

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/08/2024
NAME OF PROVIDER OR SUPPLIER  River Pointe Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  6041 Fair Oaks Blvd Carmichael, CA 95608	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>48874</p> <p>Based on observation, interview, and record review, the facility failed to provide services which meet professional standards of quality for two of 22 sampled residents (Resident 11 and Resident 5) when:</p> <ol style="list-style-type: none"> <li>1. Resident 11's medications were left on the bedside table unattended.</li> <li>2. Resident 5's oxygen tubing was left unconnected to the oxygen machine.</li> </ol> <p>These failures decreased the facility's potential to safely follow physician's order and cause health complications.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 11's Admission Record, it indicated that Resident 11 was admitted in Fall of 2022 with multiple diagnosis that included acute and chronic respiratory hypoxia (condition that can cause decreased oxygen through the body) and Type 2 Diabetes with polyneuropathy (condition that causes problems with blood sugar control with nerve ending damage).</li> </ol> <p>During a concurrent observation and interview on 11/6/24 at 8:28 a.m. with Resident 11, Resident 11 was lying in bed and a medication cup containing several medications was on the bedside table unattended. Resident 11 stated the nurses leaves the medication cup on the bedside table every day and Resident 11 will take them after the nurse has left.</p> <p>During an interview on 11/6/24 at 8:45 a.m. with Licensed Nurse (LN 2), LN 2 stated it was not the facility policy to leave medications by the bedside unattended. LN 2 stated she was not following the facility policy.</p> <p>During an interview with on 11/7/24 at 11:49 a.m., with Assistant Director of Nursing (ADON), The ADON stated it was not the facility policy to leave medications at the bedside unattended. The ADON further stated the medication could be missed and the LN would not be able to tell when the medication was taken which may interfere with the proper medication dosing for the resident.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/7/24 at 1:20 p.m. with the Director of Nursing (DON), the DON stated that it was not the facility practice to leave medications at the bedside unattended. The DON stated that if a resident has medications left at the bedside, the resident must have a Medication Administration Assessment and it should be in their care plan.</p> <p>During a review of Resident 11's records indicated no Medication Administration Assessment (a tool to assess if resident is able to do their own medication administration) was completed and Care plan dated 9/27/24, indicated no Self-Medication Administration.</p> <p>Review of facility's policy titled, Self-Administration of Medications, revised 12/2016, indicated For self-administering residents, the nursing staff will determine who will be responsible (the resident or nursing staff) for documenting that the medications were taken.</p> <p>49933</p> <p>2.A review of an Admission Record indicated Resident 5 was admitted to the facility in late 2024 with multiple diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and chronic respiratory failure with hypoxia (low levels of oxygen).</p> <p>During review of Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/10/24, indicated Resident 5 had moderate cognitive impairment. Resident 5's MDS indicated further that Resident 5 was on oxygen therapy and on hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility).</p> <p>During a concurrent observation and interview on 11/06/24 at 10:24 a.m. Resident 5 was in bed with nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) connected to nose. Resident 5 looked pale in color breathing rapidly. Resident 5's oxygen tubing was unconnected to the oxygen machine, which indicated Resident 5 was not receiving oxygen as ordered. Licensed Nurse 4 (LN 4) stated and confirmed that oxygen tubing was not connected to the machine. LN 4 checked Resident 5's oxygen level with results of 82 percent. LN 4 confirmed resident should have been on oxygen and stated that the risks could lead to Resident 5 being hypoxic (low levels of oxygen) and have shortness of breath.</p> <p>During a review of Resident 5's Order Summary Report, dated 11/8/24, indicated, Oxygen at 2 liters/min [minute] or to keep O2 [oxygen] sat [oxygen level] above 92% (for COPD 89% and above) via Nasal Cannula .Continuously via concentrator. every shift and as needed.</p> <p>During a review of Resident 5's care plan, dated 6/12/23, indicated as interventions .has severe COPD- The resident will display optimal breathing pattern daily .Give oxygen therapy as ordered by the physician.</p> <p>During an interview on 11/8/24 at 8:05 a.m., with DON, the DON stated her expectation was to ensure oxygen tubing was connected and supplying oxygen to the resident per doctor orders. The DON stated the risks of not receiving oxygen as ordered could lead to a change of condition to the resident because they are on it for medical reasons.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Administering Medications revised April 2019, the P&amp;P indicated Medications are administered in a safe .manner .and as prescribed .Medications are administered in accordance with prescriber orders.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49950</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the residents remained free of accident hazards for a census of 108 when:</p> <ol style="list-style-type: none"> <li>1) The facility did not have a smoking policy and procedure and failed to supervise residents (Resident 27 and Resident 61) smoking on facility premises.</li> <li>2) The facility did not have a smoking care plan for a resident (Resident 61) non-compliant with care.</li> </ol> <p>These failures had the potential to result in accidents including resident injury and fire.</p> <p>Findings:</p> <p>1) During a review of Resident 27's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated, Resident 27 was admitted to the facility January 2021 with multiple diagnoses which included asthma (a chronic lung disease that causes inflammation in the airways, making it difficult to breathe) and nicotine dependence (a chronic disease that occurs when someone's body and mind become used to having nicotine in their system).</p> <p>During a review of Resident 27's Smoking Assessment, dated 9/21/24, the Smoking Assessment indicated Resident 27 was a smoker.</p> <p>During an observation on 11/7/24 at 4:33 p.m., Resident 27 was smoking on a patio outside of the facility unsupervised.</p> <p>During a concurrent observation and interview on 11/8/24 at 9:27 a.m., there were 2 lighters and a pack of cigarettes in Resident 27's nightstand drawer. Resident 27 confirmed he was a smoker.</p> <p>During a review of Resident 61's face sheet, the face sheet indicated, Resident 61 was admitted to the facility May 2024 with multiple diagnoses which included Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing) and nicotine dependence.</p> <p>During a review of Resident 61's Smoking Assessment, dated 5/16/24, the Smoking Assessment indicated Resident 61 was a smoker, the resident needed one-on-one assistance while smoking, the resident needed the facility to store her lighter/cigarettes, and the resident needed a plan of care to assure resident is safe while smoking.</p> <p>During an observation on 11/05/24 at 7:45 a.m., Resident 61 was smoking on a patio outside of the facility unsupervised.</p> <p>During an observation on 11/7/24 at 2:55 p.m., Resident 61 was in the hallway with a lighter and cigarette in her hand.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/8/24 at 7:56 a.m. with Resident 61, Resident 61 confirmed she was a smoker and kept her lighter and cigarettes bedside.</p> <p>During an interview on 11/7/24 at 3:28 p.m. with Assistant Director of Nursing (ADON), ADON stated that the facility is a non-smoking facility. ADON further stated the facility did not have an active policy and procedure (P&amp;P) for smoking. ADON further stated he was aware that some residents smoke. ADON further stated residents have the right to smoke but there should be measures in place to keep them safe including polices and procedures for smoking.</p> <p>2) During a review of Resident 61's Smoking Assessment, dated 5/16/24, the Smoking Assessment indicated Resident 61 needed a plan of care to assure resident was safe while smoking including supervision.</p> <p>During a review of Resident 61's care plan, dated 6/9/24, the care plan indicated, .[Resident 61] is non-compliant with care and safety recommendations . There was no care plan for smoking or interventions addressing safety while smoking.</p> <p>During an interview on 11/7/24 at 3:28 p.m. with ADON, ADON confirmed there was no care plan in place to keep Resident 61 safe while smoking. ADON acknowledged this was a risk for fire and injury. ADON further stated there should be measures to keep Resident 61 safe including a care plan addressing smoking.</p> <p>The facility did not provide a P&amp;P for care planning when requested.