorder) 25 mg (milligram, a unit of measure) by mouth in the morning and at bedtime on 10/15/23. According to the MAR, Resident 73's quetiapine was revised by the physician on 12/28/23 to quetiapine 25 mg one tablet by mouth in the morning and 50 mg by mouth at bedtime. The physician increased Resident 73's quetiapine dose to equal 75 mg daily. A review of Resident 73's medical chart indicated no informed consent discussed between the physician and the RP for healthcare decisions about increasing the total daily dose of quetiapine from 50 mg to 75 mg. A review of nursing progress notes, dated 12/28/23 and 12/29/23, did not indicate the RP was made aware and an Informed Consent completed before giving the increased dosage of Quetiapine at bed time. A review of MARs, dated December 2023, January 2024, April 2024, and May 2024, indicated Resident 73 was administered 25 mg of quetiapine by mouth in the morning and 50 mg of quetiapine at bedtime starting on 12/28/23. In an interview with the Assistant Director of Nursing (ADON) on 5/4/24 at 9:06 a.m., the ADON confirmed an informed consent must be obtained by the physician to explain the risks and benefits of the medication to the RP before any psychotropic medications are administered. The ADON stated the Licensed Nurses (LNs) were expected to verify the physician had informed the RP of the risks and benefits of the psychotropic medication before any changes to medication or dosage of medication was administered. The ADON confirmed the physician's notes were not available on the clinical record. The ADON stated the physician will be called and the physician's notes obtained about the informed consent. In a concurrent record review and interview on 5/4/24 at 9:10 a.m., the Social Services Director (SSD) reviewed Resident 73's computerized records and confirmed there was no documented informed consent was obtained by the physician. A review of a facility provided policy and procedure titled Psychotropic Medication Management dated December 2017 indicated, .Purpose .To avoid unnecessary medications and and facilitate the proper use, dose, and duration of psychotropic agents in accordance with Resident Assessed need(s) and condition(s) . Informed Consent for psychoactive medications must be verified prior to use . A review of an All Facilities Letter (AFL) 24-07 effective 2/28/24 indicated, .Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided. If the resident or resident's representative cannot sign the form, a licensed nurse can sign the form, a licensed nurse can sign the form and document the name of the person who gave consent and the date .The signed written consent must be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident's health record contains written informed consent with the required signatures . At the conclusion of the survey on 5/24/24, there were no additional physician's notes or documentation provided for Resident 73's completed informed consents.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 41838 Based on observation, interview and record review, the facility failed to protect resident information when meal tickets (containing resident information) were discarded into the garbage and subsequently into the outside dumpster. This failure had the potential of compromising resident information for 103 residents receiving facility provided meals for a census of 109. Findings: During a visit to the kitchen on 5/22/24 at 10:33 a.m., Dietary Aide 1 (DA 1) was taking breakfast meal trays off the carts to wash. As DA 1 grabbed the trays, she separated out like items for wash, and threw leftover food, napkins, and meal tickets into the garbage. When asked, she stated that this was the usual process for setting up for dish washing. Tray tickets noted to include resident name, room number, diet order, food allergies, food preferences, and special dietary needs. Subsequent interview with Dietary Manager (DM) on 5/22/24 at 10:38 a.m., DM stated throwing tray tickets into the trash was a problem since trash is brought to the outside dumpsters which is open to the public. As such, this would be a HIPAA (Health Insurance Portability and Accountability Act, a federal law to protect medical and personal health information) violation. During an interview on 5/23/24 at 1:34 p.m., with the Assistant Director of Nursing (ADON), the ADON stated, tray cards need to be shredded and not disposed of in the regular trash. Review of facility provided policy titled Safeguarding PHI Policy revised 3/1/18 indicated the purpose of the policy was to, .establish guidelines to help safeguard Protected Health Information (PHI) from being . disclosed to those not authorized .[facility] employees must reasonable safeguard PHI to limit incidental uses or disclosures .The disposal/destruction of records will be carried out in compliance with all applicable Federal and State laws and shall be done so with the use of technology or methodology that renders the PHI unusable .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48140 Based on observations, interviews and record reviews the facility failed to develop and implement person-centered comprehensive care plans for three residents (Residents 30, 53, and 73) out of 30 sampled residents. This failure decreased the facility's potential to provide appropriate interventions in order for residents to maintain their highest medical and physical practicable level of function. Findings: A review of Resident 30's admission record indicated the resident was admitted to the facility in June 2023 with diagnoses including adult failure to thrive and generalized weakness. A review of Resident 30's Order Summary Report (OSR, physician orders) indicated an order for oxygen at 2 L (liter, a unit of measurement) per minute through a nasal cannula with a start date of 8/4/23. During an observation on 5/21/24 at 8:54 a.m., in Resident 30's room, Resident 30 was observed laying supine (on their back) in bed wearing a nasal cannula (a plastic tube used to deliver oxygen into your nose) connected to an oxygen concentrator (a medical device that provides oxygen) with oxygen running at 2 L per minute (l/min). A review of Resident 30's care plans was conducted on 5/22/24 which indicated Resident 30 did not have a comprehensive or person-centered care plan which included the use of oxygen. A review of Resident 53's admission record indicated admission to the facility in May 2023 with diagnoses which included chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe) and chronic respiratory failure (low blood oxygen levels). A review of Resident 53's OSR indicated an order for oxygen at 3 l/min through a nasal cannula with a start date of 5/18/23. A review of Resident 53's care plans was conducted on 5/22/24 which indicated Resident 53 did not have a comprehensive or person-centered care plan that included the use of oxygen. During an observation on 5/21/24 at 9:37 a.m., in Resident 53's room, Resident 53 was observed lying in bed on her right side wearing a nasal cannula connected to an oxygen concentrator with oxygen running at 3 l/min. 34328 A review of Resident 73's admission record indicated admission to the facility April 2022 with diagnoses which included COPD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 73's physician's orders dated 5/12/24 indicated, Oxygen at 2 [l/min] via NC [nasal cannula] continuous every shift. During an initial tour of the facility on the morning of 5/21/24, Resident 73 was observed in bed and receiving oxygen via nasal cannula (a tube used to deliver oxygen to the nose) from an oxygen concentrator (a machine that pulls oxygen from the surrounding air) at 6 l/min. In an observation, interview, and concurrent record review with the Licensed Nurse 5 (LN 5) on 5/21/24 at 9:30 a.m., the LN 5 confirmed Resident 73 was receiving oxygen at 6 l/min. The LN 5 stated the physician had ordered 2 l/min via nasal cannula. The LN 5 verified Resident 73 had a diagnosis of COPD. The LN 5 was observed to decrease the oxygen flow rate to 2 l/min. The LN 5 also confirmed Resident 73 had a care plan which indicated oxygen was to be delivered at 2 l/min via nasal cannula and stated the care plan was not followed. The LN 5 stated she will call the physician to inform him Resident 73 received oxygen at 6 l/min. During an interview on 5/23/24 at 1:35 p.m. with the Associate Director of Nursing (ADON), the ADON confirmed residents should have an established care plan for the use of oxygen; staff should be aware of the oxygen conditions. The ADON stated, The care plan tells staff how to take care of the resident. The care plan is personalized care for the resident, if there was no direction of care staff would not know how to care for the resident. A review of the facility's policy and procedure titled Oxygen Administration dated August 2014 indicated, . Check the physician's order for liter flow and method of administration .At regular intervals, check liter flow contents of oxygen cylinder .assess resident's respirations to determine further need for oxygen therapy . A review of the facility's policy and procedure titled Care Plan, Comprehensive dated December 2017 indicated, .The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life .Care Plans become a comprehensive tool for the IDT [Interdisciplinary Team, a group of healthcare workers