STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056222	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Care at Shasta	3550 Churn Creek Rd. Redding, CA 96002

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure the dignity of one of eight sampled residents (Resident 36) when she was left in a soiled brief, and not changed in a timely manner. This failure resulted in Resident 36 to feel increased anxiety, and depression and had the potential to result in emotional stress, embarrassment, feelings of neglect, and the potential for negative clinical outcomes. Findings: The facility's policy revised 8/2017 titled, Quality of Life-Dignity, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall be treated with dignity and respect at all times, to include promptly responding to the resident's request for toileting assistance. The facility's policy revised 5/2010 titled, Resident Rights, indicated employees shall treat all residents with kindness, respect, and dignity. This facility's policy indicated the facility will make every effort to assure each resident is always treated with dignity and respect. A review of Resident 36's clinical record indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included hypokalemia (low potassium), insomnia (difficulty sleeping), anxiety (a feeling of fear, dread, and uneasiness), depression (constant feeling of sadness and loss of interest), high blood pressure, heart disease, gastroenteritis (inflammation of the stomach and small intestine), and colitis (inflammation of the colon). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 36 dated 8/19/24, indicated that Resident 36 had no cognitive deficit, with a brief interview for mental status (BIMS) score of 14 out of 15, could verbalize her needs, and was totally dependent for staff with toileting and transfers. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/24 at 3:20 pm, Resident 36 stated, I am ok, I just wish the staff would stop telling me they have other residents to take care of when I ask for help with my incontinence. They tell me they will be back, and they have other residents to take care of, so I have to wait my turn. I cannot get up to the bathroom my myself, I would rather use the bathroom. The wait time varies, but sometimes it can be up to 30 minutes to an hour, and I cannot hold it that long. During a follow up interview on 10/10/24 at 10:05 am, Resident 36 confirmed she felt bad and had increased anxiety when she had to wait on staff for an extended time when she needed toileting assistance. Resident 36 stated, Yes, it makes me feel bad, and waiting increases my anxiety when the staff tells me they have other residents to take care of. I need help too and would like to get up to use the bathroom, but I need staff to get out of bed. During an interview on 10/10/24 at 9:35 am, the Director of Social Services (DSS) confirmed Resident 36 is not demanding, very cooperative and does have anxiety waiting on staff to return while waiting for toileting. During an interview on 10/10/24 at 10:11 am, the Resident Care Manager (RCM) 1, confirmed Resident 36 should have the choice to use the bathroom and not be left waiting on staff in a soiled brief. RCM 1 confirmed this failure was a loss of dignity and violated her resident rights. RCM 1 stated, I will update the care plan today and educate the staff they need to get her up and not leave her in the bed waiting when she needs to use the bathroom. During an interview on 10/10/24 at 10:55 am, the Director of Nursing (DON) confirmed leaving Resident 36 waiting to use the bathroom and telling her there are other residents to take care of is a violation of her rights, and loss of dignity. DON stated, I read the note, and I will talk to the staff immediately to fix this problem. This will not happen again.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure that one of eight sampled residents' bedroom (Resident 29) was maintained in a comfortable and homelike setting, when Resident 29 could not see his wife's pictures due to clutter on his dresser. This failure resulted in Resident 29 becoming frustrated and violated the right to have a home like environment. Findings: A review of the facility's policy dated 5/2011 titled, Quality of Life-Homelike Environment, indicated residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. This policy also indicated the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include cleanliness and order, personalized furniture, and room arrangements. A review of Resident 29's clinical record indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that included anxiety (a feeling of fear, dread, and uneasiness), hyperkalemia (high potassium), sepsis (a severe reaction to an infection), urinary tract infection (bladder infection), depression (constant feeling of sadness and loss of interest), and heart disease. During a concurrent observation and interview in Resident 29's room on 10/8/24 at 8:50 am, Resident 29 stated, Can you move that junk off the dresser, I cannot see my wife's picture. I would like someone to clean up around here. I was a [NAME] and I am used to things be in order. During an interview on 10/8/24 at 8:40 am, with Certified Nursing Assistant (CNA) A, CNA A confirmed there was clutter and an entire unkept area on the dresser and Resident 29 was unable to see his personal pictures of his wife. During an interview with CNA B at 9:30 am, CNA B confirmed there was clutter on the dresser and Resident 29 was unable to view his wife's pictures, and the hygiene products should not be left out in the open for all visitors to observe. During an interview on 10/9/24 at 3:15 pm, with the Director of Social Services (DSS), DSS confirmed Resident 29 was a [NAME] and prefers all things in order, and he should be able to see his personal pictures in his room. DSS stated, I agree this is all residents' rights, but of all people [Resident 29] would be upset with all the clutter because he was a [NAME]. During an interview on 10/9/24 at 2:45 pm, the Director of Nursing confirmed Resident 29 should have a homelike environment, and the clutter and personal care items should be removed from his dresser, so family pictures can be viewed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure four out of 25 sampled residents' (Resident 19, 36, 112, and Resident 121) care plans were develped, reviewed and revised when: 1. Significant unplanned weight loss for Resident 19 was not updated on the care plan. 2. Unplanned weight loss and a room change for Resident 36 was not updated on the care plan. 3. End of life care for Resident 112 was not updated on the care plan. 4. A Urinary Tract Infection (UTI, a bladder