STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056042	A. Building B. Wing	06/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Vista Healthcare & Wellness Centre, LP	5901 Downey Ave Long Beach, CA 90805

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Deficiency Text Not Available

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview and record review, the facility failed to ensure residents receiving hemodialysis ([HD], a medical procedure to remove fluid and waste products from the body) provided necessary care and services for two of two sampled residents (Resident 47 and 26). The facility failed to: a. Ensure Resident 47's blood pressure check was not measured using the left arm with the arteriovenous shunt ([AV] a connection that was made between an artery and a vein for dialysis access). This deficient practice had the potential to interrupt the blood flow to the arm and may cause the AV shunt to stop working. b. Accurately measure Resident 47 and 26's intake and output when a full pitcher of water was left and within reach for Resident 47 and Resident 26. This deficient practice had the potential to cause fluid overload (too much water in the body) for Resident 47 and Resident 26. Findings: a. During a review of Resident 47's Admission record, the Admission Record indicated Resident 47 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD- a condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis and hypertension (high blood pressure). During a review of Resident 47's Minimum Data Set ([MDS], standardized assessment and care screening tool) dated 4/23/2024, indicated Resident 47 needed set up or clean up assistance with eating, oral hygiene, personal hygiene, and Resident 47 needed partial assistance with toileting hygiene, and showering. The MDS indicated Resident 47 on hemodialysis. During a record review of the Physician Order Summary Report active as of 12/12/2023, indicated no blood pressure checks to AV shunt location as appropriate. Observe AV shunt on left upper arm for redness, tenderness, bleeding, and drainage every shift. During an observation on 6/29/2024 at 9:25 a.m. blood pressure was being taken by Certified Nurse Assistant 2 (CNA 2) on the left arm. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/30/2024 at 2:25 p.m., with Licensed Vocational Nurse 1 (LVN 1) reviewed vital signs record which indicated blood pressure measurement were taken on Resident 47's left arm on multiple dates including 6/29/2024 at 3:18 p.m., 2:06 p.m. and 11:19 a.m. and on 6/28/2024 at 10:08 a.m., 11:37 a.m., 1:33 p.m. LVN 1 stated that the order does not specify the location of the AV shunt and the BP was taken on the left arm where the AV shunt was. LVN 1 stated checking blood pressure on the left arm can interrupt the blood flow to the arm and may cause the AV shunt to stop working. LVN 1 stated there was also no signage at the bedside indicating not to take the blood pressure on the left arm. During an interview on 6/30/2024 at 5:30 p.m. with the Director of Nursing (DON), the DON stated staff should not be checking blood pressure where the AV shunt, because AV shunt might malfunction. b. During a review of Resident 26's Admission Record, the Admission Record indicated Resident 26 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including ESRD, dependence on renal dialysis and congestive heart failure (CHF-heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 26's MDS dated [DATE], the MDS indicated Resident 26's can understand others and be understood. The MDS indicated Resident 26 needed supervision with eating, substantial or maximal assistance on toileting hygiene, and showering. Resident 26 needed partial assistance with oral hygiene and personal hygiene. The MDS indicated Resident 26 on hemodialysis. During a concurrent observation and interview on 6/29/2024 at 8:20 a.m., with Resident 26, Resident 26 was observed to have can of soda, cup of coffee, bottle of juice and a water pitcher full of water at the bedside, no signage indicating that Resident 26 on fluid restriction (limiting fluids). Resident 26 stated she does not know how much fluid she takes, since staff gave her full water pitcher and she drinks whenever she was thirsty. During an observation on 6/29/2024 at 9:10 a.m., at Resident 47's bedside table, observed full water pitcher with ice. No signage indicating that Resident 26 on fluid restriction (limiting fluids). During an observation on 6/30/2024 at 12:05 p.m. at the dining room, Resident 47 has a cup of coffee and a can of soda at the table. During a review of Resident 47's care plan, titled Focused on resident having a potential for fluid volume overload dated 11/10/2023, the care plan goal indicated to remain free of symptoms for fluid overload. The care plan intervention indicated fluid restriction as ordered. During a concurrent interview and record review on 6/30/2024 at 2:20 p.m., with, LVN 1, reviewed Resident 47 physician order dated 12/1/2023, the physician order indicated to monitor fluid intake of 1200 milliliters (ml-unit of volume) per day. During a concurrent observation and interview with LVN 1 on 6/30/2024 at 2:30 p.m. in Resident 47's room, observed a full pitcher of water at the bedside within reach. LVN 1 stated staff should remove the pitcher to ensure Resident 26 and 47 will not consume water freely to prevent fluid overload. During an interview on 6/30/2024 at 5:30 p.m. with DON, the DON stated staff should ensure Resident 26 and 47 fluid consumption were monitored to prevent fluid overload. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled Dialysis Care, revised 10/1/2018, the P&P indicated dialysis residents were given fluid based on the fluid restriction as ordered by the physician. The division and distribution of fluid nursing and dietary staff will carefully organize. The P&P indicated the blood pressure should not be taken on the arm with the shunt. 44055