from different aspects of care] to utilize as a reference for identified concerns and approaches to establish guidance for meeting resident individual needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48140 Based on observation, interview and record review the facility failed to revise care plans for two residents (Resident 38 and 82) out of 30 sampled residents when the care plans were not revised within a timely manner. This failure decreased the facility's potential to provide appropriate interventions for the residents to maintain their highest medical and physical practicable level of function. Findings: A review of Resident 38's admission record indicated admission to the facility in August 2017 with diagnoses which included dysphagia (inability or refusal to swallow) and the presence of a gastrostomy tube (G-tube, an opening into the stomach for nutritional support). A review of Resident 38's Order Summary Report (OSR, physician orders) indicated Resident 38's tube feeding order started on 12/24/19. A review of Resident 38's nutritional care plan, revised on 2/15/24, indicated Resident 38 was to receive Jevity (R), therapeutic nutrition, 1.2 at 75 ml (milliliters, a unit of measurement) per hour. During on observation on 5/21/24 at 9:53 a.m. in Resident 38's room, Resident 38 was observed with Jevity (R) 1.2 running through a G-tube at 55 ml per hour. A review of Resident 82's admission record indicated Resident 82 was admitted to the facility in April 2024 with diagnoses which included urinary tract infection and muscle weakness. A review of Resident 82's care plan with an initiated date of 5/6/24 indicated Resident 82 was on antibiotic therapy for a urinary tract infection. A review of Resident 82's OSR as of 5/23/24 which indicated active orders only did not indicate Resident 82 was on an antibiotic. During an interview on 5/23/24 at 1:43 p.m. with the Assistant Director of Nursing (ADON), the ADON confirmed care plans should be revised within 72 hours if there is a change of condition or update to the resident's physician orders; including antibiotics and nutritional status. A review of the facility's policy and procedure (P&P) titled, Care Plan, Comprehensive, dated December 2017, the P&P indicated, Resident progress is regularly evaluated, and approaches revised or updated as appropriate .Problem resolution .in goals and approaches may be identified and initiated by any IDT [Interdisciplinary Team, a group of healthcare workers from different aspects of care] member. 48860 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 77's admission record indicated admission to the facility in late 2023 with diagnoses of absence epileptic syndrome (a brain disorder characterized by episodes of sudden loss of consciousness or convulsions). A review of Resident 77's progress note, dated 5/14/24 on 9:13 p.m. indicated, .New order for O2 [oxygen] via NC [nasal cannula, a tube which delivers oxygen into the nose] @ [at] 2 L . A review of Resident 77's OSR indicated a verbal order for, Oxygen at 2 LPM [l/min] via NC continuous every shift .start 5/15/24 . During an observation and interview on 5/21/24 at 9:32 a.m., Resident 77 was in her bed with an oxygen concentrator on the right side of the bed with the nasal cannula tube lying on the floor. When asked about her oxygen use, the resident replied, They gave that to me and was unable to give more information. During an observation on 5/21/24 at 3:35 p.m., Resident 77's nasal cannula tube was found on the floor by the bedside near the oxygen concentrator. During an interview and concurrent observation on 5/21/24 at 3:40 p.m., with the Certified Nursing Assistant 3 (CNA 3), the CNA 3 stated the Licensed Nurses (LN) were mainly responsible for patients who needed oxygen and tubing should be clean and not dangling on the floor. The CNA 3 also stated if there was an issue with a resident's tubing or oxygen, CNAs were to inform the LNs. The CNA 3 confirmed Resident 77's NC tubing was dated 5/20/24 without initials and was on the floor. The CNA 3 then picked up the NC tubing from the floor and placed it back on Resident 77 without informing the LN. During an interview on 5/21/24 at 3:46 p.m., the LN 8 stated, NOC [nocturnal shift] nurses are in charge of changing and dating oxygen tubing. The LN 8 was unable to state how often NC tubing was supposed to be changed. The LN 8 added CNAs are instructed to ensure the NC tubing is, connected to her [Resident 77]. The LN 8 confirmed Resident 77's physician order indicated, Continuous O2 at 2 [l/min]. The LN 8 also verified nursing staff needed to ensure care plans indicated NC tubing should be connected to the resident and to inform LNs when the NC tubing is found on the floor. On 5/22/24, a review of Resident 77's Medication Administration Record (MAR), dated May 2024, was conducted and indicated the physician's order for oxygen was discontinued on 5/21/24 at 7:45 p.m. On 5/22/24, a review of Resident 77's care plan was conducted regarding, Non-compliance with .plan of care ., which was initiated on 5/17/24, was revised on 5/21/24 to also indicate, and refuses Oxygen via Nasal Cannula. During an interview on 5/23/24 at 1:35 p.m., the ADON stated, Care plans should be updated quarterly, when there was COC (change of condition), PRN (as needed), and within three days or right away. The ADON added, Care plans are important, so we know how to take care of patients. Without care plans there would be no direction of care. The ADON also stated LNs can update and initiate care plans. A review of the facility's P&P titled, Care Plan, Comprehensive, dated December 2017, indicated, Care plans should be developed by the Interdisciplinary Team (IDT), which includes .nursing management .care plans become a comprehensive tool for the IDT to utilize as a reference for identified concerns and approaches to established guidance for meeting resident individual means. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Resident Care Procedures dated December 2017 indicated, .Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths, and individual needs .Resident progress is regularly evaluated, and approaches revised or updated as appropriate .Individualized Care Plan should be accessible to all caregivers.

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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. 34328 Based on observation, interview and record review the facility failed to ensure nursing care was provided per professional standards of quality for one resident (Resident 73) of 30 sampled residents when Licensed Nurses (LNs): 1. Did not ensure informed consent was obtained from Resident 73's Responsible Party (RP, a person who has legal authority to make health care decisions for a person who is unable to for himself) prior to the administration of psychotropic medication (medications that affect the mind, emotions, and behavior); 2. Did not obtain a physician's order to flush Resident 73's midline catheter (a thin, flexible tube inserted into the larger veins in the upper arm used to administer intravenous medication); and, 3. Did not follow the prescribed physician's order for oxygen administered to Resident 73. These failures decreased the facility's potential to provide responsible and accurate nursing care to Resident 73. Findings: 1. A review of Resident 73's admission record indicated admission to the facility in April 2022 with diagnoses which included hemiplegia (complete paralysis of one side of the body) and hemiparesis (partial paralysis of one side of the body) affecting the right side, dementia (the impaired ability to remember, think, or make decisions) with psychotic disturbance, anxiety disorder (a feeling of fear, dread, and uneasiness), personality disorder (patterns of thinking, feeling, and behaving which is different from the expectations of culture which causes distress or problems functioning), major depressive disorder (a persistent feeling of sadness), chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), and a scrotal infection. Resident 73's admission record also indicated the son was the RP for healthcare decisions. A review of Resident 73's physician's order dated 5/24/22 indicated, .MD determines that Resident DOES NOT [sic] the Mental Capacity to make Healthcare decisions as per History & Physical or Transfer orders or preferred intensity of care. A review of Resident 73's Medication Administration Record (MAR), dated May 2024, indicated Resident 73 was prescribed quetiapine (a medication used to treat major depressive disorder) 25 mg (milligram, a unit of measure) by mouth in the morning and at bedtime on 10/15/23. According to the MAR, Resident 73's quetiapine was revised by the physician on 12/28/23 to quetiapine 25 mg one tablet by mouth in the morning and 50 mg by mouth at bedtime. The physician increased Resident 73's quetiapine dose to equal 75 mg daily. A review of Resident 73's medical chart indicated no informed consent discussed between the physician and the RP for healthcare decisions about increasing the total daily dose of quetiapine from 50 mg to 75 mg. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of nursing progress notes, dated 12/28/23 and 12/29/23, did not indicate the RP was made aware and an informed consent was completed before giving the increased dosage of quetiapine at bed time. A review of MARs dated December 2023, January 2024, April 2024, and May 2024 indicated Resident 73 was administered 25 mg of quetiapine by mouth in the morning and 50 mg of quetiapine at bedtime starting on 12/28/23. In an interview with the Assistant Director of Nursing (ADON) on 5/4/24 at 9:06 a.m. the ADON confirmed an informed consent must be obtained by the physician to explain the risks and benefits of the medication to the RP before any psychotropic medications are administered. The ADON stated the Licensed Nurses (LNs) were expected to verify the physician had informed the RP of the risks and benefits of the psychotropic medication before any changes to medication or dosage of medication was administered. The ADON confirmed the physician's notes were not available on the clinical record. The ADON stated the physician will be called and the physician's notes obtained about the informed consent. In a concurrent record review and interview on 5/4/24 at 9:10 a.m., the Social Services Director (SSD) reviewed Resident 73's computerized records and confirmed there were no documented informed consent was obtained by the physician. A review of a facility provided policy and procedure titled Psychotropic Medication Management dated December 2017 indicated, .Purpose .To avoid unnecessary medications and facilitate the proper use, dose, and duration of psychotropic agents in accordance with Resident Assessed need(s) and condition(s) . Informed Consent for psychoactive medications must be verified prior to use . A review of an All Facilities Letter (AFL) 24-07 effective 2/28/24 indicated, .Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided. If the resident or resident's representative cannot sign the form, a licensed nurse can sign the form, a licensed nurse can sign the form and document the name of the person who gave consent and the date .The signed written consent must be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident's health record contains written informed consent with the required signatures . At the conclusion of the survey on 5/24/24, there were no additional physician's notes or documentation provided for Resident 73's completed informed consents. 2. During an initial tour of the facility on 5/21/24, Resident 73 was observed in bed and with an intravenous (IV) pole and an IV pump on the right side of his bed. Two empty bags of IV rocephin (an antibiotic used to treat bacterial infections) hung from the IV pole. Resident 73 was observed to have an IV device in place on the left arm. A review of Resident 73's physician's note dated 5/17/24 indicated, .scrotal pain .had previous orchitis [inflammation of the testicle caused by viruses and bacteria] /scrotal skin infection 10/23 . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an order summary report (OSR, a list of physician's orders) indicated Resident 73 was prescribed, Rocephin sodium intravenous solution reconstituted .1 gram [g, a unit of measure] .at bedtime for cellulitis [a bacterial infection of the skin] of the scrotum for 7 days .[starting on] 5/17/24. The OSR did not indicate an order for Resident 73's midline to be flushed. A review of Resident 73's nursing note dated 5/18/24 at 2:37 p.m. indicated, .[IV line insertion company] came into the building for midline insertion procedure at [1:32 p.m.] .Midline inserted on Left inside of arm . A review of a MAR dated May 2024 indicated Resident 77 had received the IV rocephin via the midline catheter between 5/18/24 and 5/22/24. This MAR did not indicate Resident 77's midline catheter had been flushed between 5/18/24 and 5/22/24. A review of Resident 73's nursing notes between 5/18/24 and 5/22/24 had not indicated any Registered Nurse (RN) flushed Resident 73's midline. In an interview on 5/21/24 at 9:30 a.m., the LN 5 confirmed only RNs may flush midline catheters. The LN 5 confirmed Resident 73's MAR and OSR did not indicate Resident 73's midline had been flushed. A review of an undated policy and procedure titled Central Access Guidelines and Procedures indicated, . Prefilled 0.9% Normal Saline (NS) [a solution used to flush IV lines] syringe for priming and flushing the access device .Document in the IV Medication Record the dressing change, securement device change, cap change for all lumens, flush for all lumens [tubes] . 3. A review of Resident 73's physician's orders dated 5/12/24 indicated, Oxygen at 2 [l/min] via NC [nasal cannula] continuous every shift. During an initial tour of the facility on the morning of 5/21/24, Resident 73 was observed in bed and receiving oxygen via nasal cannula (a tube used to deliver oxygen to the nose) from an oxygen concentrator (a machine that pulls oxygen from the surrounding air) at 6 l/min. In an observation, interview, and concurrent record review with the Licensed Nurse 5 (LN 5) on 5/21/24 at 9:30 a.m., the LN 5 confirmed Resident 73 was receiving oxygen at 6 l/min. The LN 5 stated the physician had ordered 2 l/min via nasal cannula. The LN 5 verified Resident 73 had a diagnosis of COPD. The LN 5 was observed to decrease the oxygen flow rate to 2 l/min. The LN 5 also confirmed Resident 73 had a care plan which indicated oxygen was to be delivered at 2 l/min via nasal cannula and stated the care plan was not followed. The LN 5 stated she will call the physician to inform him Resident 73 received oxygen at 6 l/min. A review of the facility's policy and procedure titled Oxygen Administration dated August 2014 indicated, . Check the physician's order for liter flow and method of administration .At regular intervals, check liter flow contents of oxygen cylinder .assess resident's respirations to determine further need for oxygen therapy .

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F 0676 Level of Harm - Actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47563 Based on observation, interview, and record review the facility failed to ensure one of 30 sampled residents (Resident 43) received services to maintain mobility when Restorative Nursing Aide services (RNA, provides residents with exercises to improve or maintain mobility and independence) were not provided to Resident 43 as recommended by a Physical Therapist (PT, a healthcare professional who specializes in helping residents improve their physical functioning). This failure resulted in Resident 43 not receiving services to maintain her highest practicable physical level of functioning and psychosocial well-being. Findings: A review of Resident 43's admission record, indicated Resident 43 was readmitted in December of 2023, with diagnoses which included spinal stenosis (space around spinal cord becomes too narrow and can cause pain or weakness in arms or legs), dorsopathy (disease of the spine), osteoarthritis (joint pain and stiffness), history of falling, muscle weakness, and abnormalities of gait (a manner of walking) and mobility. A review of Resident 43's Minimum Data Set (MDS, an assessment tool), dated 12/18/23, indicated Resident 43 had moderate cognitive impairment, used a walker (a device used for balance and support while walking) and wheelchair (WC), was able to walk at least 10 feet with partial moderate assistance (helper does less than half the effort) with a goal to be able to walk 10 feet with supervision or touching assistance. A review of Resident 43's MDS, dated [DATE], indicated Resident 43 used a walker and WC and once standing Resident 43 could walk at least 150 feet and make two turns with supervision or touching assistance. A review of Resident 43's self-care deficit care plan (CP), initiated 12/15/23, indicated, .Resident will participate with ADL's [Activities of Daily Living: fundamental skills required to independently care for oneself such as eating, bathing, and mobility] and ADL status will improve by target date . target date 6/25/24 . PT/OT [physical therapy/occupational therapy: physical therapy focuses on the resident's ability to move their body whereas occupational therapy focuses on improving the resident's ability to perform ADLs] evaluation and treatment as per MD [Medical Doctor] orders .