infection), for Resident 121 was not updated on the care plan. These failures had the potential to result in the residents' needs not being identified, and resident's feeling depressed with poor self-esteem, and had the potential to contribute to skin breakdown, infection, and negatively impact their ability to attain or maintain their highest practicable level of well-being. Findings: 1. A review of the facility's policy revised 11/2017 titled, Care Plans-Person Centered Comprehensive, indicated an individualized person-centered comprehensive care plan that includes objectives and goals to meet the resident's medical, nursing, mental and psychological needs is developed for each resident based on the resident strengths, needs, and preferences. This facility's policy also indicated assessments of residents are ongoing care plans revised as information about the resident and the resident's condition change. A review of the facility's policy revised 5/2018 titled, Weight Assessment and Intervention, indicated care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the Medical Prescriber, Nursing staff, Registered Dietician, Consultant Pharmacy, and the resident or resident's Responsible party. Individualized care plans shall identify causes of weight loss, goals and benchmarks for improvement, and time frames and parameters for monitoring and reassessment. Interventions for undesirable weight loss shall be based on careful considerations of the following: Resident choice and preference, nutrition and hydration need of the resident .and other factors that could inhibit eating and swallowing. A review of Resident 19's clinical record indicated Resident 19 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included acute respiratory failure with hypoxia (a condition that occurs when the body's tissues do not receive enough oxygen), and dementia. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 19 dated 9/17/24, indicated that Resident 19 had severe cognitive impairment with a brief interview for mental status (BIMS) score of 2 out of 15 and had experienced a significant unplanned weight loss of 5% or more in the last month or 10% or more in the last six months. On 10/9/24 at 1:40 pm, a review of Resident 19's clinical record and concurrent interview was conducted with the Registered Dietitian (RD). The RD confirmed Resident 19 had experienced a significant unplanned weight loss of 23 pounds, 10.7% from 4/8/24 to 10/2/24. The RD stated she, or nursing, were responsible to update the resident care plan with significant weight changes. The RD confirmed Resident 19's care plan was not revised to reflect the significant unplanned weight loss of 10.7%. 2. A review of Resident 36's clinical record indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included hypokalemia (low potassium), insomnia (difficulty sleeping), anxiety (a feeling of fear, dread, and uneasiness), depression (constant feeling of sadness and loss of interest), high blood pressure, heart disease, gastroenteritis (inflammation of the stomach and small intestine), and colitis (inflammation of the colon). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 36 dated 8/19/24, indicated that Resident 36 had no cognitive deficit, with a BIMS score of 14 out of 15, could verbalize her needs, and was totally dependent for staff with toileting and transfers. A review of the most recent comprehensive care plan for Resident 36 dated 10/9/24, there were no revised needs identified after Resident 36 moved to a new room. The care plans had not included Resident 36's preference to be asssited in using the bathroom. During an interview on 10/10/24 at 10:21 am, the Resident Care Manager (RCM) 1, confirmed Resident 36 should have the choice to use the bathroom and not be left waiting on staff in a soiled brief. RCM 1 stated, I will update the care plan today and educate the staff they need to get her up and not leave her in the bed waiting when she needs to use the bathroom. I have not updated [Resident 36's] care plan since she moved over here for long term care. During a concurrent interview and record review 10/10/24 at 9:38 am, the Registered Dietician (RD) confirmed Resident 36 had a weight loss greater than five pounds since admission, and no Nutritional at Risk Assessment had been completed per the facility's weight loss policy. The RD confirmed [Resident 36's] assessment was due 9/24/24, and a revised care plan with new interventions for weight loss should have been developed and interventions started to prevent further weight loss. 3. A review of Resident 112's clinical record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (syndrome of weight loss, poor nutrition, impaired immune system, loss of appetite and inactivity), heart disease, high blood pressure, unspecified severe protein-calorie malnutrition (poor nutrition), anxiety (a feeling of fear, dread, and uneasiness), diabetes (too much sugar in the blood), and repeated falls. A review of the most recent MDS, for Resident 112 dated 8/4/24, indicated that Resident 112 had a severe cognitive deficit, with a BIMS score of 2 out of 15, and was totally dependent for staff with all activities of daily living (ADLs, basic needs as personal hygiene, dressing, toileting, transferring, walking, and eating). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the most recent comprehensive care plan for Resident 112, dated 10/9/24, indicated that there were no revised needs identified or goals for end-of- life care, these revisions should have been added on 10/2/24, when Resident 112 chose Hospice services (treatment focused on end of life choices). During an interview on 10/8/24 at 2:59 pm, RCM 1 confirmed all nursing staff should coordinate all care with any Hospice agency. RCM 1 confirmed there was a lack of communication between the facility and the Hospice agency, and that Resident 112's care plans had not been updated. During a review of 112's clinical record, a document dated 10/2/24 through 12/30/24, titled, Hospice Plan of Care, goals indicated facility staff is knowledgeable and involved in Hospice plan of care for patient through end of episode. During an interview on 10/10/24 at 10:15 am, RCM 1 stated, I confirm Hospice was not on Resident 121's care plan and I added the end of life care this morning. I confirm it should have been added on 10/2/24, when resident 112 was admitted to Hospice services. During an interview on 10/10/24 at 11:10 am, the Director of Nursing (DON) confirmed the care plan had not been updated for Resident 112 for end-of-life Hospice care as of 10/9/24. 