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 38) who had a history of post-traumatic stress disorder (PTSD- a mental health condition that triggered by a terrifying event either experiencing it or witnessing it), and depression (a depressed mood or loss of pleasure or interest in activities for long periods of time) was provided individualized plan of care to address potential trauma triggers This deficient practice has the potential not to provide resident centered behavioral health care services needed for Resident 38. Findings: During a review of Resident 38's Admission Record, the Admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows), anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 38's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 4/13/2024, indicated Resident 38 has clear speech and can understand by others and understand others. The MDS indicated Resident 38 has the diagnosis of PTSD. During a concurrent interview and record review on 6/30/2024 at 10:35 a.m., the Social Services Designee (SSD), stated that she did the trauma informed care assessment dated [DATE] for Resident 38. The SSD stated Resident 38 does have a diagnosis of PTSD, but she was not aware who does the care plan and what triggers the trauma. During a concurrent interview and record review on 6/30/2024 at 10:38 a.m. with the Minimum Data Set (MDSN LVN), MDSLVN stated that she was responsible to make sure all the care plan was complete to be able to address and provide proper care and services needed to Resident 38. MDSN LVN stated that it should be person centered and specific to Resident 38's diagnosis and medical care. Reviewed Resident 38 care plans, MDS LVN stated she was unable to locate the care plan for PTSD, and unable to locate in Resident 38 Medication Administration Record (MAR) and Nurses progress notes what triggers the PTSD. During a concurrent interview and record review on 6/30/2024 at 5:15 p.m. with the Director of Nursing (DON), the DON stated that it was the responsibility of every licensed nurse to complete the care plan. Reviewed Interdisciplinary (IDT- healthcare team discussing care) Care Conference dated 4/9/2024 with the DON, the DON stated it was important that staff knows about Resident 38's trauma and whatever triggers to prevent the re-occurrence of the incident. The DON stated that it was not mentioned in the IDT Care Conference. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's policy and procedure (P&P) titled Trauma Informed Care: Screening, Training and Care Integration Program dated 06/2019, the P& P indicated The IDT will meet to discuss the results of the trauma informed screen document and implement a plan of care to address potential trauma triggers and prevent re-traumatization. Trauma informed interventions are interdisciplinary and must look at all aspects of care, including the environment, relationships, and care delivery.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 45028 Based on observation, interview and record review, the facility failed to: 1. Ensure Licensed Vocational Nurse (LVN) 5 documented medication as administered in the Medication Administration Record (MAR) immediately after administering Resident 20's Insulin Lispro (a short acting medication used to treat elevated blood sugar level). 2. Ensure LVN 5 verified Resident 20's identity with the MAR prior to medication administration. These deficient practices increased the risk of medication error, including Resident 20 not receiving the correct medication as ordered. 3. Ensure LVN 5 and LVN 2 performed a change of shift inventory of controlled medication (a term used for medications with high level of abuse and dependence) and documented on the count on the facility's-controlled drug count record (a document indicating perpetual inventory and administration of controlled substances) at the beginning and end of each shift per the facility's policy and procedure (P&P) titled, Controlled Medication Storage. This deficient practice had the potential for loss of accountability, which affected the control against drug loss, diversion, or theft. Findings: 1. During a review of Resident 20's Admission Record, the Admission Record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (damage or disease which affects the brain caused by a chemical imbalance in the blood) and type 2 diabetes mellitus ([DM] a chronic disease characterized by elevated levels of blood sugar in the blood) with hyperglycemia (elevated blood sugar level). During a review of Resident 20's History and Physical (H&P) dated 3/15/2024, indicated Resident 20 had the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/18/2024, indicated Resident 20's cognition (ability to think, understand, learn, and remember) was intact and had the ability to understand and be understood by others. The MDS indicated Resident 20 had DM and received Insulin (medication used manage blood sugar levels). During a review of Resident 20's Physician Order Summary Report dated 6/20/2024 indicated a physician's order for administration of Insulin Lispro inject eight units ([U] the amount of a medication administered to a patient in a single dose) subcutaneously (under the skin) before meals for type 2 DM. Hold if blood sugar is less than 100 milligrams ([mg] a unit of mass or weight)/deciliter ([dL metric unit of volume). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 6/29/2024 at 6:41 a.m., in the facility hallway, LVN 5 was observed walking away from the medication cart with Resident 20's Insulin Lispro on hand, walk into Resident 20's room, then administer eight units of Insulin Lispro to Resident 20. LVN 5 did not verify Resident 20's identity with the MAR prior to administering Resident 20's Insulin Lispro. During a review of Resident 20's Medication Admin Audit Report (a document indicating the exact time medications were documented as administered) dated 6/29/2024, indicated LVN 5 documented the Insulin Lispro eight units as administered at 6:39 a.m. prior to administering the medication to Resident 20. During an interview on 6/29/2023 at 6:44 a.m., with LVN 5, LVN 5 stated she documented Resident 20's Insulin Lispro eight units as administered, prior to giving the Insulin Lispro to Resident 20. LVN 5 stated she did not verify Resident 20's identity with the MAR prior to medication administration because she already knew the resident and did not have anything to compare it to since she did not bring the MAR with her. LVN 5 stated by not having the MAR with her, she was not able to validate she was administering the correct medication to the correct resident because she had left the MAR on the medication cart which was left in the hallway. 