[and] .encourage the resident to participate to the fullest extent possible with each interaction . A review of Resident 43's safety CP, initiated 12/21/23, indicated, .Goal: Resident will remain safe . Encourage use of prescribed assistive devices . A review of Resident 40's Order Summary Report, dated 5/24/24 indicated Physical Therapy Clarification Order for skilled PT services for Tx [treatment] Plan .to achieve LTG [long term goal]: SBA [stand by assistance] functional mobility with appropriate use of AD [assistive device] . (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and observation on 5/21/24 at 10:33 a.m. with Resident 43 in her room, Resident 43 was sitting up in a WC with a walker leaning against a wall in her room. Resident 43 explained when she was getting PT, she was doing well walking with the walker. Resident 43 added since PT stopped, no staff have assisted her with using her walker. Resident 43 expressed anger and frustration because without assistance her ability to use her walker has declined and she cannot walk with her walker now. During a concurrent interview and record review on 5/23/24 at 11:45 a.m. with the Area Director of Rehabilitation (ADOR), Resident 43's PT discharge summary dated 4/22/24, was reviewed. The ADOR stated a resident would be discharged from PT when the resident has reached maximum progress in PT, and added, a physical therapist would assess the resident's needs and could make a recommendation for the resident to receive RNAs when discharged from PT. The ADOR stated Resident 43's PT discharge summary from 4/22/24 indicated Resident 43 met her maximum potential when she surpassed her goals for using a walker for 30 feet with minimal assist/contact assist. The ADOR confirmed Resident 43's discharge summary included a recommendation for Resident 43 to start RNAs. During a concurrent interview and record review on 5/23/24 at 12:07 p.m., with the Minimum Data Set Licensed Nurse (MDS LN), Resident 43's CPs and assessments were reviewed. The MDS LN stated she is overseeing the RNAs program for the facility and added, residents could be entered into the RNAs when they are discharged from PT with a recommendation for RNAs. The MDS LN stated the RNAs included providing residents with exercise sessions to maintain/restore their upper and lower body abilities. The MDS LN stated residents who have been recommended to RNAs should have a restorative therapy referral under the assessments tab in the electronic health record (EHR) and an exercise plan on their CP. The MDS LN reviewed Resident 43's CP and assessments in the EHR and stated there was no restorative therapy referral and Resident 43 had not been started on RNAs. During a concurrent interview and record review on 5/23/24 at 12:22 p.m. with the ADOR, Resident 43's PT discharge summary dated 4/22/24 and assessments in EHR were reviewed. The ADOR stated when a resident is recommended to RNAs the MDS LN would be notified by a restorative therapy referral under the assessments tab in the EHR. The ADOR stated there was no referral for restorative therapy in Resident 43's assessments. The ADOR reviewed Resident 43's PT discharge summary and stated the discharge summary indicated Resident 43 could ambulate 30 feet with a walker with supervision/touching assistance and Resident 43's prognosis to maintain her current level of function at PT discharge was good with consistent staff follow-through. The ADOR clarified the prognosis was good if Resident 43 had assistance from Certified Nursing Assistants (CNAs) and RNAs. The ADOR stated a resident who does not receive the RNAs as recommended after their PT discharge could have declines in their level of functioning. During a concurrent interview and record review on 5/23/24 at 12:37 p.m. with the MDS LN, Resident 43's PT discharge summary dated 4/22/24, was reviewed. The MDS LN confirmed Resident 43's PT discharge summary indicated Resident 43 was recommended to start RNAs on 4/22/24 and should have been initiated into the RNAs by 5/23/24. The MDS LN acknowledged a resident who does not received the recommended RNAs could have declines in functioning. The MDS LN disclosed that Resident 43 was not happy with her current level of functioning because she cannot walk and will not be able to walk. An interview on 5/23/24 at 1:01 p.m., the ADOR stated she expected CNAs to tell the PT team if residents are requiring more assistance or experience declines in functioning. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	An interview on 5/23/34 at 1:37 p.m., the Assistant Director of Nursing (ADON) stated she expected residents who are recommended to start RNAs from PT should be initiated into RNAs before a month has elapsed. The ADON acknowledged residents who do not receive RNAs as expected after PT discharge would be at risk for physical declines. An interview on 5/24/24 at 9:43 a.m., CNA 4 stated Resident 43 cannot walk with a walker. An interview on 5/24/24 at 9:47 a.m., CNA 5 stated she has worked with Resident 43 for about two months, stated Resident 43 used to be able to use a walker when she was getting PT but added she has not seen or helped Resident 43 use a walker in over a month. A review of the facility's policy and procedure (P&P) titled, Restorative Nursing Programs, revised 12/2021, indicated, It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level .'Restorative nursing program' refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible .Residents .will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services may include .passive or active range of motion .training and skill practice in transfers or walking .Residents may receive restorative nursing services .upon discharge from therapy .candidates for restorative nursing services may be identified through one or more of the following processes .specialized rehabilitation assessments .in-house referrals .The Restorative Nurse is responsible for maintaining a current list of resident who require nursing services, and for ensuring that all elements of each resident's program are implemented .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49849 Based on observation, interview, and record review, the facility failed to ensure pharmacy services were maintained for a census of 109 residents, when a medication was improperly disposed of in an opened, regular trash can on the side of the medication cart. This failure decreased the facility's potential to prevent: unauthorized staff, residents, and visitors access to prescription drugs, the potential for drug diversion, and medical adverse consequences. Findings: During an inspection of medication cart two on [DATE] at 9:55 a.m., with Licensed Nurse (LN 1), the LN 1 verified there was a loose pill in the medication cart. The LN 1 was observed disposing of the loose pill in an opened, regular trash can on the side of the medication cart. The LN 1 stated, That is the trash can I use for non-narcotic [a class of medications that are not addictive] medications that need to be thrown away. When asked about the risks of throwing medications away in an open trash can, the LN 1 acknowledged throwing the pill in the trash could pose a potential safety hazard, as other people or residents could reach in and take the pill out. During an interview with the Assistant Director of Nursing (ADON) on [DATE] at 11:30 a.m., the ADON acknowledged that pills should not be disposed of in a regular trash can. The ADON stated the expectation for proper pill disposal was to, never throw away pills in a regular trash can because anyone could retrieve that pill .[and to] utilize a pill buster [a medication disposal system] . to dispose of non-narcotic pills. The ADON further acknowledged this was a safety concern. Review of the facility's policy and procedure (P&P) titled, Disposal /Destruction of Expired or Discontinued Medication dated [DATE], the P&P indicated, Facility should place all discontinued or outdated medications in a designated, secured location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction .wasted single doses of medication for disposal should be disposed of in a manner that limits access to them by unauthorized personnel and residents.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49849 Based on interview and record review, the facility failed to ensure two residents (Resident 80 and Resident 93) of 30 sampled residents had adequate indications for the use of psychotropic medications (drug prescribed to affect the mind, emotions, or behavior) when: 1. Resident 80 was administered olanzapine (a psychotropic medication indicated for psychosis); and, 2. Resident 93 was administered aripiprazole (a psychotropic medication indicated for psychosis). This failure decreased the facility's potential to prevent residents from experiencing adverse effects such as sedation, falls and abnormal involuntary movements from the use of antipsychotic medication. Findings: 1. A review of Resident 80's admission record indicated admission to the facility in February 2023 with diagnoses which included hemiplegia (paralysis that affects one side of your body) and hemiparesis (muscle weakness that affects one side of your body) following a cerebral infarction (blockage of blood flow in the brain causing brain damage due to a loss of oxygen to the area), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and altered mental status. A review of Resident 80's care plan initiated on 2/22/23 indicated Resident 80 was at risk for falls and injuries. A review of Resident 80's Minimum Data Set (MDS, an assessment tool), dated 4/19/24, indicated Resident 80 had a moderate memory problem and exhibited no indicators of psychosis, such as hallucinations (sensory experience of something not present); delusions (an impression or belief not based on reality); or verbal or physical behavioral symptoms directed toward others. A review of Resident 80's order summary report indicated a physician's order for olanzapine 5 mg (milligram, a unit of measure) to be given every six hours for, .psychotic behavior starting on 5/13/24. On 5/16/24, Resident 80 received a physician's order to discontinue olanzapine 5 mg for, psychotic behavior manifested by yelling out because, .[Responsible party, RP] does not consent. During an interview on 5/23/24 at 11:45 a.m., with Certified Nurse Assistant (CNA 1), the CNA 1 stated Resident 80 seemed confused at times, yelled and was sometimes agitated. The CNA 1 further stated, [Resident 80] is redirectable .I feel safe taking care of her. During an interview on 5/23/24 at 11:50 a.m., with Licensed Nurse (LN 4), the LN 4 stated, I know [Resident 80] well .She has some behaviors .she yells but she is redirectable. She is not a threat to herself or others. I am not aware of her ever hitting anyone or any residents. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/24 at 1:55 p.m., with Nurse Consultant (NC) and the Assistant Director of Nursing (ADON), the ADON stated, .[Resident 80] is confused and will ask for her son. Son originally agreed to have his mom on olanzapine, then he wanted it discontinued because he said it caused [her] more distress. The NC stated, We are aware that the documentation does not support the indication for the antipsychotic medication for the resident [Resident 80]. According to DailyMed, a nationally recognized drug reference, olanzapine's potential adverse effects and warnings included motor and sensory instability, dizziness, drowsiness, and increased risk of falls and fractures. During an interview with the Nurse Practitioner (NP 1) on 5/23/24 at 2:55 p.m., the NP 1 stated, I would not have prescribed anything for her. I would have started with counseling and referred her to LCSW [Licensed Clinical Social Worker] for non-pharm [does not involve the use of medication] interventions and tried a psychologist. The documentation did not support she had psychotic symptoms .the documentation did capture yelling. I know her son originally wanted mom on olanzapine, then changed his mind. During a phone interview with the facility's Consultant Pharmacist (CP) on 5/23/24 at 3:20 p.m., the CP stated, .I could not give you a clear answer on her level of depression. I see here now that she did have olanzapine but that is discontinued. Depression does not seem like a clinical indication for her to be on an antipsychotic. I would have questioned it if I did a review, but it has not come under my review yet. During an interview with the NP 2 on 5/23/24 at 4:30 p.m., the NP 2 stated she came from an acute care hospital setting. The NP 2 stated, I do not know all the regulations for the skilled nursing side. I am not used to the prescribing parameters for this population. Since I am new here, we do not have psych notes in [Electronic healthcare record (EHR) a digital platform used by healthcare professionals to document and manage patient information]. I did not know psychiatric medications were monitored so closely by CMS [Centers for Medicare and Medicaid Services]. The NP 2 reported a nurse told her Resident 80 was very agitated, looking for her son, yelling out and agitated with other residents. The NP 2 further stated, I do not know of her being a harm to others or herself .I only spoke to one nurse, but son did agree to have mom take olanzapine, then he wanted lorazepam discontinued .I am used to prescribing olanzapine short term in acute care because lorazepam is addictive, and they can become hooked up on that .lorazepam can be used as a chemical restraint. I referred her to neuro [Neurology] for dementia [a medical condition that impairs a person's ability to make decisions] evaluation and son wants to wait to see what result is before any more changes. The NP 2 acknowledged environmental factors could have contributed to behaviors. The NP 2 further acknowledged the diagnosis of schizoaffective disorder (a mental health disorder marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) was added 5/23/24. The NP 2 stated, I called and spoke to the physician, and we added it [diagnosis]. The NP 2 acknowledged to prescribe antipsychotic medications, there should be psychotic symptoms for indication. The NP 2 acknowledged documentation in the charting did not support the indication for the use of antipsychotic medication. The NP 2 further stated, I did not have my documentation in [EHR]. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/24/24 at 1:58 p.m. with Resident 80's RP, the RP stated, [Resident 80] got worse with olanzapine. The RP reported he wanted olanzapine and lorazepam discontinued. The RP reported the antidepressant medication was working and Resident 80 was calm while on it. The RP further stated, She has some behaviors. They called me about, but all those situations were caused by taking that new medication and I don't want her on that. 2. A review of Resident 93's admission record indicated admission to the facility in February 2024 with diagnoses which included depression, anxiety (a chronic feeling of fear, dread, and uneasiness), and muscle weakness. A review of Resident 93's care plans, initiated on 2/22/24, indicated Resident 93 was at risk for falls and injuries was at a high risk for abnormal bruising and bleeding due to anticoagulant (medication used to prevent blood clots) therapy. A review of Resident 80's order summary report indicated a physician's order for aripiprazole 10 mg for, mood disorder manifested by anger outbursts. According to DailyMed, aripiprazole's potential adverse effects and warnings included sedation, dizziness, and increased risk of falls and injuries. A review of Resident 93's MDS dated [DATE] indicated Resident 80 had mildly memory problems and exhibited no indicators of psychosis, such as hallucinations (sensory experience of something not present); delusions (an impression or belief not based on reality); or verbal or physical behavioral symptoms directed toward others. During an interview on 5/23/24 at 11:55 a.m., with LN 6, the LN 6 reported she knew Resident 93 and stated, He's great! The LN 6 stated he tells staff when he feels sad and is redirectable. The LN 6 further stated, He gets lonely if he is in his room by himself, so he gets out in the halls and [attends] activities that help his mood. He feels better when he is social. The LN 6 further stated the resident had an episode of suicidal ideation last week, went to the hospital, and was placed on one-to-one observation (one staff member assigned to monitor one resident). The LN 6 reported after his return from the hospital, the NP 2 changed his medication from an anti-anxiety medication to an antipsychotic medication-aripiprazole. During an interview on 5/23/24 at 12 p.m., with CNA 2, the CNA 2 stated, [Resident 93] is out right now. He is better being out. The CNA 2 reported she knew the resident well and he was a nice guy. The CNA 2 further stated when Resident 93 was sad he would tell her he was, not good today. The CNA 2 further stated he feels better when he was around people. The CNA 2 stated, I hold his hand and he says he feels better. The past few days he has been more anxious .like he asks to get up out of bed, then 20 minutes later, he wants to get back in bed then back up again .like he can't rest. During an interview on 5/23/24 at 1:55 p.m., with the ADON and the NC, the ADON stated, [Resident 93] suffers from depression. He isolates himself and wants to be alone. The ADON reported she was aware Resident 93 was prescribed an anti-anxiety medication, but stated the physician recommended to change it to an antipsychotic medication. The NC stated, We are aware that the documentation does not support the indication for the antipsychotic medication for the resident [Resident 93]. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with NP 1 on 5/23/24 at 2:55 p.m., the NP 1 stated she was aware Resident 93 had depression and had a situation recently. The NP 1 reported she saw him out in the halls. During a telephone interview on 5/23/24 at 3:20 p.m. with the CP, the CP reported she was not aware of the algorithm for treating depression. The CP stated, I see he has [buspirone, medication used to treat anxiety] 10 mg every eight hours .He has an order for aripiprazole .there was room to increase the [buspirone] dose. The CP acknowledged Resident 93 was not on the maximum dose of buspirone. During an interview with the NP 2 on 5/23/24 at 4:30 p.m., the NP 2 stated, Based on my assessment [Resident 93] had adjustment disorder and depression .when he talked about Oregon and cars, he would be happy and when he talked about being here, he would be sad .he had mania symptoms and depression, so he is bipolar. The NP 2 acknowledged antipsychotic medications increased the risk for falls. The NP 2 acknowledged Resident 93 utilized a wheelchair which further increased his risk for falls. The NP also stated she prescribed aripiprazole because it helped with suicidal ideation and depression. The NP verified Resident 93's diagnosis of schizoaffective disorder was also added on 5/23/24. A review of the facility's policy and procedure titled Psychotropic Medication Use revised on October 2022 indicated, Psychotropic medication is prescribed for a diagnosed condition and not being used for convenience or discipline .Facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, social or environmental cause of the resident behaviors .All medications used to treat behaviors must have a clinical indication .Antipsychotic medications used to treat Behavioral or Psychological Symptoms of Dementia must be clinically indicated, be supported by an adequate rationale for use and may not be used for a behavior with an unidentified cause .Where Physician/Prescriber orders a psychotropic medication for a resident, Facility should ensure that Physician/Prescriber has conducted a comprehensive assessment of the resident and has documented in the clinical record that the psychopharmacologic medication is necessary.