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>49950</p> <p>Based on observation, interview, and record review, the facility had a 20.69% error rate when six medication errors out of 29 opportunities were observed during a medication pass for one of five Residents (Residents 88).</p> <p>This failure resulted in medications not given in accordance with the prescriber's orders and potential to affect the residents' clinical conditions.</p> <p>Findings:</p> <p>During a concurrent medication pass observation and interview on 11/5/24 at 8:15 a.m. with Licensed Nurse 3 (LN 3), LN 3 was observed preparing Resident 88's medications for administration. LN 3 placed 5 ml (ml- a unit of measurement) of liquid docusate sodium (a medication to help treat constipation) 50 mg (milligram, a unit of measurement)/ml in a 15 ml medication cup. LN 3 placed 10 ml of liquid levetiracetam (a medication to prevent seizures) 100mg/ml in a separate 15 ml medication cup. LN 3 did not dilute the liquid docusate sodium or liquid levetiracetam. LN 3 placed omeprazole (a medication to treat acid reflux) 20 mg delayed release tablet, aspirin (a medication to prevent blood clots) 81 mg chewable tablet, and Cardizem (a medication to treat high blood pressure) 90 mg tablet into a clear plastic pouch and crushed them together. LN 3 poured the combined crushed medications into a clear plastic cup and diluted the medications with 120 ml warm water from the sink faucet in Resident 88's room. LN 3 administered the liquid and diluted crushed medications with a 60 ml enteral (gastrointestinal tract or intestines) syringe through Resident 88's PEG tube (percutaneous endoscopic gastrostomy - a feeding tube that's inserted through the abdomen wall and into the stomach). LN 3 did not flush Resident 88's PEG tube with water before and after administering each of the medications. While LN 3 was administering the medications, there were large particles of omeprazole floating around in the syringe and blocking the opening of the syringe into the PEG tube. LN 3 removed the syringe before the remaining omeprazole could be administered. LN 3 acknowledged that he crushed Resident 88's medication together and was unable to administer the remaining omeprazole in the syringe because it was not crushed down completely. LN 3 stated that there is a risk for air and blockage to enter the PEG tube when medications are not crushed correctly prior to administration. LN 3 confirmed he did not flush Resident 88's PEG tube before and after administration of medications.</p> <p>During a review of Resident 88's medical record indicated the following physician's orders:</p> <ul style="list-style-type: none"> <li>- Aspirin 81 Oral Tablet Chewable: Give 1 tablet via PEG tube in the morning</li> <li>- Diltiazem (Cardizem) Tablet 90 mg: Give 1 tablet via G-tube (PEG) very 6 hours</li> <li>- Omeprazole Oral Suspension 2 MG/ML: Five 20 ml via G-tube every 12 hours</li> <li>- Keppra (Levetiracetam) Oral Solution: Give 10 ml via PEG tube two times a day</li> <li>- Docusate Sodium Oral Liquid 50 mg/5ml: Give 5 ml by mouth two times per day</li> </ul> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Enteral Feed Order: Flush feeding tube with 30 ml water before administration of first medication, then flush with 5 ml water in between medications. Flush feeding tube with 30 ml of water after the last medication administration.</p> <p>During an interview on 11/7/24 at 4:17 p.m. with Assistant Director of Nursing (ADON), ADON stated the expectation is for physician orders and policy and procedure to be followed when administering medications. ADON further stated there is a risk for PEG tube blockage and absorption issues when medications are not administered correctly.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Administering Medications, dated April 2019, the P&amp;P indicated, .medications are administered in accordance with prescriber orders .</p> <p>During a review of the Institute for Safe Medication Practices (ISMP), document Preventing errors when preparing and administering medications via enteral feeding tubes, dated 11/17/22, the document indicated, . if a practitioner crushes enteric-coated, controlled-release, sustained release .medications, toxicity or reduced drug efficacy may result .practitioners often do not discover that a formulation was inappropriate for enteral tube administration until the patient experiences an occluded [blocked] tube or adverse clinical outcome .</p> <p>During a review of the facility's P&amp;P titled, Administering Medications through an Enteral Tube, dated November 2018, the P&amp;P indicated, .administer each medication separately and flush between medications . do not crush enteric coated, sustained released medications .use warm purified water for diluting medications and for flushing .dilute liquid medication with 30 ml or more purified water .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>49950</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of 22 sampled residents (Resident 88) was free of a significant medication errors when he received omeprazole (a medication to treat acid reflux) in crushed pill form instead of the physician ordered liquid suspension through his percutaneous endoscopic gastrostomy (PEG - a feeding tube that's inserted through the abdomen wall and into the stomach) tube.</p> <p>This deficient practice had the potential for ineffective use of omeprazole resulting in a blocked PEG tube and decreased absorption of the medication.</p> <p>Findings:</p> <p>During a review of Resident 88's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated, Resident 88 was admitted to the facility February 2024 with multiple diagnoses which included cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain) and gastro-esophageal reflux disease (GERD- a chronic condition that occurs when stomach contents leak into the esophagus).</p> <p>During a review of Resident 88's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/20/24, the MDS indicated, Resident 88 had a feeding tube.</p> <p>During a review of Resident 88's Care Plan, initiated 2/5/24, the Care Plan indicated, Resident 88 had a PEG tube and will remain free from complications related to PEG tube.</p> <p>During a concurrent medication pass observation and interview on 11/5/24 at 8:15 a.m. with Licensed Nurse 3 (LN 3), LN 3 was observed preparing Resident 88's medications for administration. LN 3 placed omeprazole (a medication to treat acid reflux) 20 mg (milligram, a unit of measurement) delayed release tablet, aspirin (a medication to prevent blood clots) 81 mg chewable tablet, and Cardizem (a medication to treat high blood pressure) 90 mg tablet into a clear plastic pouch and crushed them together. LN 3 poured the combined crushed medications into a clear plastic cup and diluted the medications with 120 ml (milliliter, a unit of measurement) warm water. LN 3 administered the diluted crushed medications with a 60 ml enteral (gastrointestinal tract or intestines) syringe through Resident 88's PEG tube. While LN 3 was administering the medications, there were large particles of omeprazole floating around in the syringe and blocking the opening of the syringe into the PEG tube. LN 3 removed the syringe before the remaining omeprazole could be administered. LN 3 acknowledged that he crushed Resident 88's medication together and was unable to administer the remaining omeprazole in the syringe. LN 3 stated that there is a risk for air and blockage to enter the PEG tube when medications are not crushed correctly prior to administration.</p> <p>During a review of Resident 88's physician orders, dated 7/18/24, the physician orders indicated, Omeprazole Oral Suspension 2 mg/ml: Give 20 ml via G-Tube (PEG) every 12 hours for GERD. There were no orders allowing a substitution for omeprazole oral suspension with omeprazole delayed release tablet.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the Institute for Safe Medication Practices (ISMP), document Preventing errors when preparing and administering medications via enteral feeding tubes, dated 11/17/22, the document indicated, . if a practitioner crushes enteric-coated, controlled-release, sustained release .medications, toxicity or reduced drug efficacy may result .practitioners often do not discover that a formulation was inappropriate for enteral tube administration until the patient experiences an occluded [blocked] tube or adverse clinical outcome .</p> <p>During an interview on 11/7/24 at 4:17 p.m. with Assistant Director of Nursing (ADON), ADON stated the expectation is for physician orders and policy and procedure to be followed when administering medications. ADON further stated there is a risk for PEG tube blockage and absorption issues when medications are not administered correctly.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Administering Medications, dated April 2019, the P&amp;P indicated, .medications are administered in accordance with prescriber orders .</p> <p>During a review of the facility's P&amp;P titled, Administering Medications through an Enteral Tube, dated November 2018, the P&amp;P indicated, .do not crush enteric coated, sustained released medications .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49933</p> <p>Based on observation, interview, and record review the facility failed to store discontinued medications and destroyed medications in locked compartments and permit only authorized personnel to have access to the keys in two medication rooms for a resident census of 108.