3. During an observation on 6/29/2024 at 7:10 a.m., in the facility hallway, LVN 2 was observed organizing the South Medication Cart narcotic drawer. During a review of the facility's Controlled Drugs - Count Record for South Medication Cart, dated 6/29/2024 for the 7 a.m. to 3 p.m. shift., indicated LVN 5's signature was missing in Out (out-going nurse), and LVN 2's signature was missing for In (in-coming nurse) During an interview on 6/29/2024 at 7:11 a.m., LVN 2 stated she had received the South Medication Cart keys from LVN 5 and was making sure the medication cart was organized prior to her shift. LVN 2 stated she did not complete the shift-to-shift count with LVN 5 prior to LVN 5 handing her the South Medication Cart keys. During an interview on 6/29/2024 at 7:12 p.m., LVN 5 stated she did not complete the change of shift narcotic count with LVN 2 prior to handing LVN 2 the keys to the South Medication Cart. LVN 2 stated at the beginning and end of each shift, the outgoing nurse and the incoming nurse must count the narcotics that are in the medication cart for each resident and sign the Controlled Drugs - Count Record immediately following the count to validate the count was correct. LVN 2 stated the medication cart keys are not to be handed over or received until after the narcotic count was validated. During an interview on 6/30/2024 at 6:04 p.m., the Director of Nursing (DON) stated at the beginning and end of each shift the outgoing nurse and the incoming nurse must sign the Controlled Drugs - Count Record immediately after the narcotic count was completed to validate all narcotics are accounted for. The DON stated there was a possibility of drug diversion if the narcotic counts are not done. The DON stated the correct way to prepare medications for administration was to take the medication cart to the resident's doorway, verify using the resident's MAR with the medications ordered, prepare the medications, identify the correct resident, administer the medication to the resident, and document the medication as given. The DON stated the licensed nurses should not document on the MAR that medications as given prior to physically administering the mediation to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Medication Administration, revised 1/2012, the P&P indicated the licensed nurse will chart the drug, time administered and initial his/her name with each medication administration. The P&P indicated nursing staff will keep in mind the seven rights of medication when administering medication which include: the right medication, the right amount, the right resident, the right route. The P&P indicated the time and dose of the drug or treatment administered to the patient will be recorded in the patient's individual medication record and will include the date and time of administration. During a review of the facility's P&P titled, Controlled Medication Storage, dated 8/2014 the P&P indicated medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations. The P&P indicated at each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 27), who was prescribed with antipsychotic drug (a type of medication prescribed to treat mental health problem) and an anxiolytic drug (anti-anxiety medications, that treat anxiety symptoms and disorders) were monitored for behaviors of bipolar (a mental health condition that causes extreme mood swings) and anxiety episodes every shift. This deficient practice has the potential for Resident 27's behavior of psychosis and anxiety to be unmonitored and has the potential for an inaccurate information necessary for gradual dose reduction ([GDR] tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. and/ or readjustment) of Resident 27 psychotropic (any drug that affects brain activities associated with mental processes and behavior) medications. Findings: During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, anxiety disorder and major depressive disorder (a mood disorder that causes persistent feelings of sadness). During a review of Resident 27's Physician Order Summary dated 6/2024, the Physician Order Summary indicated Resident 27 was prescribed the following medications: a. Latuda (anti-psychotic agent) 60 milligrams ([mg] unit of measurement) one tablet by mouth once a day for bipolar depression manifested by crying and labile (rapid exaggerated changes in mood) mood, and b. Ativan (an anti-anxiety/ anxiolytic agent) 0.5 mg one tablet by mouth twice a day for anxiety as manifested by inability to relax. During a review of Resident 27's Medication Administration Record (MAR) dated 6/2024, the MAR did not indicate an order for behavioral monitoring of Resident 27's bipolar depression episodes and behavioral monitoring of Resident 27's anxiety episodes every shift. During a review of Resident 27's care plan titled Psychotropic medication (Latuda) revised 6/20/2024, indicated a goal for Resident 27's dose of psychotropic medication to be reduced. The care plan interventions including to monitor and record occurrence of target behavior symptoms per facility's protocol. During a review of Resident 27's care plan titled Anti-anxiety medication dated 6/13/2024, indicated a goal for Resident 27 to be free from discomfort and/ or adverse reactions to anti-anxiety therapy with interventions including to monitor and record occurrence of target behavior symptoms per facility's protocol. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/29/2024 at 4:05 p.m., Licensed Vocational Nurse 4 (LVN 4) stated and confirmed Resident 27 has not been monitored every shift for behavioral episodes related to prescribed anti-psychotic and anxiolytic medications. LVN 4 stated the behavioral episodes must be documented every shift because this information was needed to Resident 27's GDR and readjustment of her medications. During an interview on 6/30/2024 at 5:15 p.m., the Director of Nursing (DON) stated behavior monitoring every shift was important and should always be conducted and documented by the licensed nurses to ensure the residents' behaviors were accounted for to justify the use of psychotropic medications. During a review of the facility's policy and procedure (P&P) titled Behavioral/ Psychoactive Drug Management revised 11/2018, the P&P indicated the residents in need of psychotherapeutic medications receive appropriate assessment and interventions to achieve their highest practicable level of functioning. The P&P indicated occurrences of behavior for which psychoactive medications are in use will be entered with hashmarks on the medication administration record every shift.