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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. 49849 Based on observation, interview, and record review the facility failed to ensure the medication error rate did not exceed 5% (five percent) for one resident (Resident 712) of 30 sampled residents when Licensed Nurse 3 (LN 3) administered Resident 712's medications not in accordance with standard nursing principles and practices or the facility policy. This failure resulted in a medication error rate of 30.3%. Findings: During an observation on 5/21/24 at 8:08 a.m. of a medication administration through a gastrotomy tube (GT, also known as a Peg-tube, a placed into a patient's stomach through the abdominal wall), the LN 3 was observed crushing six pills together and at the same time. The LN 3 immediately placed the crushed pills in a 110 milliliter (ml, a unit of measure) medication cup with two liquid medications and two powdered medications. The mixture of the crushed pills, powdered medication and liquid medication were administered at the same time in a bolus (medical administration given all at one) administration with a 60 ml syringe, in two parts through the GT. The LN 3 did not flush between the first and second bolus administration. A review of Resident 712's order summary report (physician orders) printed 5/21/24 indicated no active orders for Resident 712 to receive a bolus medication administration via the GT. A reconciliation of Resident 712's Medication Administration Record dated May 2024 indicated the following orders: 1. Sennosides 8.6 mg [milligram, a unit of measure]- give two tablets via Peg-tube every 12 hours for constipation; 2. Multi-vitamin- give one tablet via Peg-tube one time a day for supplement; 3. Folic acid 1 mg- give one tablet via Peg-tube one time a day for supplement; 4.) Levetiracetam 100 mg/ml- give 5 ml via Peg-tube two times a day for seizures; 5.) Lactulose 20 gm per 30 ml via Peg-tube one time a day for hyperammonemia [a medical condition caused by high levels of ammonia in your blood]; 6.) Silodosin 8 mg- give one capsule via Peg-tube for urine retention; and, 7.) Polyethylene glycol 17 gm [grams, a unit of measure] per scoop- give 17 gm via Peg-tube one time a day for bowel care. Mix with 4-8 oz [ounces, a unit of measure] of liquid. (continued on next page)

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Courtyard Health Care Center	1850 East 8th Street Davis, CA 95616

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/24 at 2:16 p.m., with the LN 3, the LN 3 stated she always mixed all of Resident 712's medications all together in one administration. The LN 3 verified the medications were all mixed together and the medications were not completely mixed or dissolved in the cup together and it had a brown foam on top. The LN 3 acknowledged there could be an issue with incompatibility of the medications when mixed in one administration and acknowledged if the resident refused one of the medications which were already mixed, she would have to waste all the meds since she could not separate one medication out. The LN 3 stated she was not aware of a policy and procedure for GT medication administration. During an interview on 5/23/24 at 11:30 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the expectation is to give each medication separately and to flush between each medication administration. During a review of the facility's policy and procedure (P&P) titled, Medication Administration through an Enteral tube dated January 2022, the P&P indicated, Facility should administer each medication separately and flush the tubing between each medication administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49849 Based on observation, interview, and record review, the facility failed to ensure medications were stored in a clean and sanitary environment and labeled correctly with open and discard dates, when: 1. A loose pill was found in medication cart 2; 2. A medication cup was found stored in the top drawer of medication cart 2, containing 11 loose pills and was not labeled with resident's name or drug identifiers; 3. An opened inhaler and eye drops were not dated with open or discard dates in medication cart 2; and, 4. A medication blister pack found displaced and in the back of medication cart 1. These failures decreased the facility's potential to prevent drug diversion and medication administration errors. Findings: 1. During an inspection of medication cart two on 5/22/24 at 9:55 a.m. with Licensed Nurse 1 (LN 1), the LN 1 verified there was a loose pill in the medication cart. During an interview with the Assistant Director of Nursing (ADON) on 5/24/24 at 11:30 a.m., the ADON acknowledged having loose pills in the medication cart was an issue. The ADON stated, NOC [night] shift should be checking for loose pills and blister packs. They are the ones responsible to clean the carts. 2. During an inspection of medication cart two on 5/22/24 at 9:55 a.m. with LN 1, the LN 1 verified there was a medication cup containing 11 pills, stored in the top drawer of medication cart two. The LN 1 further confirmed this medication cup which contained 11 loose pills, was not labeled with a resident's name or drug identifiers. The LN 1 stated, This resident was outside smoking when I went to give him his medications. I saved his medications in this cup, so I wouldn't have to throw them away. During an interview with the ADON on 5/23/24 at 11:20 a.m., the ADON acknowledged having a medication cup, containing 11 loose pills with no patient or drug identifiers, stored in the top drawer of a medication cart was an issue. The ADON stated, Nurses should never pre-pour pills. The ADON acknowledged this was an improper practice and stated, Anyone could take those pills. The ADON reported the expectation was for nurses to open and give pills when in front of the resident and after identifying the correct resident and the medication order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure (P&P) titled, Storage and Expiration Dating of Medication and Biologicals dated January 2022, indicated, Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers . A review of facility's P&P titled, General dose preparation and Medication Administration revised on 4/30/24, indicated, Ensure that dose preparation areas are well lit and medication carts are clean, properly stocked and organized. 3. During an inspection of medication cart two on 5/22/24 at 9:55 a.m. with LN 1, the LN 1 verified there were no open and/or discard dates on three bottles of eye drops and one: -cyclopentolate [hydrocholoride] 1% drops [eye drops used to dilate eyes] opened and without an open or discard date; -brimonidine tartrate 0.2% drops [eye drops used to lower pressure in the eye] without a discard date; -prednisolone acetate drops [eye drops used to reduce swelling and irritation in the eyes] without a discard date; and, -fluticasone propionate and salmeterol inhaler [an inhaler used to control wheezing and shortness of breath] opened with 53 uses and without an open or discard date. During an interview with the ADON on 5/23/24 at 11:20 a.m., the ADON acknowledged not having an open or expiration date on inhalers and eye drops in the medication cart was an issue. The ADON stated the expectation was to label pharmaceutical products with an open date and to dispose of them after 28 days. The ADON acknowledged after 28 days these pharmaceutical products should have been discarded. The ADON further stated, The nurses have all pharmacy information in the binder, in all medication carts and should know when the medications should be discarded. A review of the facility's P&P titled, General dose preparation and Medication Administration revised on 4/30/24 indicated, Facility staff should enter the date opened on the label of medications with shortened expiration dates . A review of the facility's P&P titled, Storage and Expiration Dating of Medication and Biologicals dated January 2022 indicated, Once a medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened .when an ophthalmic solution or suspension has a manufacturer shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container. The facility was unable to provide a policy addressing the 28-day discard date requirement. 4. During an inspection of medication cart 1 on 5/22/24 at 10:31 a.m., with LN 2, the LN 2 verified there was a medication blister pack displaced and in the back of the medication cart. The LN 2 stated, The blister pack should not be there .maybe it fell back because the cart was over-filled, and it fell back there. NOC shift is supposed to check the carts at night .it could lead to a resident missing a medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADON on 5/23/24 at 11:20 a.m., the ADON acknowledged the blister pack should not be displaced and in the back of the medication cart. The ADON stated it was a safety concern. The ADON stated, NOC shift should be checking for loose pills and blister packs. They are the ones responsible to clean the carts.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49950 Based on observation, interview, and record review the facility failed to ensure pureed (cooked food blended to the consistency of a cream paste) foods were prepared in a manner that conserved nutritive value and palatability (taste) when foods were thinned with an unmeasured amount of tap water or liquid from the can containing the food. This failure decreased the facility's potential to ensure food met resident nutritional needs and was flavorful. Findings: During an observation and concurrent interview on 5/22/24 at 9:08 a.m., Cook 1 (CK 1) was preparing pureed roast beef. The CK 1 opened a bag of precooked roast beef and drained off the liquid. The CK 1 placed meat in blender and added an unmeasured amount of hot tap water. The CK 1 blended the roast beef and water until the mixture was a smooth, pureed texture. The CK 1 proceeded to blend a second batch of roast beef which was too watery and needed to be corrected to thicken the product. The CK 1 next made mashed sweet potatoes by placing canned sweet potatoes and an unmeasured amount of liquid from the can into the blender. After finishing the product, CK 1 stated she should have used milk to thin the sweet potatoes instead of the canned liquid, according to the recipe. During a review of the facility provided standardized recipe titled, Pureed Meats dated 2024, the recipe indicated, .gradually add warm liquid (low sodium broth or gravy) .the recommended amount of liquid for 12 servings of meat is 12- 24 oz [ounces, a unit of measurement] of liquid. During a review of the facility provided standardized recipe titled, Mashed Sweet Potatoes dated 2024, the recipe indicated, .mash the potatoes .add milk and margarine .mix together well .the recommended amount of milk for 96 servings is 1 1/2 qts [quarts, unit of measurement] .the recommended amount of margarine for 96 servings is 1 lb [pound, a unit of measurement]. During an interview on 5/24/24 at 9:49 a.m. with the Dietary Manager (DM), the DM stated the expectation was for dietary staff to follow the recipes in the book. The DM further stated for pureed diets; the dietary staff should count out portions, ground down the meat, add measured amount of gravy/broth, blend and add small amounts liquid as needed. The DM further stated if a recipe was not followed for a pureed diet, this can affect nutritional value and flavor.