</p> <p>These failures had the potential for medication loss and diversion or misuse of medications from not being securely stored.</p> <p>Findings:</p> <p>During an concurrent observation and interview on 11/5/24 at 9:30 a.m. with Licensed Nurse 1 ( LN1) of Medication room [ROOM NUMBER] drug storage, there was a cabinet with a single door that had a metal latch on it. The cabinet was unlocked with no padlock on the latch. Observations of the cabinet opened revealed multiple packets of medications, bottles of pills and liquid medications. LN 1 stated that this cabinet is not locked and is kept unlocked.</p> <p>During an observation on 11/5/24 at 10:08 a.m. with LN 1 of Medication room [ROOM NUMBER], a double door cabinet with 2 metal latches connecting the 2 doors together was unlocked with no padlock(s) on the latches. Observations of the cabinet opened revealed approximately 160 packets of medications with some bottles of liquid medications. Further observation in Medication room [ROOM NUMBER] was a large blue Medi Waste Disposal Biohazard bin. This bin was easy to access and was not secured. Upon lifting the lid to this bin, the bin was approximately 1/3 full of multiple pills, bottles, and liquid. The insides of this bin could be easily accessed by staff. LN 1 stated that this bin was unsecured and is usually kept this way.</p> <p>During an interview on 11/5/24 at 1:13 p.m. with the Director of Nursing (DON) , the DON stated and confirmed that the discontinued medications were not secured in Medication room [ROOM NUMBER] and 2 to limit access to staff availability of these medications. The DON also confirmed that the blue Medi Waste Disposal Biohazard bin was not secured in Medication room [ROOM NUMBER].</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Storage of Medications, revised November 2020, the P&amp;P indicated, The facility stores all drugs and biologicals in safe, secure, and orderly manner. The P&amp; P further indicated . Drugs and biologicals used in the facility are stored in locked compartments . only persons authorized to prepare and administer medications have access to locked medications.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40830</p> <p>Based on observation, interview, and record review, the Dietary Services Supervisor (DS) failed to demonstrate the appropriate competencies and oversight to carry out the functions of the food and nutrition services.</p> <p>These deficient practices had the potential to cause food borne illness for 105 of 108 of the highly susceptible residents who consumed food from the kitchen of the facility as evidenced by:</p> <ol style="list-style-type: none"> <li>1. DS was unable the verbalize the proper procedure of thawing meats by using the refrigeration method (cross refer to F812, #6);</li> <li>2. DS did not have proper knowledge about the correct concentration of the sanitizer for the dishwashing machine (cross refer to F812, #9), and</li> <li>3. DS did not have knowledge about the proper process for manual dishwashing by the three-compartment sink (cross refer to F812, #10)</li> <li>4. DS did not have hair fully covered by hair restraint (cross refer to F812, #8)</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation of the walk-in refrigerator on [DATE], at 9:55 a.m., there was a three-level carts with boxes of foods and the boxes were wet and observed liquid was leaking out of the boxes. Food items per each level as followed:</li> </ol> <p>Top level of the cart:</p> <ul style="list-style-type: none"> <li>-a box of bags of carrot (soft and mushy to touch, observed water at the bottom of the bags)</li> <li>-a box of bags of corn</li> <li>-a box of bags of mix vegetables</li> <li>-a box of bags of English muffins</li> </ul> <p>Second level of the cart:</p> <ul style="list-style-type: none"> <li>- a box of pork loin</li> <li>-a box of ground pork</li> </ul> <p>Third level of the cart:</p> <ul style="list-style-type: none"> <li>-two boxes of ground beef</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  River Pointe Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  6041 Fair Oaks Blvd Carmichael, CA 95608	
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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was a box of fish fillet on the bottom of the second rack with wet corner and yellow liquid leaked out from the box dripping on the floor. On the bottom shelf of the third rack with a box of raw bacon was placed together with boxes of deli meats. All the thawing food items did not indicate any date of pulled from the freezer or used-by after thawed.</p> <p>During a concurrent interview with DS, he verified those boxes of vegetables, bread and meats were for thawing. DS stated he could not determine when the kitchen staff started thawing the food items with no dates on them. He stated the kitchen had a system for thawing food and meats and he stated he would follow the policy. DS could not state the policy for thawing when asked.</p> <p>A review of facility policy and procedure titled, Thawing of meats, dated 2023, it stated, Thawing meat .in a refrigerator .allow 2 to 3 days to defrost .label defrosting meat with pull and use by date .use a drip pan under food being thawed so drippings do not contaminate other food .store raw meat .separately from cooked and ready-to-eat food to prevent cross contamination .store cooked or ready-to-eat food above raw meat .</p> <p>2. During a concurrent observation and interview on [DATE], at 10:33 a.m. with the Dietary Aide (DA 1) and DS, DA 1 demonstrated and verbalized the process of dishwashing with the dishwashing machine. She stated she would use the test strip to check the concentration of the sanitizer (Chlorine) if the sanitizer was effective, and the concentration should be 200 ppm (parts per million - a measurement unit for the concentration of solution).</p> <p>DS confirmed DA 1's answer was correct. DS took the test strip container out and showed the container with the color indicators had different levels of concentration which were 10 ppm, 50 ppm, 100 ppm and 200 ppm. He stated all the ppm indicators on the test strip container were correct. He further stated if the tested strip matched any of those color indicators meant the tested sanitizer was in the right concentration range.</p> <p>At the same time, observed DA 1 tested the sanitizer concentration during the wash/rinse cycles and DA 1 stated the test strip did not show any color. DS told the DA 1 needed to test after the completion of wash/rinse cycles. DA 1 used the same used test strip to test again and showed no color. DS stated DA 1 should use the new strip to test. Then DA 1 used the new one to test and the concentration read 50 ppm.</p> <p>A concurrent review of the Dishwashing Machine Temperature Log on the dishwashing room wall with DS and DA 1, it indicated the concentration of the sanitizer (Chlorine) should be at ,d+[DATE] ppm. Therefore, DS stated concentration range of ,d+[DATE] ppm was not correct.</p> <p>A review of facility policy and procedure titled, Dishwashing, dated 2023, it indicated the test of sanitizer should be after wash and rinse cycles, and the concentration level of the sanitizer (Chlorine) was crucial and should be at ,d+[DATE] ppm.</p> <p>3. During a concurrent interview and sanitizer bottle instruction review on [DATE], at 10:39 a.m., with DA 1 and DS, DA 1 verbalized the process of manual dishwashing by using three-compartment sinks. DA 1 stated the steps were wash, rinse, sanitize and air-dried. For the sanitize step, DA 1 stated the immersion time of the dishes should be 10 seconds and the concentration of the sanitizer (quaternary ammonium) should be 50 ppm. DS could not verify DA 1's answer and he could not provide the answer of the immersion time and correct concentration of the sanitizer.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A concurrent review of instruction on the sanitizer bottle with DS and DA 1, it indicated the immersion time was 60 seconds and the concentration should be ,d+[DATE] ppm.</p> <p>A review of facility policy and procedure titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, it stated the sanitizer immersion time should be at least one minute (60 seconds), and the concentration of the sanitizer (quaternary ammonium) should be at ,d+[DATE] ppm.</p> <p>4. During an observation of the kitchen on [DATE], at 9:50 a.m., noted DS had ,d+[DATE] inches of shoulder length hair extending outside of the hair restraint and walking around the kitchen.</p> <p>During a concurrent observation and confirmation interview with Registered Dietitian (RD) on [DATE], at 10:17 a.m., RD verified and stated DS did not have his hair fully covered which he should.</p> <p>A review of facility policy and procedure, Dress Code, dated 2023, it indicated the hair should be completely covered with hair restraint.</p> <p>During an interview with DS on [DATE], at 9:50 a.m., he stated his overall main role for the food service operation were food and supplies ordering and budgeting. DS further stated his other main role was to ensure the food quality and taste for the residents. For the competency for the kitchen staff, he stated Registered Dietitian and himself did in-services based on found issues and would do 12 topics per year.