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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** 43906 Based on observation, interview and record review, the facility failed to obtain informed consent (process by which a healthcare provider educates a resident about the risks and benefits, and alternatives of a given procedure or intervention) prior to the administration of psychotropic drugs (medication that affects brain activities associated with mental process and behavior) for two of four sampled residents (Resident 64 and Resident 41). This deficient practice had the potential to place Resident 64 and 41 at risk of receiving unnecessary psychotropic medication including Lorazepam (brand name Ativan-medication used to treat anxiety [feeling of fear, dread, and uneasiness], Olanzapine (antipsychotic medication that can treat several mental health conditions) and lithium carbonate (a medication used to treat manic episodes of bipolar disorder) and Resident 41 receiving olanzapine, and Ativan without clinical justification for use. Findings: a.During a review of Resident 64's Admission Record, the Admission Record indicated Resident 64 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), unspecified dementia (the loss of cognitive [thinking, remembering, and reasoning] functioning). During a review of Resident 64's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/29/2024, indicated Resident 64's has clear speech and sometimes understand others and sometimes understand by others. The MDS indicated Resident 64 has a behavioral symptom not directed towards others such as hitting or scratching self. During a concurrent interview and record review on 6/29/2024 at 4:16 p.m. with Licensed Vocational Nurse 4 (LVN 4) reviewed psychotropic consent, physician's order, and medication administration record (MAR) for Resident 64, LVN 4 stated informed consent was important to make sure the resident or Responsible party (RP) was allowing the facility to give psychotropic medication, risk and benefits will be explained to the resident or RP during the process of getting consent. LVN 4 stated prior to starting the medication and increasing the medication informed consent should be obtained. LVN 4 added there was no change of condition for Resident 64 before initiating the Ativan medication that was started on 6/25/2024 and Resident 64 took the medication on 6/26/2024 at 11:51 p.m. and 6/28/2024 at 7:58 a.m. and 6:19 p.m. LVN added no consent for increasing the Lithium carbonate 150 milligram (mg-unit of measurement) by mouth once a day to two times a day dated 6/22/2024. b. During a review of Resident 41's Admission Record, The Admission Record indicated Resident 41 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (a mental illness that causes unusual shifts in a person's mood, pressure ulcer (an injury that breaks down the skin and underlying tissue) of left buttocks unstageable, pressure ulcer of sacral region, unstageable. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 41's MDS dated [DATE], indicated Resident 41's has clear speech and can understand others and can be understand by others. The MDS indicated behavior of such as physical behavior symptoms directed towards other, verbal behavior symptoms directed towards other and other behavioral symptoms not directed towards others occurred one to three days in a week. During an observation on 6/29/2024 at 8:27 a.m., with Resident 41 in her bedroom, Resident 41 was observed calm and cooperative. No behaviors were observed. During an interview on 6/28/2024 at 8:38 a.m. with Certified Nurse Assistant (CNA 1), CNA 1 stated for the most part Resident 41 was cooperative no yelling or behavior she noticed lately. During a record review of Resident 41's Physician Order Summary report dated 6/22/2024 indicated Ativan one mg every 12 hours for anxiety manifested by inability to relax as exhibited by agitation for 14 days, olanzapine give 1 tablet by mouth two times a day for bipolar disorder manifested by refusal of ADL's supervised self-medication, consent obtained and verified dated 6/24/2024. During a concurrent interview on 6/30/2024 at 4:30 p.m. with the Minimum Data Set Nurse (MDS LVN) and record review of the psychotropic consent. MDS LVN stated that consent was initiated before starting any psychotropic medication, MDS LVN stated staff should start with non- pharmacological (intervention which is not primarily based on medication) interventions then whoever received the order for psychotropic medicine will ensure consent was obtained prior to medication administration. Resident 41 does not have a current or active consent dated 6/22/2024 for Ativan. MDS LVN added that a consent for Olanzapine 10 mg twice a day was incomplete since it was not checked who gave the consent. During an interview on 6/30/2024 at 5:30 p.m. with the Director of Nursing (DON), the DON stated that consent needs to be initiated every time resident will be started on any anti-psychotropic medication to allow the facility staff to administer medication. DON stated she did not obtain a consent prior to starting Ativan for Resident 41 Ativan. The DON further added she increase the Lithium carbonate but did not verify if the consent was in the medical chart. During a record review of the facility's policy and procedure (P&P) titled Behavior/psychoactive Medication Management dated 01/2024 indicated Facility must obtain a resident's written informed consent for treatment using psychotropic drugs and consent renewal every six (6) months. During a record review of the facility's (P&P) titled Informed Consent dated 01/2024 It is the healthcare practitioner's responsibility to obtain informed consent for psychoactive medications (including increased dosages). The P &P also indicated before administering the first dose or first increased dose of psychoactive medication, applying physical restraints or medical devices, the licensed nurse will confirm that the healthcare practitioner obtained informed consent and will document the verification on the resident's medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five percent (%). Two medication errors out of 27 opportunities contributed to an overall medication error rate of 7.14 % affecting one of four residents observed (Resident 33) during medication administration. The medication errors were as follows: 1. Calcitonin Salmon Nasal Solution (a medication used to treat osteoporosis [a disease which causes bones to weaken and break more easily]) 200 units ([U] the amount of a medication administered to a resident in a single dose) one spray was administered in Resident 33's right nostril (outer openings of the nose through which one breathes) instead of left nostrils as ordered by Resident 33 physician. 