4. A review of Resident 121's clinical record indicated Resident 121 was admitted to the facility on [DATE], with diagnoses that included dementia (a decline in thinking, memory, and reasoning), depression (constant feeling of sadness and loss of interest), sepsis (a response to a severe infection), and anxiety (a feeling of fear, dread, and uneasiness), and history of UTIs. A review of the most recent MDS, for Resident 121 dated 9/13/24, indicated that Resident 121 had a severe cognitive (term for mental processes) deficit, with a BIMS score of 3 out of 15, and was totally dependent for staff with all ADLs. During a record review a document dated 9/30/24 titled, Active Orders, indicated Resident 121 was ordered Ciprofloxacin (an antibiotic), give 500 milligrams (mg, a unit of measure), by mouth two times daily for a UTI for seven days. A review of the most recent comprehensive care plan for Resident 121 dated 10/9/24, reflected no revised identified needs or goals for the UTI discovered on 9/30/24. During an interview on 10/9/24 at 2:50 pm, RCM 1 confirmed the care plan for Resident 121 was never revised to include a new UTI that was diagnosed on [DATE]. RCM 1 stated, I confirm the UTI was diagnosed on [DATE], and the UTI needs to be on the care plan, but I did not get to it. During an interview on 10/9/24 at 11:15 am, the DON confirmed the care plans were not either developed, reviewed or revised for Resident's 19, 36, 112, and 121.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADLs, basic needs as personal hygiene, dressing, toileting, transferring, walking, and eating), were provided for three of eight sampled dependent residents (residents who depend on staff to help them), (Resident's 2, 29 and 112), when: 1. Routine grooming activities were not completed for Resident 2 and Resident 29. 2. Routine and scheduled showers were not completed for Resident 112. These failures had the potential to result in the residents feeling depressed with poor self-esteem, and had the potential to contribute to skin breakdown, infection, and negatively impact their ability to attain or maintain their highest practicable level of well-being. Findings: 1. During a review of the facility's policy revised 8/2017 titled, Care of Fingernails/Toenails-Level II, indicated this purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection. Nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed. During a review of the facility's policy, not dated, titled, Facility's Standard of Care, indicated shower/tub bath two times weekly, according to schedule, resident preferences, and as directed by Licensed Nurse (LN). During a review of the facility's policy revised 8/2017, titled, Shower/Tub Bath-Level II, indicated the purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Trim the resident's toe nails or fingernails except resident with Diabetes or as identified on the resident's plan of care. Report other information in accordance with facility policy and professional standards of care. A review of Resident 2's clinical record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included contracture (joints that have become stiff and unable to move), diabetes (too much sugar in the blood), quadriplegia (paralyzed, unable to move arms or legs), and mild intellectual ability (cognitive deficit such as learning, problem solving, and judgement). A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 2 dated 8/30/24, indicated that Resident 2 had a moderate to severe cognitive deficit, with a brief interview for mental status (BIMS) score of 8 out of 15, and was totally dependent for staff with all activities of daily living (ADLs, basic needs as personal hygiene, dressing, toileting, transferring, walking, and eating). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 10/8/24 at 1:53 pm, Certified Nurse Assistant (CNA) C confirmed Resident 2's fingernails were long and irregularly jagged with sharp edges. Resident 2's right hand fingernails were pushing into his right hand due to contractures of all right fingers, and Resident 2 was wearing a splint on his right hand for stability. During a concurrent observation and interview on 10/8/24 at 1:50 pm, Licensed Nurse (LN) 4 confirmed Resident 2 had not had his fingernails trimmed and since he had diabetes a nurse would need to trim his nails. LN 4 stated, I confirm [Resident 2] does need all his nails trimmed, and Resident 2 does have the risk of skin problems due to his contractures. A review of Resident 29's clinical record indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that included anxiety (a feeling of fear, dread, and uneasiness), hyperkalemia (high potassium), sepsis (a severe reaction to an infection), urinary tract infection (bladder infection), depression (constant feeling of sadness and loss of interest), and heart disease. A review of the most recent MDS for Resident 29 dated 9/10/24, indicated that Resident 29 had a moderate cognitive deficit, with a BIMS score of 99; which indicated that Resident 29 was not able to participate in the interview. Resident 29 was able to verbalize needs and was totally dependent for staff with all ADLs. During a concurrent observation and interview on 10/8/24 at 8:48 am, Resident 29 had long, jagged, uneven fingernails with sharp edges. Resident stated, Yes, I would like my fingernails trimmed, I just lay here and think of things to do, but I cannot cut my nails, someone has to do it for me. During a concurrent interview and observation on 10/8/24 at 10:05 am, CNA A confirmed Resident 29's fingernails were long and irregularly jagged with sharp edges and not filed. During an interview on 10/8/24 at 10:08 am, CNA C stated, I agree [Resident 29's] fingernails are too long. [Resident 29] is not a diabetic, I can trim his fingernails. During an interview on 10/8/24 at 3:35 pm, the Director of Nursing (DON) confirmed Resident 2 and Resident 29 needed their nails trimmed. DON confirmed the facility's policy for nail care was not followed. 