</p> <p>On [DATE], at 3:22 p.m., a review of DS's employee file with date of hire of [DATE], it showed he was certified as State program with Dietary Service Supervisor completed on [DATE]. He had ServSafe (sets of training courses for food safety) certificate but expired on [DATE]. The most recent annual performance evaluation was done on [DATE] by the previous facility administrator.</p> <p>During an interview with facility Administrator (ADM) on [DATE], at 3:42 p.m., ADM acknowledged the last performance evaluation of DS. ADM stated he did not do any evaluation for DS yet. ADM further stated he was aware of the issues found about the kitchen and would put those issues under QAPI (quality and assurance performance improvement) to monitor the improvement process.</p> <p>A review of undated facility's job description for Dietary Services Supervisor, it stated, .Duties and Responsibilities .administrative functions .assume administrative authority, responsibility, and accountability of supervising the Dietary Department .participate in the planning, conducting, and scheduling of timely in-service training classes .that ensure a well-educated dietary service department .make daily rounds to assure dietary personnel are performing required duties and to assure that appropriate dietary procedures are being rendered to meet the needs of the facility .Ensure that all dietary personnel follow established departmental policies and procedures, including appropriate dress codes .Monitor dietary service personnel to assure they are following established safety regulations in the use of equipment and supplies .</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>40830</p> <p>Based on observation, interview and record review, the facility failed to ensure Dietary Aide (DA 1) had the appropriate skill set to safely perform the daily operations of the food and nutrition services department when:</p> <ol style="list-style-type: none"> <li>1. DA 1 was unable to demonstrate and verbalized the correct use of the test strip and the correct concentration of the sanitizer (Chlorine) for the dishwashing when using the dishwashing machine, and</li> <li>2. DA 1 was unable to verbalize the correct process of manual dishwashing with three-compartment sink.</li> </ol> <p>These failures had the potential to place 105 out of 108 highly susceptible residents who consumed food from the facility at risk for food borne illness.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on 11/5/24, at 10:33 a.m. with DA 1 and Dietary Services Supervisor (DS), DA 1 demonstrated and verbalized the process of dishwashing with dishwashing machine. She stated to check the effectiveness of the sanitizer (Chlorine) was to use the test strip to check the concentration and it should be 200 ppm (parts per million - a measurement unit for concentration of solution). Observed DA 1 tested the sanitizer concentration during the wash/rinse cycles and stated the test strip did not show any shades of colors (the shades of colors indicate the detection of different levels of concentration and the levels were 10 ppm, 50 ppm, 100 ppm, and 200 ppm). DS told the DA 1 needed to test after the completion of wash/rinse cycles. Observed DA 1 used the same used test strip to test again and showed no color. DS stated DA 1 should use the new test strip, then DA 1 used the new one to test and the concentration read 50 ppm.</li> </ol> <p>A concurrent review of the Dishwashing Machine Temperature Log posted on the dishwashing room wall with DS and DA 1, it indicated the concentration of sanitizer (Chlorine) should be at the range of 50-100 ppm.</p> <p>A review of facility policy and procedure titled, Dishwashing, dated 2023, it indicated the test of sanitizer should be after wash and rinse cycles, and the concentration level of the sanitizer was crucial and should be at 50-100 ppm.</p> <ol style="list-style-type: none"> <li>2. During a concurrent interview and sanitizer bottle instruction review on 11/5/24, at 10:39 a.m., with DA 1 and DS, DA 1 stated the staff would start manual dishwashing when the dishwashing machine was not working. DA 1 verbalized the steps of manual dishwashing with three-compartment sinks. DA 1 stated the steps were wash, rinse, sanitize and air-dried. During verbalizing the sanitize step, DA 1 stated the dishes immersed into the sanitizer (quaternary ammonium) for 10 seconds before taking out for air-dried. She stated the concentration of the sanitizer should be 50 ppm. DS could not verify DA 1's answer and could not provide the correct immersion time and concentration of the sanitizer.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the instruction on the sanitizer bottle with DA 1 and DS, it indicated the immersion time was 60 seconds and the concentration should be 150-400 ppm.</p> <p>A review of facility policy and procedure titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, it stated the sanitizer immersion time should be at least one minute (60 seconds), and the concentration of the sanitizer (quatarnary ammonium) should be at 200-400 ppm.</p> <p>During an interview with Registered Dietitian (RD) on 11/8/24, at 9:25 a.m., RD stated all the dietary staff should know about both process of dishwashing by the dishwashing machine and the manual washing. RD further stated it was a sanitation process for the dishes and the kitchen used the dishes or kitchenware to prepare and deliver food to the residents who were susceptible for food borne illness.</p> <p>A review of DA 1's employee file, it indicated her date of hire was on 9/15/17 for dietary aide position. DA 1's had a ServSafe (sets of training courses for food safety) food handler certificate with expiration date of 6/7/2025.</p> <p>A review of departmental document titled, Verification of Job Competency Demonstration - Dietary Aides, completed for the year of 2024 by RD, it indicated DA 1 was competent on Sanitation method used in dish machine and proper concentration, and Emergency dish washing procedure and when to use it categories by verbalization.</p> <p>A review of departmental documents titled, Food &amp; Nutrition Services In-Service, Topic: Dishwasher, and Food &amp; Nutrition Services In-Service, Topic: 3-Compartment Sink,, both completed on 7/8/24 and given by RD and DS. Both documents indicated DA 1 attended both in-services. Both in-services explained about the proper steps, temperature requirements, sanitizer used and testing and the policies and procedures for dishwashing machine and three-compartment sink methods.</p> <p>A review of undated facility job description titled, Dietary Aide, it stated, .Essential Job Functions .ensure all dietary procedures are followed in accordance with established policies .attend trainings, in-services, and meetings .prepare, serve, and store food, etc., in accordance with sanitary regulations and established policies and procedures .</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>50121</p> <p>Based on observation, interview, and record review, the facility failed to ensure the planned menu was followed for lunch on 11/6/24 when:</p> <ol style="list-style-type: none"> <li>Two of four residents (Resident 25 and Resident 38) with large portion diets received incorrect portions of meatballs (5 counts of meatballs instead of 6 counts.)</li> <li>Four of four residents (Resident 6, 29, 38, and 40) with Renal or CKD5 diets (diets for people managing chronic kidney disease) received tapioca pudding instead of cookie as dessert.</li> <li>Three of three residents (Resident 10, 24, and 100) with low fat and low cholesterol (a type of fat, LFLC) diets received whole milk and margarine with wheat roll instead fat free milk and no margarine with wheat roll.</li> <li>Two of two residents (Resident 64 and Resident 81) with finger food diets received rice and tapioca pudding instead of diced/sliced potato and pudding on graham crackers</li> <li>105 of 105 residents did not receive garnish with parsley for their meals.</li> </ol> <p>These deficient practices had the potential to result in residents having meals which would not meet their nutritional needs.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During a concurrent observation and interview on 11/6/24 at 11:59 a.m. with the Registered Dietitian (RD), the cook was observed placing five meatballs on large portion plates for Resident 25 and Resident 38. In a concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, the spreadsheet indicated two meatballs for a regular portion and three for a large portion. RD stated meatballs were small, and four were appropriate for regular portion, and six meatballs were a large portion.</li> <li>During a clarifying interview on 11/6/24 at 11:45 a.m. with RD, RD confirmed the CKD5 diet was a renal diet and for all renal diets, facility used the 80-gram protein renal diet menu on the spreadsheet titled, Fall Menus, Week 2 Wednesday.</li> </ol> <p>During a concurrent observation on 11/6/24 at 12:15 p.m. and record review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, the spreadsheet indicated renal diet should receive cookie. Residents 6, 29, 38, and 40 received tapioca pudding.</p> <p>During a review of the facility document titled, Diet Manual for Long Term Care and Residential Facilities, dated 2023, it indicated, .Renal Diet .regulates the dietary intake of sodium, potassium and protein to lighten the work of the diseased kidney .protein restricted diets allow small cookies and avoid puddings.