2. Omission of Calcitonin Salmon Nasal Solution 200 U one spray in Resident 33's left nostril. These deficient practices resulted in failing to administer Calcitonin Salmon Nasal Solution in accordance with the physician's orders and increased the risk of irritation (dryness, itching, redness, swelling, and tenderness) and burning of the right nostril due to prolonged treatment. Findings: During a review of Resident 33's Admission Record, the Admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses including lumbar intervertebral disc (elastic structures found between the vertebrae [the small circular bones that form the spine]) degeneration (breakdown) and chronic pain syndrome persistent pain). During a review of Resident 33's History and Physical (H&P) dated 7/28/2023, indicated Resident 33 had the capacity to understand and make decisions. During a review of Resident 33's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/1/2024, the MDS indicated Resident 33's cognition (loss of memory, language, problem-solving and other thinking abilities) was moderately impaired and had the ability to understand and be understood by others. During a review of Resident 33's Physician Order Summary Report (a list of all current active medical orders), dated 6/1/2024 indicated Resident 33 to receive the following medications: 1. On 5/15/2024, an order was placed for Resident 33 to receive Calcitonin Salmon Nasal Solution 200 U one spray in the left nostril one time a day on odd days for hypocalcemia (low calcium level in the blood). 2. On 5/15/2024, an order was placed for Resident 33 to receive Calcitonin Salmon Nasal Solution 200 U one spray in the right nostril every morning on even days for hypocalcemia. (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 observation of medication administration and interview with the Licensed Vocational Nurse (LVN) 2 on 6/29/2024 at 8:23 a.m., LVN 2 was observed preparing Calcitonin Salmon Nasal Solution 200 U for Resident 33. During a continued observation on 6/29/2024 at 8:24 a.m., the pharmacy label on the Calcitonin Salmon Nasal Solution 200 U was observed, the pharmacy label indicated to administer one spray in Resident 33's left nostril on odd days and to administer one spray in Resident 33's right nostril on even days. During an observation on 6/29/2024 at 8:33 a.m., Resident 33 was observed administering one spray of the Calcitonin Salmon Nasal Solution in her right nostril. During a review of Resident 33's Medication Admin Audit Report (a document indicating the exact time medications were documented as administered) dated 6/29/2024, indicated LVN 2 documented the Calcitonin Salmon Nasal Solution as administered in Resident 33's left nostril at 8:44 a.m. During an interview on 6/29/2024 at 8:46 a.m., with LVN 2, LVN 2 stated she got mixed up with the days and thought Resident 33 received the Calcitonin Salmon Nasal Solution in the left nostril on the previous day, hence why she gave the Calcitonin Salmon Nasal Solution in Resident 33's right nostril. LVN 2 stated she did not pay attention to the day if it was an even or odd day, nor did she check the previous administration on the MAR or the pharmacy label on the Calcitonin Nasal Solution bottle to double check she was administering the medication in the correct nostril. During an interview on 6/30/2024 at 6:04 p.m., with the Director of Nursing (DON) stated failing to administer medication according to the physician's orders may cause unnecessary complications and depending on the medications could lead to adverse reactions possibly resulting in hospitalization and/or death. The DON stated the MAR must accurately reflect care provided to the residents otherwise it could cause medical providers to make unnecessary dosage changes to medications that could result in poor outcomes for the resident's negatively affecting their quality of life. During a review of the facility's policy and procedure (P&P) titled, Medication - Administration, revised 1/2012, indicated the purpose of the policy is to ensure the accurate administration of medications for residents in the facility. The P&P indicated medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner. The P&P indicated medications and treatments will be administered as prescribed to ensure compliance with dosage guidelines. The P&P indicated nursing staff will keep in mind the seven rights of medication when administering medication which include the right route.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 30) Responsible Party (RP) was notified when the dentist recommended the need for dentures (an artificial placement of one or more teeth). This deficient practice had the potential to cause a delay in dental treatment for Resident 30. Findings: During a review of Resident 30's Admission Record, indicated Resident 30 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (damage or disease which affects the brain), Alzheimer's disease (a progressive disease which destroys memory and other important mental functions), and unspecified dementia (loss of cognitive functioning [thinking, remembering, and reasoning]). During a review of Resident 30's History and Physical (H&P) dated 2/1/2024, indicated Resident 30 did not have the capacity to understand and make medical decisions. During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30 had severe cognitive (ability to think, understand, learn, and remember) impairment, was sometimes understood and was sometimes able to understand others. During a review of Resident 30's Dental Notes dated 2/5/2024, the Dental Notes indicated Resident 30's dental status was edentulous (all teeth are missing). The Dental Note indicated Resident 30 was not sure about dentures. During a concurrent observation and interview on 6/29/2024 at 8:57 a.m., with Licensed Vocational Nurse (LVN) 2, in Resident 30's room, Resident 30's oral status was observed. LVN 2 stated, Resident 30 did not have any upper or lower teeth. During a concurrent interview and record review on 6/29/2024 at 7:24 p.m., with the Social Service Director (SSD), Resident 30's Social Services Notes were reviewed. The SSD stated there was no documentation indicating Resident 30's RP was notified of the dentist recommendation for dentures after the dental visit on 2/5/2024. The SSD stated it was the responsibility of the SSD to notify the RP of the dentists' recommendations the day of the dental visit or the day after the visit so the process of any dentures or procedures can be initiated. During an interview on 6/30/2024 at 11:13 a.m., with the Minimum Data Set Nurse Licensed Vocational Nurse (MDSN LVN), the MDSN LVN stated Resident 30 did not have any upper or lower teeth and could not find any dentures in Resident 30's belongings or at the bedside. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Rights - Accommodation of Needs, revised 1/2012, the P&P indicated the facility's environment is designated to assist the resident in achieving independent functioning and maintaining the resident's dignity and well-being. The P&P indicated the facility staff will assist residents in achieving these goals. The P&P indicated residents' individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis.