2. During a review of the facility's policy, not dated, titled, Facility's Standard of Care, indicated shower/tub bath two times weekly, according to schedule, resident preferences, and as directed by a LN. During a review of the facility's policy revised 8/2017 titled, Shower/Tub Bath-Level II, indicated the purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. This policy also indicated to notify the LN if the resident declines the shower/tub bath. Report other information in accordance with facility policy and professional standards of care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 112's clinical record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (syndrome of weight loss, poor nutrition, impaired immune system, loss of appetite and inactivity), heart disease, high blood pressure, unspecified severe protein-calorie malnutrition (poor nutrition), anxiety (a feeling of fear, dread, and uneasiness), diabetes (too much sugar in the blood), and repeated falls. A review of the most recent MDS for Resident 112 dated 8/4/24, indicated that Resident 112 had a severe cognitive deficit, with a BIMS score of 2 out of 15, and was totally dependent for staff with all ADLs. A review of Resident 112's clinical record document dated 8/01/2024 through 8/31/2024 titled, Follow up question report for Bath/Shower, indicated Resident 112 had eight scheduled showers, and only received three on 8/5/24, 8/15/24, and 8/22/24. No refusals were documented, No was documented if the task of a shower or bath had been completed on all other days of August 2024. A review of Resident 112's clinical record document dated 9/01/2024 through 9/30/2024, titled, Follow up question report for Bath/Shower, indicated Resident 112 had eight showers scheduled and received four on 9/2/24, 9/9/24, 9/16/24 and 9/30/24. No refusals were documented, No was documented if the task of a shower or bath had been completed on all other days of September 2024. A review of Resident 112's clinical record document dated 10/01/2024 through 10/10/2024, titled, Follow up question report for Bath/Shower, indicated Resident 112 should of had four showers, and received one shower on 10/9/24. No refusals were documented, No was documented if the task of a shower or bath had been completed for the other days in October 2024. During an interview on 10/8/24 at 10:40 am, LN 4 confirmed that the CNAs had not reported to her that Resident 112 had refused any showers. During an interview on 10/8/24 at 2:59 pm, Resident Care Manager (RCM) 1 confirmed that it was the facility's responsibility to make sure Resident 112 received a bath at least two times a week. During an interview on 10/10/24 at 11:17 am, the DON confirmed Resident 112 should have been showered twice a week and any refusals should have been documented by the CNAs and followed up on by the LNs.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observation, interview, medical record review and Policy and Procedure (P&P) review, the facility failed to ensure one of 25 sampled residents (Resident 19), received acceptable nutritional services when: 1. Resident 19's nutritional status was not assessed by the Registered Dietitian (RD) upon admission. 2. Resident 19's significant unplanned weight loss was not assessed by the RD and the Interdisciplinary Team (IDT, facility managers who discuss resident concerns and develop plans to correct them). 3. Resident 19's admission weight was not obtained in a timely manner upon readmission, in accordance with the facility policy. As a result of these failures, Resident 19's compromised nutritional status was not addressed timely, which could lead to further medical complications. Findings: 1. A review of the facility policy titled, Nutritional Assessment revised 5/2028, showed, that a nutrition assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. 1. The Dietitian will conduct a nutritional assessment for each new admit within the first seven to 21 days of admission, or as requested by nursing staff or Medical Prescriber. Nursing and/or Medical Prescriber may request Dietitian assessment sooner, as indicated by resident nutritional needs and/or a change in condition that places the resident at risk for impaired nutrition. A review of Resident 19's medical record showed Resident 19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included acute respiratory failure with hypoxia (a condition that occurs when the body's tissues do not receive enough oxygen), and dementia. A review of the most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 19 dated 9/17/24, showed that Resident 19 had severe cognitive impairment with a brief interview for mental status (BIMS) score of 2 out of 15. A review of Resident 19's medical record titled, Active Orders 10/1/24 to 10/31/24, showed the Physician ordered a Consistent Carbohydrate diet (a diet for diabetes management) pureed texture, mildly thick consistency, NEM (Nutrition Enhanced Meal), Large portion of meat and vegetables. On 9/25/24 the Physician ordered house supplement (drink to add calories), no sugar added 120 ml four times a day. (continued on next page)

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	056222	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Care at Shasta	3550 Churn Creek Rd. Redding, CA 96002

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 1:40 pm, a review of Resident 19's medical record and concurrent interview was conducted with the RD. The RD was asked what was the expected time frame for nutritional assessments when a resident was admitted . The RD stated 14 days. The RD confirmed Resident 19's nutritional status had not been assessed since he was readmitted to the facility on [DATE]. The RD was asked how she was notified of new admissions. The RD stated she ran a report on the computer weekly. The RD was asked if she had a system in place to prevent missed nutritional assessments. The RD confirmed she did not have a system in place to prevent missed nutritional assessments. 2. A professional reference review of, American Academy of Family Physicians Journal titled, Unintentional Weight Loss in Older Adults, dated 2014 showed, Unintentional weight loss (i.e., more than a 5% reduction in body weight within six to 12 months) occurs in 15% to 20% of older adults and is associated with increased morbidity and mortality. In this population, unintentional weight loss can lead to functional decline in activities of daily living, increased in-hospital morbidity, increased risk of hip fracture in women, and increased overall mortality. Further, cachexia (loss of muscle mass with or without loss of fat) has been associated with negative effects such as increased infections, pressure ulcers, and failure to respond to medical treatments . https://www.aafp.org/afp/2014/0501/p718.html - afp20140501p718-b1. A review of the facility's policy revised 5/2018, titled, Weight Assessment and Intervention, indicated that the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The nursing staff nursing staff will measure resident weights on admission (within 72 hours) .Any weight change of five pounds (lbs. a unit of measurement) or more since the last weight assessment (if the resident weighs 100 lbs. or more) if verified, nursing will notify the Dietician. The Dietician will respond, and the facility will review monthly weight variances to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/(usual weight) x 100]: one month: 5% weight loss is significant; greater than 5% is