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a concurrent observation of tray line [portioning food on meal trays in an assembly line-fashion] and interview on 11/6/24 at 12:20 p.m. with Dietary Aide (DA) 2, DA 2 stated only regular milk and nectar-thickened milk were portioned for tray line. DA 2 placed 4 oz. glass of milk on tray for Resident 10, 24, and 100, who had LFLC diets ordered. DA 1 placed margarine on those trays. In a concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, the spreadsheet indicated residents on a LFLC diet should receive fat free milk and no margarine.</p> <p>During a review of the facility document titled, Diet Manual for Long Term Care and Residential Facilities, dated 2023, it indicated, .Low Fat/Low Cholesterol Diet .a diet designed to lower elevated cholesterol and other lipids [fats] to reduce the risk of heart disease .margarine is not to be given with bread .allowed fat free milk .avoid whole milk, 1% or 2% milk.</p> <p>4. During an observation on 11/6/24 at 12:02 p.m., found Resident 64 and Resident 81 with finger food (FF) diet received rice for starch and tapioca pudding for dessert. In a concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, the spreadsheet specified for FF diet should receive dice potatoes as the starch and mousse (changed to tapioca) on graham crackers for dessert.</p> <p>During a review of the facility document titled, Diet Manual for Long Term Care and Residential Facilities, dated 2023, it indicated, Finger Foods Diet .provides food in appropriate size and shape to be eaten without utensils, but rather with fingers [to] . allow residents to maintain independence, dignity, and quality of life.</p> <p>5. All meals without modified texture (such as mechanically soft or pureed) delivered did not have parsley garnish. During a concurrent review of the facility spreadsheet titled, Fall Menus, Week 2 Wednesday, it indicated all diets should receive a parsley garnish.</p> <p>During an interview on 11/6/24 at 1:40 p.m. with Dietary Supervisor (DS) and RD, RD stated rice and tapioca were not finger foods and menu had not been followed. DS and RD acknowledged the issues found during tray line meal service.</p> <p>During an interview on 11/8/24 at 9:25 a.m. with RD, RD acknowledged issues that were found during tray line meal service on 11/6/24. RD stated residents should receive the food items reflected on the menu. RD further stated, kitchen staff needed to follow the menu and spreadsheet. RD stated when the residents with large portion diets, received only five meatballs, the risk was the residents with medical conditions which require extra protein would not get enough protein. RD stated residents were placed on a LFLC diet as part of a treatment plan for special medical conditions, and the staff needed to follow the menu and spreadsheet to ensure the medical condition was managed according to the medical treatment plan. RD stated the cookie was specified for the renal diet because pudding had more protein and phosphorus which should be limited in residents with renal disease. RD stated residents, on a finger foods diet, may not eat foods that cannot be eaten with fingers resulting in an insufficient intake of calories.</p> <p>During a review of the facility's policy titled, Menu Planning dated 2023, it indicated, .menus are planned to meet nutritional needs of residents in accordance with established national guidelines .the facility's diet manual and diets are ordered by the physician should mirror the nutritional care provided by the facility . menus are written for regular and therapeutic diets in compliance with the diet manual.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of undated document titled Job description, Dietary Aid, document indicated dietary aids were to assist in preparing food for therapeutic and texture modified diets in accordance with planned menus and established portion control procedure.</p> <p>During a review of undated document titled Job description, Dietary Cook, document indicated the dietary cook was to Prepare food for therapeutic and texture modified diets in accordance with planned menus and established portion control procedure.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50121</p> <p>Based on observation, interview and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food serve safety when:</p> <ol style="list-style-type: none"> <li>1. The ice machine was not clean; and</li> <li>2. Kitchenware was stacked and stored while wet in the clean and ready-to-use storage area; and</li> <li>3. Fry pans stored in the clean and ready-to-use storage area were not clean; and</li> <li>4. Food in open packages was not covered and open food items lacked complete label; and</li> <li>5. Expired food was available for use; and</li> <li>6. Food thawing processes were not followed; and</li> <li>7. Outdated resident food brought from the outside was not discarded; and</li> <li>8. One dietary staff did not have hair fully covered; and</li> <li>9. Two dietary personnel were not able to demonstrate and verbalize correct concentration testing and concentration range of dishwasher sanitizer; and</li> <li>10. Two dietary personnel were not able to verbalize the correct manual dishwashing process.</li> </ol> <p>These failures had the potential to result in food contamination which could cause illness in the 105 of 105 residents receiving food prepared in the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on [DATE] at 11:03 a.m. with the Environmental Services Manager (EVSM), the ice machine's machinery was accessed, and the water curtain (a plastic cover rest on the ice making panel to redirect the ice to the ice storage bin) had white and pink slimy substances upon it, and the pink slimy substances could be removed easily by wiping with a paper towel. When the water trough was taken apart, black substances were found on the side of the trough interior and at the bottom of the evaporator unit, and those substances were rough to touch. EVSM stated he sometimes performed the ice machine deep cleaning (cleaning and sanitizing the machinery parts on the top section of the ice machine and the ice storage bin on the bottom section of the machine with chemical solutions designed to remove lime scale and mineral deposits and to remove algae and slime, then sanitize with chemical agent), but more often he delegated it to an outside vendor. Dietary Supervisor (DS) and EVSM confirmed the ice machine was not clean. EVSM stated he would contact the vendor to come for cleaning again.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview with the outside vender technician (OVT) on [DATE], at 3:03 p.m., OVT stated the process of the cleaning and sanitizing the ice machine began with removing the ice from the storage bin, continued with putting the descaling solution in the trough and running the cleaning cycle. OVT stated next, he would take the parts apart to clean and scrub them by hand using plastic tools taking care not to scratch the smooth surface, followed by sanitizing the parts prior to putting the parts back. OVT stated the next step was to put the sanitizer solution in the trough and to run the cleaning cycle and then to clean and sanitize the ice storage bin. OVT stated the final step was to run the clean cycle a few more time with water and to discard the first few batches of ice to ensure the machine was fully rinsed. OVT looked at picture taken during earlier observation ([DATE] at 11:03 a.m.) of the bottom of the evaporator unit with significant black substances and rough texture. OVT confirmed it looked rough and stated it needed to be scrubbed more, and the calcium deposit buildup occurred quickly. OVT stated he needed to see if the water filter needed to be changed more frequently. OVT concurred the hard deposits would make the area hard to clean and easy to harbor dirt and bacteria.</p> <p>During an interview on [DATE] at 9:25 a.m. with Registered Dietician (RD), RD stated she expected the ice machine to be cleaned and maintained per manufacturer's guidelines and facility staff also needed to inspect the machine to ensure it was clean.</p> <p>During a document review of [Vendor Name] invoice # 17999, serviced on [DATE], the invoice indicated the ice machine had preventative maintenance, cleaning and sanitization performed.</p> <p>During a review of the facility policy and procedure (P&amp;P) titled, Ice Machine Cleaning Procedures, dated 2023, P&amp;P indicated, The internal components [of the ice machine] cleaned monthly or per manufacturer's recommendation.</p> <p>During a review of the kitchen ice machine manual titled, [Manufacturer's brand] Ice Machines Installation, Operation and Maintenance Manual, dated ,d+[DATE], the manual indicated, .You are responsible for maintaining the ice machine in accordance with the instructions in this manual . CLEANING/SANITIZING PROCEDURE This procedure must be performed a minimum of once every six months .Removes mineral deposits from areas or surfaces that are in direct contact with water. CLEANING PROCEDURE . Ice machine cleaner is used to remove lime scale and mineral deposits. Ice machine sanitizer disinfects and removes algae and slime .