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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. 45537 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Dusty fan was located near the dishwasher and a dusty radio was located near the kitchen prep table (workstation for food preparation). 2. Facility freezer and refrigerator were not in safe operating condition. 3. A green substance was observed on the spout of the ice dispenser These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (illnesses contracted from eating contaminated food or beverages) of residents who received food from the facility. Findings: 1. During an observation on 6/28/2024 at 3:12 p.m., of the facility's kitchen, a dietary staff was unloading the newly sanitized dishes from the dishwasher and a dusty fan was situated over the dishwasher equipment blowing air to the newly sanitized dishes. Observed a dusty radio was placed close to the kitchen prep table. 2. During an observation on 6/28/2024 at 3:24 p.m., at the facility's food pantry with the Dietary Supervisor (DS), the following were observed: a. Freezer #1 that stored several bags of frozen tortilla have no thermometer to monitor the freezer's temperature. There was an opened bag of tortilla with no opened date tag and another tortilla bag unopened with ice crystals inside the bag. b. Freezer #2 that stored packed bags of vegetables had a temperature of 2 (two) degrees Fahrenheit (F a temperature scale) and there was an ice buildup observed on the upper portion of the freezer. c. Freezer #3 that stored sliced carrots and french fries had a temperature of 0 (zero) F and there was an ice buildup at the bottom of the freezer and clear liquid substance on the floor (outside of the freezer). During an observation on 6/28/2024 at 5:02 p.m., at the facility's kitchen, the following were observed: a. Freezer # 4 that stored frozen meat, ice cream, butter and popsicles had a temperature of one F and b. Refrigerator #1 that stored milk and eggs had a temperature of 60 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.During an observation on 6/28/2024 at 5:15 p.m. of the facility's ice dispenser with the Maintenance Director (MD), observed a green substance from the spout of the ice dispenser. During a concurrent observation and interview on 6/29/2024 at 9:46 a.m. with the MD, the following were observed: a. Refrigerator #1 that stored milk had a temperature of 38 F, there were no food items inside the refrigerator; and b. Freezer #4 that stored frozen meat, ice cream, butter and popsicles had a letter D noted at the outside temperature monitor, meaning defrosting was taking place in the freezer, which was confirmed by MD as a normal mechanism of the freezer to give the condenser coils to work. c. the food storage room in the kitchen has no designated thermometer and no temperature monitoring log. During an observation on 6/29/2024 at 10:11 a.m., of the facility's kitchen with the Administrator, the following were observed: a. Refrigerator #1 that stored milk had a temperature of 38 F and there were no food items inside the refrigerator; and b. Freezer #4 that stored frozen meat, ice cream, butter and popsicles had a temperature of 1 F. During an observation on 6/29/2024 at 12 p.m., of the facility's kitchen with the Administrator, Maintenance Supervisor and Dietary supervisor, the following was observed: a. Freezer #4 that stored frozen meat, ice cream, butter and popsicles had an ice buildup on the upper section of the freezer with a temperature of 18.5 F as checked by the Maintenance Supervisor utilizing the facility's thermometer gun and the thermometer inside the freezer was 16 F. During an observation on 6/29/2024 at 12:52 p.m., in the facility's kitchen with the Administrator, Maintenance Supervisor and Dietary supervisor, the following was observed: a. Freezer #4 that stored frozen meat, ice cream, butter and popsicles had an ice buildup on the upper section of the freezer with a temperature of 5 F as checked by the Maintenance Supervisor utilizing the facility's thermometer gun and the thermometer inside the freezer was 4 F. During an interview on 6/28/2024 at 3:17 p.m., Dietary Aide 1 (DA1) stated and confirmed there was a dusty radio near the kitchen prep table and the dusty fan was blowing directly to the newly sanitized dishes. DA 1 stated these items should have been removed from the kitchen because it was unsanitary. During an interview on 6/28/2024 at 5:15 p.m., the Maintenance Supervisor (MS) confirmed there was a green substance obtained from the spout of the ice dispenser and it meant a concern for sanitation. (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 6/28/2023 at 5:20 p.m., the Dietary Supervisor (DS) stated kitchen equipment such as the freezer and the refrigerator should be in operating in proper temperatures (freezer must have a temperature of 0 [zero] F and below and refrigerator must operate with 40 F and below) to ensure residents' food were stored safely and the quality of the food was maintained. DS stated all opened food items must have a tag and labelled to identify when it is supposed to disposed. DS stated unclean equipment such as a fan and a radio must be removed from the kitchen area due to sanitary concerns. DS further stated food storage room inside the kitchen temperature must be monitored and logged by ensuring there was thermometer in the location for safe food storage. During an interview on 6/29/2024 at 9:46 a.m., the Maintenance Supervisor (MS) stated leakage and water condensation/ ice buildup inside the freezer signifies the equipment was not functioning properly and need to be replaced. MS stated the food storage area in the kitchen must have a designated thermometer and the temperature should be logged respectively to prevent spoilage of the residents' food. During an interview on 6/29/2024 at 10:11 a.m., the Administrator stated she was not aware of the concerns of the kitchen and pantry cold storage equipment. During an interview on 6/29/2024 at 5:06 p.m., the on call Registered Dietician stated the temperatures of the facilities cold storage equipment such as the freezer and refrigerator will have fluctuating temperatures depending on how often the kitchen staff were using them; however, the cold storage equipment must stay in the proper temperature and a thermometer must be delegated in each of the equipment to ensure the equipment temperature was monitored and functioning safely. During a review of the facility's freezer equipment manual titled Commercial Freezer Defrost Cycles Explained undated, the equipment manual indicated Defrost cycles of the freezer avoid problems caused by the buildup of ice and defrosting does not affect the interior temperature of the freezer cabinet and the food held in the freezer. During a review of the facility's policy and procedure (P&P) titled Equipment Operation revised 11/ 2014, the P&P indicated appropriate and safe equipment are being used in the facility. During a review of the facility's P&P titled Food Storage and Handling revised 2/29/2024, the P&P indicated The residents' food items must be stored at a safe and appropriate temperature in the freezer at a temperature of 0-degree F and below and in the refrigerator at a temperature of below 41 F and the dry food storage must be well lit and ventilated. The P&P indicated food items will be stored, thawed, and prepared in accordance with sanitary practices and all items will be correctly labeled and dated to prevent/avoid foodborne illnesses. Cross reference F908