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46242 Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and distributed in accordance with professional standards for food service safety when: 1. There were no functional thermometers for dry storage room monitoring and for internal temperature monitoring for freezer #1; 2. There were incomplete records of daily temperature logs for refrigerators, freezers, and dry storage area; 3. Food items were not properly labeled or sealed and expired foods were not discarded; 4. The racks in refrigerator #2 and refrigerator #3 had rust on the surface and were unable to be readily sanitized; 5. The facility did not install or maintain a drain air gap in the sink used to prepare fruits and vegetables; 6. The facility did not maintain a clean can opener; 7. The facility did not ensure the exterior surface of the dishwasher and drawers containing kitchen utensils were clean; 8. The kitchen surfaces were stained, had chipped paint, and missing floor tiles; 9. Kitchen staff did not perform hand hygiene when moving from dirty to clean surfaces; 10. Kitchen staff did not properly fill the red sanitizer bucket with correct concentrations of sanitizer; 11. There were incomplete records of concentration tests and temperature logs for the red sanitizer bucket and dishwasher disinfectant; and, 12. Kitchen staff were unable to verbalize the manual dishwashing procedure with correct sanitizer solution used. These failures decreased the facility's potential to prevent food borne illness for the 103 residents who ate facility prepared food out of census of 109. Findings: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a concurrent kitchen observation and interview on [DATE] which started at 8:48 a.m. with the Dietary Manager (DM), the reach-in freezer #1 was observed without an internal thermometer. In the dry storage room, the thermometer indicated a temperature of 38 degrees Fahrenheit (deg. F., a unit of measurement). When checked against surveyor's calibrated thermometer, the thermometer indicated a temperature of 76 deg. F. A Pantry Storeroom Temperature Log dated [DATE] was posted in the room and indicated, Temperature range for storeroom [should be between] ,d+[DATE] degrees F [Fahrenheit]. The DM agreed the dry storage room thermometer was not working properly and needed to be replaced. The DM further stated the freezer should have a thermometer inside it for accurate temperature monitoring. The DM agreed functional thermometers were needed to ensure foods were stored within acceptable temperatures to ensure food quality. A review of facility policy and procedure (P&P) titled Food Safety in Receiving and Storage, dated February 200, indicated, Food is received and stored by methods to minimize contamination and bacterial growth .A thermometer will be kept in each refrigerator and freezer unit. A review of California Department of Education publication titled Proper Storage Temperatures for USDA Foods, revised [DATE] indicated, Dry Storage .Many items such as canned goods, baking supplies, grains, and cereals may be held safely in dry storage areas .Store dry foods at 50 F [deg. F.] for maximum shelf life. However, 70 F [deg. F.] is adequate for dry storage of most products. 2. During a concurrent kitchen observation and interview on [DATE] commencing at 8:48 a.m. with the DM, three reach-in freezers #1, #2 and #3 and three reach-in refrigerators #1, #2, and #3 and a dry storage room were observed with posted temperature monitoring logs. All observed temperature logs were dated [DATE]). The freezer and refrigerator logs had columns for temperature entries twice a day and marked AM [morning] and PM [afternoon]; the dry room temperature log had a column for temperature entry once a day. All observed refrigerator and freezer logs were incomplete and did not have any temperature data entered for the entire day on [DATE]-2 and [DATE]-13. Several other dates had only one entry for the day. The dry storage room log had no temperature entered for [DATE]-5, ,d+[DATE], and ,d+[DATE]. The DM confirmed the missing data in the logs and agreed the logs were supposed to be completely filled out and up to date for temperature monitoring and ensuring food quality. A review of the facility's P&P titled Food Safety in Receiving and Storage, dated February 2009, indicated, Food is received and stored by methods to minimize contamination and bacterial growth .Cooler and freezer temperatures will be checked and recorded daily, using the internal thermometers .Temperatures not in the appropriate range should be reported to the Food and Dining Services Manager, or maintenance, immediately .Refrigerated foods should be 41 degrees F [deg. F.] or below; frozen foods should be 0 degrees F or below . 3. During an initial kitchen tour on [DATE] at 8:08 a.m. the following issues were observed: -A box of vanilla wafers was not tightly closed, and fish fillets in the freezer were not covered and had freezer burn. -Multiple food items lacked proper labels for received, use by, or expiration dates: a bag of fish fillets, 14 hamburger patties, two trays of pudding, one tray of pureed brownie, one tray of thawed nutritional shakes, one bottle of opened olive oil, 10 pounds of white rice, six bottles of seasoning, and one bag of mashed potatoes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One container of brown sugar was mislabeled as brown rice and one container of white rice was mislabeled as white beans. -A gallon of milk with an expiration date of [DATE] was in the refrigerator. During an interview on [DATE] at 9:09 a.m., with the DM, the DM confirmed food items found in the kitchen freezers and refrigerators, as well as the dry pantry did not have labels on them or were mislabeled and should be tightly sealed. During a concurrent observation and interview on [DATE] at 9:21 a.m., the DM confirmed there was an expired gallon of milk in the refrigerator. The DM further stated the expired milk should have been disposed during daily rounds. During an interview on [DATE] at 9:49 a.m., with the DM, the DM stated the expectation was food items in the kitchen including the refrigerator, freezer, and dry pantry should be labeled with an open, use by, and expiration date. The DM further stated if kitchen items are not labeled correctly, this can be a risk for having expired food items in the kitchen. During a review of the facility's P&P titled, Food Safety in Receiving and Storage, effective February 2009, indicated, .food will be inspected when it is delivered to the facility and prior to storage for contamination . signs of contamination include .large ice crystals .solid areas of ice .discolored or dried out foods .expiration dates and use-by dates will be checked to assure the dates are within acceptable parameters .food that is repackaged .will be labeled with name of the contents and dated with the date it was transferred to the new container . During a review of the Food and Drug Administration (FDA) Food Code 2022, 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 .mark the date or day of preparation, 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 . 4. During a concurrent kitchen observation and interview on [DATE] commencing at 8:48 a.m. with the DM, two reach-in refrigerators #2, and #3 were observed with racks with peeling paint on the edges and exposed dark, orange, rough material with some discolored deposits. The DM confirmed the observations and agreed the racks presented sanitation challenges and increased the potential for cross-contamination. A review of facility P&P titled Food Safety in Receiving and Storage, dated February 2009, indicated, Food is received and stored by methods to minimize contamination and bacterial growth . A review of the FDA Food Code 2022 indicated, Nonfood-Contact Surfaces shall be free of .crevices, and designed and constructed to allow easy cleaning . 5. During the initial kitchen tour on [DATE] at 9:53 a.m., an air gap was not found under the fruit/vegetable wash sink. The DM confirmed there was no visible break in the line going to the sewer. During an interview on [DATE] at 4:15 p.m. with the Maintenance Director (MD), the MD confirmed there was not an air gap on the fruit and vegetable wash sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the U.S. Department of Agriculture 2022 Food Code indicated, During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system .The water outlet of a drinking water system must not be installed so that it contacts water in sinks, equipment, or other fixtures that use water. Providing an air gap between the water supply outlet and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow. 6. During a concurrent kitchen observation and interview on [DATE] at 9:41 a.m. with the DM, near the kitchen sink by the entry to the dry storage are, a can opener was observed with dark residue buildup around the blade. The DM confirmed the observation and stated the can opener was supposed to be cleaned after each use. A review of the FDA Food Code 2022 indicated, Equipment food-contact surfaces and utensils shall be cleaned .At any time during the operation when contamination may have occurred. 