</p> <p>According to 2022 FDA (Food and Drug Administration) Food Code, on section ,d+[DATE].11 Equipment Food-Contact Surface and Utensils, it stated equipment like ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms (a living thing that is so small it must be viewed with a microscope, such as bacteria or algae). In addition, on Section ,d+[DATE].11 Food-Contact Surfaces, it stated, .The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food-contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts . and .Multiuse Food-Contact Surfaces shall be: 1. Smooth; 2. Free of breaks, open seams, cracks, chips, inclusions, pits .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. During a concurrent observation and interview on [DATE] at 9:30 a.m. with DS, DS confirmed the following items were wet and stacked in clean and ready-to-use storage area:</p> <ul style="list-style-type: none"> <li>- two metal bowls</li> <li>- 18 full sheet metal pans</li> <li>- two full sheet metal strainers</li> <li>- five ,d+[DATE]-sheet metal pans</li> <li>- one cooking pot</li> <li>- two ,d+[DATE]-sheet metal pans</li> <li>-11 ,d+[DATE]-sheet metal pans</li> </ul> <p>DS stated items needed to be air dried, and it was his responsibility to check the items before they were stored away.</p> <p>During an interview on [DATE] at 9:25 a.m. with RD, RD stated the dishes needed to be completely dried before stored to prevent bacteria growth caused by the moisture.</p> <p>During a review of policy and procedure (P&amp;P) titled, Dishwashing, dated 2023, the policy indicated Dishes are to air dried in racks before stacking and storing.</p> <p>3. During a concurrent observation and interview on [DATE] at 9:28 a.m. with DS, DS confirmed a ring of black flaky debris around inside edge of three large fry pans located in clean and ready-to-use storage area. DS stated Those pans are old and need to be thrown away.</p> <p>During a review of P&amp;P titled, Sanitation dated 2023, All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair .</p> <p>According to 2022 FDA (Food and Drug Administration) Food Code, on section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the document indicated (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations.</p> <p>4. During a concurrent observation of the dry storage room and interview on [DATE] at 9:12 a.m. with DS, DS confirmed an opened box of chocolate chips with open, unclosed inner bag, and no opened and used by date. DS confirmed chips were spilling outside the bag into the box. DS stated opened bags or boxes of dry food need to be sealed tightly to prevent pest or rodent contamination. DS stated opened packages need to have opened and used by dates.</p> <p>During a concurrent observation on [DATE] at 9:35 a.m. with DS, DS confirmed cart adjacent to cook workstation had undated, open, unsealed packages of cornstarch and cream of wheat. DS confirmed cook was not using this in current meal preparation. DS stated opened, unsealed boxes might be contaminated and needed to be discarded.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 9:25 a.m. with RD, RD stated opened packages of food items should be resealed tightly and labeled with the opened and used by dates.</p> <p>During a review of P&amp;P titled, Labeling and Dating of Foods, dated 2023, policy indicated Newly opened foods need to be closed and labeled with an open date and used by date</p> <p>During a review of P&amp;P titled, Storage of Food and Supplies, dated 2023, policy indicated dry food items which have been opened, such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles, etc., will be tightly closed, labeled and dated.</p> <p>5. During a concurrent observation and interview on [DATE] at 9:12 a.m. with DS, bulk dry milk was stored in the container with a label of opened [DATE] and used by [DATE]. DS confirmed that dry milk was expired and needed to be discarded. DS confirmed an opened bag of lime gelatin wrapped with plastic wrap with open date of [DATE] and used by [DATE] and stated it was expired and needed to be discarded.</p> <p>During a concurrent observation in walk-in refrigerator and interview on [DATE] at 9:55 a.m. with DS, DS confirmed container of deli turkey with label of used by date of [DATE] and a container of deli ham with label of used by date of [DATE] were expired and needed to be discarded.</p> <p>During an interview on [DATE] at 9:25 a.m. with RD, RD stated expired products should not be used and on the daily rounds done by RD or DS, the expired products should be removed so they were not used.</p> <p>During a review of P&amp;P titled, Procedure for Refrigerated Storage: dated 2023, the policy indicated All refrigerated foods are to be kept the amount of time per refrigerated storage guide .luncheon meats maximum refrigerated time 5 days .This storage length is to be followed.</p> <p>During a review of P&amp;P titled, Refrigerator and Freezer, dated 2023, the policy indicated Check all food . being mindful of expiration and used by date.</p> <p>During a review of P&amp;P titled, Storage of Food and Supplies, dated 2023, the policy indicated All food will be dated . and will be used per the times specified in the Storage Guidelines .The storage times in the guidelines are intended to be on the safe side.</p> <p>6. During a concurrent observation of the walk-in refrigerator and interview on [DATE] at 9:55 a.m. with the DS, a cart contained thawing food (meat, bread, and vegetables) all without pulled on or use by dates indicated when the staff pulled out the item from the freezer and when should be used or discard if not used. All food items were in cardboard boxes with no drip pans and had liquid dripping from the boxes.</p> <p>On the top tier of the cart:</p> <ul style="list-style-type: none"> <li>- one box of bags of thawing carrot (soft and water on the bottom of the bag)</li> <li>- one box of bags of thawing corn</li> <li>- one box of bags of thawing mixed vegetable</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the undated P&amp;P Foods Brought to the Facility by Friends/Family, the policy indicated food items placed under refrigeration must be labeled with the name/date and discarded after 48 hours.</p> <p>8. During an observation on [DATE] at 9:50a.m. of DS in kitchen, DS noted to have ,d+[DATE] inches of shoulder length hair extending outside of hair net.</p> <p>During a concurrent observation and interview on [DATE] at 10:17 a.m. with RD, RD confirmed signage at entrance to kitchen door stated hair covering was required for entrance, and confirmed DS did not have hair fully covered.</p> <p>During a review of facility P&amp;P titled, Dress Code, date 2023, Hat for hair, if hair is short, which completely covers the hair; Hair net for hair, if hair is long (over the ears or longer).</p> <p>9. During a concurrent observation and interview on [DATE] at 10:33 a.m., DA 1 stated the chlorine solution used during the sanitizing cycle of the dishwashing machine operation needed to be tested with a test strip to know if it was effective. DA 1 stated the color change that resulted when test strip was dipped in the solution should indicate the concentration was in the range of 200 parts per million (unit of measure, ppm). DS confirmed DA1's answer was correct. Test strip vial had various shades of violet labeled as 10ppm, 50 ppm, 100 ppm and 200 ppm as indicators for the different levels of concentration. DS stated all the ppm levels were correct, and if the test strip matched any of those colors, it indicated the concentration was in the right concentration range. DA 1 demonstrated use of the test strip by dipping in the solution during the wash/rinse cycle and stated there was no color change. DS stated test strip should be used after the wash/rinse cycles were completed, during the sanitizing cycle. DA 1 used a new test strip during the final rinse/ sanitizing cycle and stated the test strip had a color change that indicated 50 ppm. Concurrent review of the dishwashing machine temperature log with DS, log indicated the concentration of chlorine should be at ,d+[DATE] ppm.</p> <p>During a review of P&amp;P titled Dishwashing, dated 2023, the policy indicated The chlorine should read , d+[DATE] ppm on dish surface in final rinse.</p> <p>10. During an interview on [DATE] at 10:39 a.m. with DA 1, DA 1 stated if the dishwasher was not operational, she would switch to manual dishwashing with the 3-compartment sink. DA 1 and DA 2 stated the steps were washing, rinsing, sanitizing, and air-drying. DA 1 and DA 2 stated the water temperature for the wash and rinse steps should be at 110 degrees Fahrenheit (F). DA 1 stated the dishes should be soaked in the sanitizing solution (quaternary ammonium) in the third sink compartment for 10 seconds and the concentration should be 50 ppm.</p> <p>During the concurrent interview with DS, DS did not respond when asked how long dishes needed to remain in the sanitizing solution and the concentration of the sanitizer solution. Concurrent review of the instruction of the [Brand name] sanitizer solution bottle with DA 1 and DS, manufacturing instructions indicated the immersion time was 60 seconds and the concentration should be ,d+[DATE] ppm.