severe. Three months: 7.5% weight loss is significant; greater than 7.5% is severe. Six months: 10% weight loss is significant; greater than 10% is severe. This facility's policy also indicated care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the Medical Prescriber, Nursing staff, Registered Dietician, Consultant Pharmacy, and the resident or resident's Responsible party. Individualized care plans shall identify causes of weight loss, goals and benchmarks for improvement, and time frames and parameters for monitoring and reassessment. Interventions for undesirable weight loss shall be based on careful considerations of the following: Resident choice and preference, nutrition and hydration need of the resident and other factors that could inhibit eating and swallowing. A review of the most recent MDS for Resident 19 dated 9/17/24, showed, Section K - Swallowing/Nutritional Status, Resident 19 weighed 195 lbs. and had experienced a 5% or more weight loss in the last month or a 10% or more weight loss in the past six months and he was not on a physician-prescribed weight-loss program. A review of Resident 19's medical record titled, Weights and Vitals Summary dated 9/3/24, showed, Resident 19 weighed 200.4 lbs. On 9/17/24 Resident 19 weighed 194.8 lbs. a 5.6 lb. unplanned weight loss from his previous admission weight. On 10/2/24 Resident 19 weighed 192.4 lbs., a 23 lb., 10.6% severe unplanned weight loss in six months; comparison weight 4/8/24 215.4 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/9/24 at 1:40 pm, a review of Resident 19's medical record and concurrent interview was conducted with the RD. The RD confirmed Resident 19 had experienced a 5.6 lb. unplanned weight loss on readmission and a 23 lb. 10.6% severe unplanned weight loss since 4/8/24. The RD confirmed she had not assessed Resident 19's 5.6 lb. weight loss upon readmission and the severe unplanned weight loss of 23 lbs. 10.6% since 4/8/24. The RD further confirmed there was no documented evidence Resident 19's unplanned weight loss of 5.6 lbs. on readmission and the 23 lbs., 10.6% severe unplanned weight loss had been addressed by the IDT in the Nutrition at Risk (NAR) meeting. On 10/10/24 at 9:25 am, an interview was conducted with Licensed Nurse (LN) 8. LN 8 confirmed on 9/17/24 Resident 19 weighed 194.8 lbs., a 5.6 lb. weight loss since his previous admission. LN 8 was asked if nursing notified the RD of Resident 19's weight loss. LN 8 stated nursing did not notify the RD of Resident 19's weight loss, since the RD was in charge of weights. LN 8 was asked about the NAR meetings to address resident weight loss. LN 8 stated she entered a progress note dated 9/25/24 which indicated, per NAR meeting, frequency of NSA (no sugar added) house supplement increased to QID (four times a day) related to resident weight loss. LN 8 was asked to show the NAR meeting documentation to support the progress note. LN 8 was not able to show any documentation the NAR meeting was held. LN 8 stated she was not sure if the IDT documented when NAR meetings were held. On 10/10/24 at 9:41 am, an interview was conducted with the RD. The RD was asked how she was notified of resident weight loss. The RD stated she would be notified of resident weight loss in the stand-up meetings (daily meeting for all facility managers), but stated she wasn't sure she had been notified of Resident 19's 5.6 lb. weight loss upon readmission or the severe unplanned weight loss of 23 lbs. 10.6% in six months. The RD was asked about NAR meeting documentation. The RD stated she was responsible to document NAR meetings in the resident's clinical record. The RD confirmed she had not documented any NAR meetings for Resident 19 which addressed the 5.6 lb. weight loss on readmission or the 23 lb., 10.6% weight loss since 4/8/24. On 10/10/24 at 10:35 am, an interview was conducted with the Director of Nursing (DON). The DON confirmed if a resident had experienced weight loss the RD must be notified. The DON added there was a weight board that reflected resident's weights and the RD could refer to that. On 10/10/24 at 11:09 am, an additional interview was conducted with LN 8. LN 8 was asked how resident orders were entered in the clinical record. LN 8 stated if there was a recommendation from the NAR meeting, she would enter the order in the computer. LN 8 confirmed there was no order which reflected the recommendation on 9/25/24 to increase Resident 19's NSA house supplement to four times a day. On 10/10/24 an observation of Resident 19 during the lunch meal and concurrent interview was conducted with Resident 19's wife. Resident 19's wife stated she came at least once a day to feed her husband to ensure he ate at least one meal. Resident 19's wife stated yesterday when she came at lunch time, she found Resident 19 sitting unattended while eating. Resident 19's wife stated Resident 19 should not eat alone. Resident 19's wife complained the puree meat served at the facility had small chunks of meat in it and Resident 19 had a history of aspiration pneumonia and she was concerned he could choke. Resident 19 was observed with several small pieces of meat on his clothing protector. Resident 19's wife stated Resident 19 spit out the meat that was not completely pureed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. A review of the facility's policy revised 5/2018, titled, Weight Assessment and Intervention, The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The nursing staff nursing staff will measure resident weights on admission (within 72 hours) . A review of Resident 19's clinical record titled, Weights and Vitals Summary dated 9/17/24, showed Resident 19 weighed 194.8 lbs. On 10/9/24 at 2:42 pm, a review of Resident 19's clinical record and concurrent interview was conducted with LN 8. LN 8 was asked the expected time frame to obtain a resident's weight upon admission. LN 8 stated newly admitted residents should be weighed the day of admission or the day after admission. LN 8 confirmed Resident 19 was readmitted to the facility on [DATE]. LN 8 confirmed Resident 19 was not weighed until four days after admission. LN 8 was asked when the facility would address resident weight loss. LN 8 stated the facility would address 5% weight loss in 30 days. LN 8 confirmed Resident 19 triggered for significant weight loss on 10/2/24. LN 8 stated the RD was responsible to document the IDT NAR meeting. LN 8 confirmed there was no documentation the IDT held a NAR meeting that addressed Resident 19's severe unplanned weight loss of 23 lbs., 10.6% since 4/8/24. LN 8 further confirmed Resident 19's severe unplanned weight loss had not been addressed on Resident 19's