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 45028 Based on interview and record review, the facility's Quality Assessment and Assurance committee ([QAA] a group of facility staff who identifies, evaluates, and implements measures to improve the quality of care and life for the residents in the facility) and Quality Assurance Performance Improvement ([QAPI] a group who takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) committee failed to ensure continued oversight of the facility's plan of correction (POC) of the deficient practices identified during the previous recertification survey (7/19/2021). This deficient practice resulted in the facility having repeat deficiencies in quality of care, such as pharmaceutical services (procuring, dispensing, distributing, storing, and administering of medications), medication error rate of five percent or more, infection control, and physical environment. Findings: During a review of the facility's Statement of Deficiencies for the 2021 Recertification Survey, the Statement of Deficiencies indicated the following repeat deficiencies were identified: quality of care, pharmaceutical services, medication error rate of five percent or more, infection control, and physical environment. During a review of the facility's current QAPI plan updated 11/10/2023 and revised 5/28/2024, indicated there was an ongoing QAPI for fall management. During a review of the facility's current QAPI plan initiated 6/1/2024, indicated there was an ongoing QAPI for behavior management. During an interview on 6/30/2024 at 6:04 p.m., with the Director of Nursing (DON), the DON stated the identified deficient practices in medication administration errors and infection control practices would be addressed immediately. During an interview on 6/30/2024 at 6:49 p.m., with the Administrator (ADM) the ADM stated key measures, risks and action plans are discussed during the QAPI meetings. The ADM stated current ongoing QAPI's include fall management, behavior management and a previous deficiency regarding abuse. The ADM stated the facility did not have a focus QAPI prior to the finding of the issues with the facility's freezers which were identified again during the recertification survey nor a system in place to ensure the freezers were functioning correctly. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance (QAPI) Program, revised 3/28/2024, indicated the facility implements and maintains an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) Program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality of care, and resolve identified issues. The P&P indicated the purpose of the QAPI program is to implement a process that identifies opportunities for improvement and leads to optimal achievement in clinical and operational outcomes, and overall quality of care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview, and record review the facility failed to ensure infection control practices was implemented. The facility failed to: 1. Ensure personal protective equipment (PPE- equipment used to prevent or minimize exposure to hazards) was easily accessible for direct patient care staff on residents with Enhanced Barrier Precaution (EBP- use of a gown and gloves for residents with wounds, and indwelling devices). These deficient practices had the potential for the spread and transmission of multidrug resistant organism (MDROs- microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents) in the facility. 2. Ensure the facility's Water Management Plan (plan that identifies hazardous conditions and steps to take to minimize the growth and spread of bacteria[germs]) indicated testing protocols (deliberate action to see if something works) for control measures (actions taken to reduce the potential of exposure to the hazard) and documented results of testing completed. This deficient practice had the potential to expose residents and staff to Legionella (bacteria that can cause serious lung infections) and water borne infections. Findings: 1.During an initial tour to the facility on [DATE] at 7:26 a.m., observed Certified Nursing Assistant (CNA) 1 walking in the hallway with gloves on. CNA 1 entered a resident room with EBP signage on the door. During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), pressure ulcer (an injury that breaks down the skin and underlying tissue) of left buttocks unstageable, pressure ulcer of sacral region, unstageable. During a review of Resident 41's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 6/5/2024, indicated Resident 41's has clear speech and can understand others and can be understand by others. During a concurrent observation and interview on 6/29/2024 at 8:10 a.m., with CNA1, CNA 1 stated Resident 41 had pressure ulcer at the buttocks area, so she was only allowed to be up in the wheelchair for two (2) hours and goes back to bed to relieve the pressure from her back. CNA 1 stated she will be providing morning care to Resident 41 and there was no PPE cart close by to get the gloves or gowns needed to provide care for Resident 41, so she needs to walk from where the PPE cart was located and then she puts the gloves and carry the gown until she goes to resident room and don (put on) the gown. (continued on next page)

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	056042	A. Building B. Wing	06/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Vista Healthcare & Wellness Centre, LP	5901 Downey Ave Long Beach, CA 90805

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/29/2024 at 1:39 p.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated that CNAs should not be walking around with gloves on because of infection control. LVN 3 stated that Infection Preventionist (IP) reminds every staff about infection control. During an interview on 6/30/2024 at 8:30 a.m., with the IP, the IP stated that his main role was infection control and prevention. The IP stated staff should not walk around the facility with gloves on or any PPE. The IP added that soiled linen should not be carried around the facility to drop off to laundry. During a record review of the facility's policies and procedure (P &P) titled Enhanced Barrier Precautions dated 6/7/2024, the P & P indicated during high contact resident care activities dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting toileting gloves and gown prior to the high contact care activity (change PPE before caring for another resident) face protection may also be needed if performing activity with risk of splash or spray. To facilitate compliance with EBP make PPE, including gowns and gloves, available immediately outside of the resident room. PPE stations may be positioned between adjacent rooms for convenience, gowns