7. During a concurrent kitchen observation and interview on [DATE] around 9:52 a.m. with the DM, the utensil storage drawers and dishwashing machine were inspected. The drawer underneath the steamer and the drawer by the sink where the blender was located contained kitchen utensils and had discolored spots and particles inside of it. The top of the dishwasher had heavy brown-white crusted residue in the corners. The DM confirmed the drawers and the dishwasher were not clean and needed cleaning. A review of the FDA Food Code 2022 indicated, Equipment food-contact surfaces and utensils shall be cleaned .At any time during the operation when contamination may have occurred .NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 8. During the initial kitchen tour on [DATE] at 9:10 a.m., the ceiling was noted to have a discolored patch approximately 1.5 feet wide and 3 feet in length. The DM stated it looked like an old leak, but it would have been before she had started. During the kitchen tour on [DATE] at 10:07 a.m., the dishwashing area walls, and ceiling were noted to have areas of chipped paint, as well as markings of dark particles. A tile under the dish machine was cracked and had missing areas. The DM confirmed the area was dirty and the floor had missing tile. She further explained they would increase the possibility of cross contamination. During an interview on [DATE] at 4:15 p.m. with the MD in the kitchen, he confirmed the patch in ceiling was due to previous leak which had never been completed. He also confirmed the need for paint in the kitchen and dishwasher area. He also concurred the tile in the dishwash area needed to be repaired. A review of the FDA Food Code 2022 indicated, Hard-to-clean areas could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms .materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be .smooth, durable, and easily cleanable for areas where food establishment operations are conducted .Physical facilities shall be maintained in good repair .Physical facilities shall be cleaned as often as necessary to keep them clean . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. During a concurrent kitchen observation and interview on [DATE] at 4:28 p.m. with the DM, Dietary Aide (DA 2) was observed demonstrating dishwasher use. The DA 2 placed unwashed ice tray from the dirty side of the dishwasher (on his right side), closed dishwasher doors, and completed washing cycle. Without performing hand hygiene, the DA 2 proceeded to open the dishwasher doors and pulled out washed ice tray to the clean [left] side of the dishwasher. The DM confirmed the DA 2 did not perform hand hygiene when moved from dirty to clean sides and handling the cleaned tray. During a tray line observation on [DATE] in the kitchen around 12:43 p.m., three surveyors observed food being plated and placed on the trays and loaded to the meal carts for distribution. The DA 1 was observed several times using her hands to adjust face mask. Without performing hand hygiene DA 1 continued touching meal tray items including plates, desserts and placing eating utensils on the tray. In an interview on [DATE] at 9:42 p.m. DM confirmed staff needed to perform hand hygiene after touching face or face mask and before handling food trays and utensils. A review of the FDA Food Code 2022 indicated, The hands are particularly important in transmitting foodborne pathogens .any activity which may contaminate the hands must be followed by thorough handwashing .The hands of employees can be contaminated by touching their nose or other body parts. 10. During concurrent observation and interview on [DATE] at 9:57 a.m. with DA 3 and DM, the DA 3 demonstrated filling up the red bucket with sanitizer solution. She grabbed an empty bucket and placed it in the sink under two automatic dispenser outlet hoses (adjacent to each other). The dispenser contained one hose for sanitizer and one hose for foaming detergent. The DA 3 pressed both dispensing buttons at the same time. The DA 3 filled the bucket approximately halfway with the mixture and then added hot water from the sink to fill up the bucket. The DA 3 stated mixing the two products was the way she had been taught. The DM intervened and stated this was not the correct way to fill up the sanitizer solution bucket and confirmed the provided mixture would be below effective sanitizer concentration. The DM dumped the bucket contents and filled it up using dispenser for sanitizer only (without foaming detergent or additional water). The DM tested the quaternary ammonia (sanitizing agent) concentration level and the color strip indicated effective sanitizer concentration at 200 parts per million (ppm, a unit of measurement). A review of facility's P&P titled Chemical Sanitizing, dated February 2009, indicated, Proper concentration of chemicals will be used to sanitize equipment and work surfaces after cleaning .Clean the surface or equipment. Use a solution of all purpose detergent and hot water .Rinse off detergent .Dilute the sanitizing agent to proper strength .Ammonia 200 ppm .For equipment that cannot be put in water, use double strength sanitizer and water .Ammonia 220 ppm .Completely dip in sanitizing solution for one minute or spray with double strength sanitizing solution .Allow to air dry. 11. During a concurrent interview and record review on [DATE] commencing at 9:21 a.m., the logs for the current month were reviewed with the DM and found to have missing entries. The red bucket sanitizer log had 5 columns for solution concentration records for each calendar day. No data was entered for the entire day on the following dates: [DATE], [DATE], and [DATE]. The DM confirmed the log was incomplete and was supposed to be completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055922	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Health Care Center	1850 East 8th Street Davis, CA 95616

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] commencing at 9:21 a.m. with DM, the dishwasher sanitizer concentration and temperature log for the current month was reviewed and contained the following directions, Record wash and rinse temperatures of the dish machine daily at the beginning of each meal .Also, dishes must be sanitized with a chlorine, iodine, or quaternary ammonia solution containing a minimum of ,d+[DATE] ppm .Chlorine .or ,d+[DATE] ppm quaternary ammonia. No chemical concentration entries were made for lunch time [DATE]-23 and for dinner time of [DATE]-19 and temperature entries were not completed for lunch time [DATE]-23 and for dinner time [DATE]-23. The DM confirmed the log was incomplete and was supposed to be completed. A review of facility's P&P titled Dish Machine Usage, dated February 2009, indicated, .Check the temperature of the wash and rinse cycles .check the sanitizer level using a litmus strip test [color changing indicator strip]. Temperatures should be checked at the beginning of each meal. Record data on the dish machine temperature log. 12. During a concurrent observation and interview on [DATE] at 10:11 a.m. with the DA 3, the DA 3 was observed working in the dishwashing area and was asked about process for manual dishwashing. The DA 3 stated they would use four buckets for the following steps: prewash, wash, rinse, and sanitize. She was unable to state what sanitizer and at what concentration would be used for the sanitation step. In an interview on [DATE] at 9:42 a.m. with the DM, the DM agreed staff needed to be knowledgeable of the manual dishwashing process to ensure the dishes are cleaned and sanitized properly. A review of facility's P&P titled, Manual Cleaning & Sanitizing, dated February 2017, indicated, A three-compartment sink is used for manual washing, rinsing and sanitizing utensils and equipment . Sanitizing Method: immersion for at least 30 seconds in clean hot water at 171 degrees F [deg. F.] or hotter . Immersion for at least 7 seconds in sanitizing solution containing at least 50 ppm of chlorine at 75 degrees F [deg. F.] or hotter .Immersion for at least 30 seconds in a sanitizing solution of 220 ppm of quaternary ammonia at 75 degrees F [deg. F.] or hotter .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055922	A. Building B. Wing	05/24/2024

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 46242 Based on observation, and interview, the facility failed to maintain two reach-in freezers (freezer #1 and #3) and two reach-in refrigerators (refrigerator #2 and #3) in safe operating condition when door seals were observed with tears or gaps and did not provide a complete seal. This decreased the facility's potential to ensure food safety and quality for 103 residents who ate facility prepared meals with a census of 109. Findings: During the initial kitchen tour on 5/21/24 at 8:48 a.m. with the Dietary Manager (DM) reach-in refrigerator and freezer doors were checked for complete seals. The seal on freezer #1 had two gaps in two opposite corners about one inch wide. The freezer #3 had two gaps in the bottom corners of the door: one gap at the door hinge side about one inch wide, and on the opposite corner gap under one inch wide. The refrigerator #2 had two smaller gaps at the bottom (under one inch) and a black tape covering majority of the bottom seal. The refrigerator #3 had torn seal on the unhinged part of the door with about 2-3 inches of seal material hanging down. The DM confirmed the seals were broken and needed to be replaced and stated it was being looked at by maintenance. In an interview on 5/21/24 at 4:15 p.m. with the Maintenance Director (MD), the MD confirmed the seals on some refrigerators and freezers were broken and needed replacement. The MD stated he was making some phone calls to the manufacturers looking for suitable replacement parts, but he was not able to provide any quotes or other written proof of the progress in obtaining new seals. A review of the United States Food and Drug (FDA) Food Code 2022 indicated, EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2 EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. The FDA Food Code 2022 further indicated, Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk. For example, refrigeration units in disrepair may no longer be capable of properly cooling or holding time/temperature control for safety foods at safe temperatures.