care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49934 Based on observation, interview, and record review the facility failed to provide pharmaceutical services to meet the needs of each resident when expired medications and an expired Emergency Drug Kit (E-Kit, medications that are readily available for use when the Pharmacy is closed), were available for use in the [NAME] Unit medication room. This had the potential for the residents to receive expired medications that are no longer considered viable, safe or effective for treating their illnesses. Findings: During an observation of the [NAME] Unit medication room conducted on 10/09/24 at 1:13 pm, the following expired medications were found to be available for resident use; Two bottles of unopened Acetaminophen (pain reliever and fever reducer), 500 milligram tablet (mg, a unit of measure), expired 09/2024. Soothing 12 Hour Nasal Decongestant (relieves nasal congestion) Spray, 30 milliliter (ml, a unit of measure), expired 09/2024. An E-Kit that expired 09/2024, and contained the following; Cefazolin (antibiotic), 1 gram (gm, a unit of measure), 4 vials Cefepime (antibiotic),1 gm, 2 vials Ceftazidime (antibiotic), 1 gm, 2 vials Ceftriaxone (antibiotic), 2 gm, 1 vial Ceftriaxone (antibiotic), 1 gm, 2 vials Ertapenem (antibiotic), 1 gm, 1 vial Levofloxacin (antibiotic), 500 mg, 1 bag (for intravenous use, IV-administered in the veins) Meropenem (antibiotic), 1 gm, 2 vials Vancomycin (antibiotic), 500 mg, 2 vial Vancomycin (antibiotic), 1 gm, 3 vials Piperacillin/Tazobactam (antibiotic), 3.375 gm, 2 vials (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Water, 20 ml, 3 vials Sodium Chloride (salt water for IV), 0.9%, 100 ml, 4 mini bags Sodium Chloride (for IV), 0.9%, 100 ml, 2 single bags Sodium Chloride (for IV), 0.9%, 250 ml, 2 bags Dextrose (sugar water for IV), 5%, 250 ml, 2 bags Vial Mate Adapter (medical device), 3 devices During an interview conducted on 10/09/24 at 3:23 pm, the Director of Nursing (DON) stated that a medication review for expired medications should be conducted monthly, but admitted she was unsure why expired medications were still present despite the review schedule. She further stated that nurses should ideally check for expired medications every 2 to 4 weeks, and the consultant pharmacist is expected to perform a similar review every 3 months. However, the DON clarified that there doesn't appear to be a strictly established schedule for these reviews.

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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** 49934 Based on observations, interviews, and record reviews, the facility failed to maintain a medication error rate below five percent (5%). During the medication pass on 10/08/24 and 10/09/24, four medication errors were observed out of twenty-seven opportunities for four of six residents (Residents 17, 328, 103), which resulted in an overall medication error rate of 14.81%, when: 1. Licensed Nurse (LN) 4 administered an iron supplement to Resident 17 with milk. This failure had the potential to reduce absorption of the iron supplement. 2. LN 6 did not follow the manufacturer's instruction for administration of the Breo Ellipta Inhaler (a medical device for administering a respiratory medication, which is to be inhaled). This failure had the potential for Resident 328 to not receive the full dose of the medication and could possibly cause contamination of the inhaler and its contents. 3. LN 7 did not follow the manufacturer's instruction for administration the Breo Ellipta Inhaler. The omissions in instruction could potentially result in inadequate delivery of the medication to the Resident 328's lungs. 4. Registered Nurse (RN) 1 crushed medications with special coatings for Resident 103. Compromising the coatings could cause suboptimal (not at the best possible level) absorption and a reduced therapeutic (helps to heal or restore health) effect for Resident 103. Findings: 1. A review of the facility's policy and procedure titled, Administering Medications, revised 8/2017, indicated the purpose of this policy is to ensure medications will be given in a safe and timely manner, and as prescribed. One way to accomplish this, the policy indicated at paragraph number 7, that those administering medications must check and verify the several Resident Rights. One in particular is the right method of administration before administering a medication. According to medical guidelines from nationally recognized organizations such as the American Academy of Family Physicians (AAFP), American Medical Association (AMA), and the American Gastroenterological Association ([NAME]), iron supplements like iron sulfate should not be consumed alongside milk or other calcium-rich foods. The rationale behind this recommendation is that calcium has been found to impede the absorption of iron, thereby decreasing its efficacy in treating iron deficiency anemia (disorder in which the blood has a reduced ability to carry oxygen). Supporting these guidelines, a study published in the National Library of Medicine (available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9219084/) confirms that specific dietary components can impact iron absorption. The study identifies calcium as one such inhibitor that can hinder the absorption of iron, further emphasizing the importance of avoiding the co-ingestion of calcium-rich foods and iron supplements. During an observation on 10/08/24 at 8:11 am, LN 4 administered ferrous sulfate (iron supplement) to Resident 17. It was observed that Resident 17 took all her medications with milk. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/08/24 at 2:26 pm, LN 4 stated that she was not aware that milk affected the absorption of iron. 2. A review of the manufacturer insert for the Breo Ellipta Inhaler, 100-25 microgram (ug, a unit of measurement), indicated to properly administer the medication, it is essential to follow the manufacturer's instructions. Begin by opening the cover of the inhaler to expose the mouthpiece. A click sound should be heard and the counter will count-down by one digit. You do not need to shake this inhaler before using. The inhaler is ready for use. While keeping the inhaler away from the mouth, exhale deeply through the mouth and breathe out fully to completely empty the lungs. Then place the inhaler at your mouth and tightly close your lips on the mouthpiece. Inhale, taking one long, steady deep breath in through your mouth. Do not block the vent that sits below the mouthpiece with your fingers. Remove the inhaler and hold your breath for 3 to 4 seconds to allow the medication to distribute through the lungs. Then exhale a slow and