and gloves are to be donned before each high contact task not prior to entering the room. 2. During an interview on 6/29/2024 at 5:30 p.m., the Administrator (ADM) stated facility water quality has not been tested and was unable to provide documentation of testing. During a review of the facility policy and procedure titled Water Management Plan, revised 5/25/2023, the P&P indicated there will be quarterly measurement of water quality throughout the system to ensure changes that may lead to legionella growth were During a review of the Centers for Disease Control and Prevention Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings, a Practical Guide to implementing industry standards, dated 6/24/2021, the guide indicated: a. Water quality should be measured throughout the system to ensure that changes that may lead to legionella growth. b. Document confirmatory procedures, including verification steps to show that the program was being followed as written and validation to show that the program is effective. https://www.cdc.gov/control-legionella/php/toolkit/wmp-toolkit.html 44055

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 45537 Based on observation, interview and record review, the facility failed to ensure three freezers and one refrigerator in the facility's kitchen and food pantry were maintain in safe operating condition. This failure had the resident food items stored in an unsafe condition that could potentially place the residents at risk for food-borne illnesses (illness cause by food contaminated with bacteria, viruses, parasites, or toxins). Findings: During an observation on 6/28/2024 at 3:24 p.m., at the facility's food pantry with the Dietary Supervisor (DS), the following were observed: a. Freezer #1 that stored several bags of frozen tortilla have no thermometer to monitor the freezer's temperature. There was an opened bag of tortilla with no opened date tag and another tortilla bag unopened with ice crystals inside the bag. b. Freezer #2 that stored packed bags of vegetables had a temperature of 2 (two) degrees Fahrenheit (F a temperature scale) and there was an ice build up observed on the upper portion of the freezer. c. Freezer #3 that stored sliced carrots and french fries had a temperature of 0 (zero) F and there was an ice buildup at the bottom of the freezer and clear liquid substance on the floor (outside of the freezer). During an observation on 6/28/2024 at 5:02 p.m., at the facility's kitchen, the following were observed: a. Freezer # 4 that stored frozen meat, ice cream, butter and popsicles had a temperature of one F and b. Refrigerator #1 that stored milk and eggs had a temperature of 60 F. During an observation on 6/29/2024 at 9:46 a.m. at the facility's food pantry with the Maintenance Director (MD), the following were observed: a. Freezer #2 that stored packed bags of vegetables had a temperature of four F, and b. Freezer #3 that stored sliced carrots and french fries had a temperature of 4 F and there was an ice buildup at the bottom of the freezer and clear liquid substance on the floor (outside of the freezer). During a concurrent observation and interview on 6/29/2024 at 9:46 a.m. with the Maintenance Director (MD), the following were observed: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Refrigerator #1 that stored milk had a temperature of 38 F, there were no food items inside the refrigerator; and b. Freezer #4 that stored frozen meat, ice cream, butter and popsicles had a letter D noted at the outside temperature monitor, meaning defrosting was taking place in the freezer, which was confirmed by MD as a normal mechanism of the freezer to give the condenser coils to work. During an observation on 6/29/2024 at 10:11 a.m., of the facility's kitchen with the Administrator, the following were observed: a. Refrigerator #1 that stored milk had a temperature of 38 F and there were no food items inside the refrigerator; and b. Freezer #4 that stored frozen meat, ice cream, butter and popsicles had a temperature of 1 F. During an observation on 6/29/2024 at 12 p.m., of the facility's kitchen with the Administrator, Maintenance Supervisor and Dietary supervisor, the following was observed: a.Freezer #4 that stored frozen meat, ice cream, butter and popsicles had an ice buildup on the upper section of the freezer with a temperature of 18.5 F as checked by the Maintenance Supervisor utilizing the facility's thermometer gun and the thermometer inside the freezer was 16 F. During an observation on 6/29/2024 at 12:52 p.m., in the facility's kitchen with the Administrator, Maintenance Supervisor and Dietary supervisor, the following was observed: a. Freezer #4 that stored frozen meat, ice cream, butter and popsicles had an ice buildup on the upper section of the freezer with a temperature of 5 F as checked by the Maintenance Supervisor utilizing the facility's thermometer gun and the thermometer inside the freezer was 4 F. During an interview on 6/28/2023 at 5:20 p.m., the Dietary Supervisor (DS) stated the kitchen equipment such as the freezer and the refrigerator must be operating in proper temperatures (freezer must have a temperature of 0 [zero] and below F and refrigerator must operate with 40 F and below) to ensure the residents' food were stored safely, prevent the growth of bacteria that can cause food borne illnesses and the quality of the food was maintained. During an interview on 6/29/2024 at 9:46 a.m., the Maintenance Supervisor (MS) stated leakage and water condensation/ ice buildup inside the freezer signifies the equipment was not functioning properly and need to be replaced. During an interview on 6/29/2024 at 10:11a.m., the Administrator stated she was not aware of the concerns of the kitchen and pantry cold storage equipment. During an interview on 6/29/2024 at 5:06 p.m., the on call Registered Dietician stated the temperatures of the facilities cold storage equipment such as the freezer and refrigerator will have fluctuating temperatures depending on how often the kitchen staff were using them; however, the cold storage equipment must stay in the proper temperature and a thermometer must be delegated in each of the equipment to ensure the equipment temperature was monitored and functioning safely. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's freezer equipment manual titled Commercial Freezer Defrost Cycles Explained undated, the equipment manual indicated defrost cycles of the freezer avoid problems caused by the build up of ice and defrosting does not affect the interior temperature of the freezer cabinet and the food held in the freezer. During a review of the facility's policy and procedure (P&P) on Equipment Operation revised 11/ 2014, the P&P indicated appropriate and safe equipment are being used in the facility. During a review of the facility's P&P titled Food Storage and Handling revised 2/29/2024, the P&P indicated the residents' food items must be stored at a safe and appropriate temperature in the freezer at a temperature of 0-degree (zero) Fahrenheit and below and in the refrigerator at a temperature of below 41 degrees Fahrenheit. Cross Reference F812