</p> <p>During an interview on [DATE] at 9:25 a.m. with RD, RD stated dietary staff should know about the machine dishwashing process and the manual dishwashing process because dishwashing was important in the sanitation of the dishes, and the kitchen used kitchenware to prepare and delivery food to a vulnerable population who was susceptible for food borne illness.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of P&amp;P titled 3-Compartment Procedure for Manual Dishwashing, dated 2023, policy indicated Test the concentration with the appropriate test strip, which is dipped in the sanitizer solution 10 seconds before reading Must read ,d+[DATE] ppm. Immerse all washed items for at least 1 min (60 seconds).</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>50121</p> <p>Based on observation, interview, and record review, the facility failed to ensure garbage and refuse were disposed of properly when two of the two outside dumpsters were not adequately closed, and the surrounding area was littered with debris for a census of 108.</p> <p>This failure had the potential to expose the residents, visitors, and staff to pests, odor, or disease.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 11/5/24 at 10:49 a.m. with the Dietary Supervisor (DS), the lid of facility garbage dumpster containing bags of trash was not tightly closed. Urinal with brown and yellow liquid observed on ground next to the garbage bin. DS confirmed lid was open and should be tightly closed.</p> <p>During a follow-up observation on 11/6/24 at 7:45 a.m., gate to dumpster area was open, and hatch doors on top of both garbage dumpster and recycling dumpster were open.</p> <p>During a follow-up observation on 11/6/24 at 4:45 p.m., both garbage dumpster and recycling dumpster lids were open.</p> <p>During a concurrent observation and interview on 11/7/24 at 7:55 a.m. with the Environmental Services Manager (EVSM), EVSM confirmed the lid to garbage dumpster was open and stated lids were supposed to be kept tightly closed. EVSM confirmed scattered trash around dumpster and stated, Area is dirtier than I would like. EVSM stated the area around the dumpsters should be kept clean. When asked about urinal containing brown liquid with white tissue inside, EVSM stated, That shouldn't be there.</p> <p>During an interview on 11/8/24 at 9:25 a.m. with Registered Dietitian (RD), RD stated the garbage bin lids needed to be closed all the time, and the surrounding area should be kept clean to prevent pest and rodents. RD stated the maintenance department should monitor the dumpster and ensure the dumpster and surrounding area clean.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Sanitation: Miscellaneous Areas, dated 2023, the policy indicated, Garbage and trashcans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed and The trash collection area is a potential feeding ground for vermin [cockroaches, mice, rats, and similar pests that carry disease] and rodents and must be kept clean.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>49933</p> <p>Based on interview and record review the facility failed to implement action plans in their Quality Assurance and Performance Improvement (QAPI) program for an identified infection control issue for a census of 108 residents.</p> <p>This failure had the potential to affect infection prevention in the facility.</p> <p>Findings:</p> <p>During a review of the facility's system for their QAPI program, it was noted that a Performance Improvement Project (PIP) dated 8/16/24 was identified for an infection control issue. It had review dates for 9/16/24, 10/16/24, and planned complete date of 11/16/24. No documented evidence the following tasks were done: 1) In-Service to all nursing department .2) 100% Competency skills check for current Full Time Employees and upcoming new hires CNAs and LNs . 3) 100% Skin Sweep Weekly x 6 weeks and 4) Findings of the audits in #1, 2 and 3 will be reported in the QAA(quality assessment and assurance) Monthly Meeting. There was no further documented evidence that the facility had follow up reviews or meetings in September 2024 or October 2024 as required per the PIP.</p> <p>During an interview on 11/7/24 at 3:49 p.m., with the Infection Preventionist (IP), the IP stated that some trainings were completed for the infection control issue mentioned in the PIP. The IP was unable to provide documented evidence that 100% competency skills or that 100% weekly skin sweeps were completed as required in the PIP.</p> <p>During a concurrent interview and record review on 11/8/24 at 10:33 a.m. with the Administrator (ADM), a review of the PIP dated 8/16/24 was reviewed. The ADM stated that there were no monthly meetings or reviews completed in September 2024 or October 2024 as required per the PIP. The ADM stated they did not implement the plan for this infection control issue. The ADM confirmed that there was no documented evidence that the competency skills and weekly skin sweeps were completed.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Quality Assurance and Performance Improvement (QAPI) program, dated February 2020, the P&amp;P indicated, The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48874</p> <p>Based on observation, interview and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 108 residents when:</p> <ol style="list-style-type: none"> <li>1. Staff failed to properly store Resident 1's personal items found on the floor</li> <li>2. Facility staff provided care without wearing all the required personal protective equipment (PPE) for Resident 21 who was on Enhanced Barrier Precaution (EBP) (EBP - infection control intervention designed to reduce transmission of multidrug-resistant organisms, MDROs- bacteria that resist treatment with more than one antibiotic] that requires gown and glove use)</li> <li>3. Resident 80 and Resident 66 urinals (a hand-held bottle for urination) were not labeled with a resident identifier and the date it was initially used;</li> <li>4. A blood pressure cuff was not cleaned and sanitized in between resident use; and</li> <li>5. Linens and a soiled incontinence (involuntary leakage of urine or feces) pad were observed on the floor of Resident 56's room.</li> </ol> <p>These failures had the potential to result in the spread of infection in the facility.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on 11/6/24 at 8:40 am with Resident 1, observed several personal items including blankets on the Resident's 1 floor near the bed. Resident stated that she did not like her items being on the floor and needed help putting her things away and that no staff members had offered to help her.</p> <p>During an interview on 11/6/24 at 9:05 am with Licensed Nurse 1 (LN 1), LN 1 stated that personal items should not be stored on the floor, and this was an infection control risk for the resident.</p> <p>During an interview on 11/7/24/at 11:15 a.m., with the Social Service Director (SSD), the SSD who was also a LN stated that a resident's personal items should not be found on the floor and the process for personal items is that an inventory is taken on admission and then a staff member, usually a CNA (certified nursing assistant) or LN will help the resident put the belongings away. She further stated the staff is responsible for helping residents with moving personal items when help is needed.</p> <p>During an interview on 11/7/24 at 12:05 p.m. with the Director of Nursing (DON), the DON stated her expectation would be to have the resident's personal items not stored on the floor. She stated this practice put the resident at an increased risk of infection.</p> <p>During review of the facility policy (P&amp;P) titled, Infection Control, revised October 2018, the P&amp;P indicated, The objective of our infection control policies and practices are to maintain a safe, sanitary and comfortable environment for personal, residents, visitors and the general public.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49933</p> <p>2) During a review of Resident 21 Admission Record indicated Resident 21 was admitted early 2020 with multiple diagnoses that included pressure ulcer of left buttock, stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and infection and inflammatory reaction (swelling) due to indwelling urethral catheter (tube placed in the body to drain urine from the bladder).</p> <p>During an observation on 11/06/24 at 11:05 a.m. outside of Resident 21's room, a sign was posted under resident name card with an orange sticker which indicated, Enhanced Barrier Precaution. Across Resident 21's room, a wall compartment was observed to contain blue gowns and gloves available for staff to use.</p> <p>During a concurrent observation and interview on 11/06/24 at 11:10 a.m., Licensed Nurse 4 (LN 4) and Certified Nursing Assistant 1 (CNA 1) entered Resident 21 without putting on gown and gloves. LN 4 came out of the room followed by CNA 1 pushing Resident 21 on a shower bed into the hallway. CNA 1 was observed not wearing gown or gloves. LN 4 confirmed that they did not wear gown and gloves when transferring and assisting Resident 21 into the shower bed.</p> <p>During a concurrent observation and interview on 11/6/24 at 11:39 a.m. CNA 1 was seen pushing Resident 21 back to the room after the shower without gown and gloves. CNA 1 did not come out of the room to put on a gown. CNA 2 who was wearing gown and gloves and was helping CNA 1 transfer Resident 21 out of the shower bed, confirmed that staff needed to wear gown and gloves for Resident 21 and stated it's reverse protection for the resident.