gentle breathe. Close the inhaler by sliding the cover up and over the mouthpiece as far as it will go. Rinse your mouth with water and spit out the water once done. Do not swallow. By carefully following these steps, you can ensure that the medication is administered effectively, reaches the lungs, and maintains the integrity of the medication and dispenser, which will provide the intended therapeutic effect. During an observation on 10/08/24 at 12:48 pm, LN 6 administered the Breo Ellipta Inhaler, 100-25 ug, to Resident 328. Resident 328 covered the vent with two fingers. The resident also did not hold her breath for a count of 3 to 4 seconds, and before removing the inhaler from her mouth, the resident started exhaling. During an interview on 10/08/24 at 2:32 pm, LN 6 acknowledged that Resident 328 possibly did not receive the full dose of the administered medication, due to the vent being covered by two fingers of the resident. Additionally, LN 6 acknowledged that the resident did not hold her breathe for 3 to 4 seconds, which is an important step in ensuring proper medication dosing. LN 6 confirmed he was unaware that Resident 328 began exhaling before removing the inhaler. 3. During an observation on 10/09/24 at 8:17 am, of the administration of Breo Ellipta Inhaler to Resident 328, it was observed that LN 7 did not provide adequate instruction for proper inhalation technique. Specifically, LN 7 failed to inform Resident 328 to exhale before inhaling the medication and did not instruct the resident to hold their breath for the recommended 3 to 4 seconds. During an interview on 10/09/24 at 8:33 am, LN 7 stated that she did not provide specific instructions to Resident 328 regarding the proper use of the Breo Ellipta inhaler. LN 7 confirmed that she did not advise the resident to hold her breath for 3 to 4 seconds or instruct her to exhale before taking in the medication, as required by the proper administration technique for the Breo Ellipta Inhaler. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A review of the facility's policy and procedure titled, Crushing Medications, revised 08/2017, indicated the purpose of this policy is to ensure medications are crushed only when it is appropriate and safe to do so, consistent with the physician orders. To capture this, the policy defines specific steps to ensure acceptable medication administration. First, the Medical Director and Director of Nursing, along with a Consultant Pharmacist, will identify appropriate indications and procedures for crushing of medications. Secondly, if there is an order to crush a medication, Nursing Staff and/or the Consultant Pharmacist will notify the Attending Physician if a manufacturer states that a specific medication should not be crushed. By adhering to this facility policy, medications will be appropriately administered and will minimize the risks of adverse events and/or complications. During an observation on 10/09/24 at 8:52 am, Registered Nurse (RN) 1 was observed crushing Resident 103's pills prior to administering them. Upon examination of the resident's medications, it was discovered that two of the crushed pills, Aspirin (pain reliever, fever, and inflammation reducer), 81 milligram (mg, a unit of measure), enteric coated (the coating prevents the breakdown of the medication in the stomach and helps protect the stomach lining and prevent bleeding and ulcers), and Metoprolol Succinate (treats chest pain and high blood pressure), 100 mg, delayed release (the release of the medication is intended to be slowly over many hours, instead of all at once which can happen when crushed and cause serious adverse effects). During an interview on 10/09/24 at 9:43 am, RN 1 confirmed that Enteric Coated and Delayed Release medications should not be crushed and will consult with the attending physician and request alternative medications that can be crushed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 39856 Based on observation, and interview, the facility failed to ensure federal regulations related to the education qualification requirements of the dietary manager were followed as outlined in the California Code, Health and Safety Code (HSC 1265.4). This failure had the potential to result in inadequate oversight of the food and nutrition services department associated with meal distribution accuracy, safe food handling and sanitation guidelines. Findings: According to the HSC 1265.4, (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. On 10/7/24 at 10:31 AM, an interview was conducted with the Certified Dietary Manager (CDM). The CDM stated he received his CDM certificate from the University of Florida. The CDM confirmed he had not received specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859 Based on observation, interview, and record review, the facility failed to ensure that the pureed food (food that is either ground, mashed or blended into a pudding like consistency), recipes were followed. This failure resulted in unappetizing food and had the potential for 11 residents who received pureed food, to receive diets that had not met their nutritional needs. Findings: A review of the facility Matrix (a record of residents and their needs), showed that 11 of 115 residents received pureed diets. A review of the facility's policy titled, Cooking Food dated 8/23/23, indicated, Recipes will be followed for the menu items. A review of the facility's recipe titled, P Seas Spinach no date, indicated that this recipe made 5 servings and called for 2.5 cups of seas spinach, and 3 tablespoons of thickener. The recipe provided instructions to reserve cooking liquid and add the liquid back to the spinach when pureeing it in the Robot Coupe (RC a device used to grind or puree food), and reheat to 165 degrees Fahrenheit (F). During a concurrent observation and interview on 10/8/24 at 11:23 am, [NAME] 1, was observed adding 11 number 8 scoops (equivalent to five and a half cups) of cooked spinach into the RC, instead of 2 and a half cups as the recipe indicated. [NAME] 1 then added an unmeasured amount of hot water to the spinach. [NAME] 1 was observed adding one fourth of a cup, instead of 3 tablespoons, of thickener to the cooked spinach in the RC and blended the product until smooth. A review of the facility's recipe titled, P Cornbread/[NAME] no date, indicated that this recipe made 20 pureed cornbread muffins. The recipe directed to use 1 quart of hot water and 1 teaspoon of margarine for each cornbread muffin. The recipe provided instructions to place the cornbread muffins and margarine into the RC and process until fine crumbs, then add warm milk or water until smooth. During an observation on 10/8/24 at 11:31 am, [NAME] 1 was observed adding 11 cornbread muffins, instead of 20, into the RC and added hot water from a pitcher without measuring the water and blended the product until smooth. A review of the facility's recipe titled, Sweet Potatoes no date, indicated that this recipe made 50 pureed servings and called for 10 pounds plus 6 and a half ounces of potato, sweet, chunks, frozen and 1 and a half teaspoons of spice, nutmeg, ground. The recipe provided instructions to sprinkle the sweet potatoes with nutmeg, heat thoroughly until tender, and for puree to place portions needed into the RC and process until smooth and reheat to 165 degrees F. (continued on next page)