</p> <p>During a review of Resident 21's Order summary report, dated 11/8/24, indicated, Enhanced Barrier Precautions during high contact time secondary to HX (history) of MRSA [a bacteria that does not respond to antibiotics] in nares [the opening of the nose]/resident with indwelling device: (Suprapubic Catheter) [medical device in the abdomen that helps drain urine from the bladder].</p> <p>During a review of the facility's P&amp;P titled, Enhanced Barrier Precautions, dated 9/18/24, the P&amp;P indicated, . Enhanced standard precautions (ESPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents .high contact care activities requiring the use of gown and gloves for EBP's include . dressing . showering; transferring .EBPs are indicated .for residents with wounds and/or indwelling medical devices .</p> <p>3) During a review of Resident 80's Admission Record indicated Resident 80 was admitted late 2023 with multiple diagnoses that included heart failure and failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity).</p> <p>During a review of Resident 66's Admission Record indicated Resident 66 was admitted late 2023 with multiple diagnosis of morbid obesity and benign prostatic hyperplasia (enlarged gland that can cause urination difficulty).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  River Pointe Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  6041 Fair Oaks Blvd Carmichael, CA 95608	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 11/5/24 at 8:48 a.m. in Resident 80 and 66's room, Resident 80 had a total of three urinals; one urinal containing dark yellow liquid, a second empty urinal on the bedside cabinet, and a third urinal that hung on the bedside rail, with no labels. Resident 66 had a total of two urinals: one urinal containing dark yellow liquid and one empty urinal on bedside table, with no labels.</p> <p>During a concurrent interview and record review on 11/8/24 at 8:35 a.m. with the Infection Preventionist (IP), the IP stated if a urinal was not labeled with a resident identifier and the date it was initially used, there would be a risk for residents to use each other's urinal, and staff would not know who the urinal is for. The IP further stated that urinals stored on bedside tables and cabinets was a risk for infection control if urine spilled on resident items. The IP confirmed that both Residents 80 and 66 did not have documented evidence to use and store multiple urinals on the bedside cabinet or bedside table.</p> <p>During a review of Resident 66's care plan, dated 10/13/24, the care plan indicated Resident 66 has bladder . incontinence (inability to control the flow of urine). There was no documented evidence that Resident 66 used a urinal for incontinence.</p> <p>During a review of Resident 80's care plan, dated 10/31/24, the care plan indicated Resident 80 has bladder . incontinence. There was no documented evidence that Resident 80 used a urinal for incontinence.</p> <p>During a review of the facility's P&amp;P titled, Cleaning and Disinfecting of Resident-Care Items and Equipment, revised October 2018, indicated, Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards [e.g., .urinals].</p> <p>49950</p> <p>4) During a concurrent observation and interview on 11/5/24 at 8:15 a.m. with Licensed Nurse 3 (LN 3), LN 3 was observed checking Resident 88's blood pressure with a blood pressure cuff. LN 3 placed the blood pressure cuff on Resident 88's arm and checked the resident's blood pressure. LN 3 exited the room with the blood pressure cuff and placed it on the medication cart. LN 3 proceeded to use the same blood pressure cuff on Resident 17 without sanitizing it prior to using on Resident 17. LN 3 acknowledged he did not sanitize the blood pressure cuff in between residents and stated that the blood pressure cuff should have been sanitized in between resident use.</p> <p>During an interview on 11/7/24 at 4:17 p.m., with Assistant Director of Nursing (ADON), ADON stated that blood pressure cuffs should be sanitized in between residents. ADON further stated there is a risk of spreading infection when medical equipment is not sanitized after use.</p> <p>During a review of the facility's policy and procedure (P&amp;P), titled Cleaning and Disinfection of Resident-Care Items and Equipment, dated October 2018, the P&amp;P indicated, .resident care equipment will be decontaminated and/or sterilized between residents .</p> <p>5) During a concurrent observation and interview on 11/5/24 at 9:29 a.m., Resident 56 had linens and soiled incontinence pad on the left side of his bed on the floor. Resident 56 stated he threw his incontinence pad on the floor earlier so he could use his bedside urinal. Resident 56 further stated he doesn't know how long the linens and incontinence pad were on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/6/24 at 11:05 a.m. with Licensed Nurse 5 (LN 5), LN 5 stated Certified Nursing Assistants (CNAs) and housekeeping should be doing rounds to clean up resident's rooms during each shift. LN 5 further stated it is not acceptable for linen and soiled incontinence pad to be on the floor.</p> <p>During an interview on 11/7/24 at 4:12 p.m. with ADON, ADON acknowledged that Resident 56's linens and soiled incontinence pad on floor were an infection control issue.</p> <p>During a review of the facility's P&amp;P titled, Policies and Practices - Infection Control, dated October 2018, the P&amp;P indicated, .maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>49933</p> <p>Based on observation, interview, and record review the facility failed to provide a safe and sanitary environment for one of 22 sampled residents (Resident 66) when:</p> <ol style="list-style-type: none"> <li>1. Electrical devices were not checked and safe for use</li> <li>2. Oxygen tubing was found lying on the floor</li> <li>3. Power strip and scattered electrical cords were found on the floor and not secured</li> <li>4. A medical device was plugged into a power strip; and</li> <li>5. Unclean floors</li> </ol> <p>These failures had the potential for Resident 66 to experience a preventable fall, unsafe and unsanitary living conditions.</p> <p>A review of Resident 66's Admission Record indicated Resident 66 was admitted late 2023 with multiple diagnosis of obstructive sleep apnea (a disorder that causes you to stop breathing while asleep), acute respiratory failure and history of falling.</p> <p>During an observation on 11/6/24 at 1:37 p.m. in Resident 66 room, Resident 66 was lying in bed with CPAP (continuous positive airway pressure-a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) machine, a personal fan, and a laptop computer. These electronic devices were plugged into a power strip that was located under the right side of the bed. The power strip on the floor was surrounded by other loose electrical cords, packaged disposable wipes, nebulizer machine (machine that turns liquid medicine into mist), personal belongings, a plastic clothing hanger, food items, food wrappers, scattered papers, and oxygen tubing.</p> <p>During an interview on 11/6/24 at 2:00 p.m. with Administrator (ADM) with Resident 66 present, in Resident 66's room, the ADM stated that the electrical cords and power strip clutter on the floor were a fire hazard. The ADM further stated that having a fan, CPAP machine and laptop on the bed were unsafe and a fire hazard and would not meet Life Safety Code (set of requirements for designed to provide a degree of safety from fire) and federal regulations.</p> <p>During an interview on 11/6/24 at 3:00 p.m. with Environmental Services Manager (EVSM), the EVSM stated that the facility did not screen all items that Resident 66 purchased online.</p> <p>During an interview on 11/8/24 at 7:55 am with Infection Preventionist (IP), the IP stated that It's harder to clean an area if it is cluttered. IP further stated it created an increased for bacterial growth and infection in the room.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 11/08/24 at 10:58 a.m., in Resident 66's room a dry dark matter was on the floor and the floor was sticky. Resident 66 stated that there was poop on the floor for several days. Resident 66 stated it was not acceptable to him. The IP was in the room and confirmed that there was dark matter on the floor and the floor was sticky.</p> <p>During a review of Resident 66's care plan, revised 12/16/23, the care plan indicated Resident 66 had a fall on 12/15/24 .will be free from injuries related to fall .maintained clear pathway, free of obstacles/clutters maintain hazard-free environment.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Electrical Safety for Residents, dated 2011, the P&amp;P indicated, The resident will be protected from injury associated with the use of electrical devices . Inspect electrical outlets .power strips, and electrical devices .fire safety and maintenance inspections . Power strips shall not be used with medical devices in resident care areas . Secure power strips so that they do not cause trips or falls.</p> <p>During a review of the facility's P&amp;P titled, Quality of Life- Homelike Environment, dated May 2017, the P&amp;P indicated, Residents are provided with a safe, clean, comfortable .environment.</p>