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	056222	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Care at Shasta	3550 Churn Creek Rd. Redding, CA 96002

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 10/8/24 at 11:38 am, observed [NAME] 1 take the sweet potatoes out of the foil they had been cooked in, then peeled the skins off, and added 20 sweet potatoes, instead of the frozen sweet potato chuncks, into the RC. [NAME] 1 then added hot water from a pitcher without measuring the water, and blended the product until smooth. A review of the facility's recipe titled, P Roast Turkey no date, indicated that this recipe made 5 servings of pureed turkey. The recipe called for 10 ounces of roast turkey, one fourth cup of thickener, and 1 cup of hot liquid, hot water, or low sodium broth. The recipe provided instructions to grind the turkey to a fine texture, prepare a slurry with thickener and hot liquid and mix well with a wire whip, add half the slurry to the processed roast turkey, process for 1 minute and if too dry add more slurry until meat is a pudding consistency, scrape down sides of the RC bowl and reprocess for 30 seconds, and reheat to 165 degrees F. During an observation on 10/8/24 at 12:05 pm, observed [NAME] 1 add 11 two-ounce pieces (22 ounces), of cooked turkey, an unmeasured amount of hot water from a pitcher, and add an unmeasured amount of thickener from an amber colored pitcher with visible white debris on the inside, outside, and handle of the pitcher to the RC and blend the product until smooth. During an interview on 10/10/24 at 9:46 am, with the Registered Dietitian (RD), the RD confirmed that she expected the cooks to follow the recipes exactly. The RD confirmed that recipes could not be altered or revised, without the RD's approval.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observations and interviews, the facility failed to ensure the facility food was appetizing and palatable when 14 of 115 residents (Residents 328, 329, 36, 576, 72, 26, 529, 86, 580, 119, 587 and three confidential residents), who received food prepared in the facility kitchen were not satisfied with the facility food. This failure had the potential for 14 residents to have decreased intake which could lead to unplanned weight loss and other medically related concerns. Findings: 1. A review of Resident 328's medical record indicated that Resident 328 was admitted on [DATE] with diagnoses that included Hypertension, Atrial Fibrillation (irregular, often rapid heart rate causes poor blood flow), and Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that blocks airflow and make it difficult to breathe). A review of Resident 328's Minimum Data Set, (MDS, a standardized assessment tool), dated 10/2/24, indicated that the Brief Interview for Mental Status (BIMS) score in Section C, rated 15/15, which equates to cognition intact. Resident 329 was their own Responsible Party (RP), and made their own medical decisions. During an interview on 10/7/24 at 11:30 am, with Resident 328 while in the resident's room at the bedside, Resident 328 stated, Food is not good, it is not to my taste. 2. A review of Resident 329's medical record indicated that Resident 329 was admitted on [DATE] with diagnoses that included Squamous cell carcinoma of skin (skin cancer), Diabetes Mellitus (DM, abnormal blood sugar levels), and Hypertension (high blood pressure). The MDS, dated [DATE], indicated Resident 329 rated 15/15, which equates to cognition intact. Resident 329 was their own RP, and made their own medical decisions. During an interview on 10/07/24 at 11:30 am, with Resident 329 while in the resident's room at the bedside, Resident 329 stated, Food is not always warm, and is not very good. 3. A review of Resident 36's clinical record indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included hypokalemia (low potassium), insomnia (difficulty sleeping), anxiety (a feeling of fear, dread, and uneasiness), depression (constant feeling of sadness and loss of interest), high blood pressure, heart disease, gastroenteritis (inflammation of the stomach and small intestine), and colitis (inflammation of the colon). A review of Resident 36's most recent MDS, dated [DATE], indicated that Resident 36 had no cognitive deficit, with a BIMS score of 14 out of 15, and could verbalize her needs. During an interview on 10/7/24 at 11:54 am, Resident 36 stated, The food is sometimes cold, and the alternates are not good. I don't ask them to warm it up, they do sometimes, but not often. During a follow up interview on 10/10/24 at 10:18 am, Resident 36 stated, The food is cold sometimes, and I don't like a lot of their alternate choices. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/10/24 at 9:38 am, the Registered Dietician (RD) confirmed Resident 36 had a weight loss, and no Nutritional at Risk Assessment had been completed. RD stated, I am running late on assessments, but supplements are now indicated for Resident 36 to be offered daily. 4. During a review of Resident 576's clinical record, Resident 576 was admitted to the facility on [DATE] with diagnoses that included, diabetes, right ankle sprain, irregular heart rate, and falls. A review of Resident 576's most recent MDS, dated [DATE], indicated that Resident 576 was cognitively intact (able to think and reason). During an interview on 10/07/24 at 12:18 pm, with Resident 576, Resident 576 stated, Sometimes the meat is very hard. Like a hockey puck. Last week I had lemon chicken, and it was rock hard. 5. A review of Resident 72's medical record showed Resident 72 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one side of the body), and hemiparesis (weakness of one side of the body) following a cerebral infarction (ischemic stroke). On 10/7/24 at 12:55 pm, an observation of the lunch meal in the dining room and concurrent interview was conducted with Resident 72. Resident 72 stated the food served at the facility was horrible. The fresh fruit was often spoiled, vegetables were overcooked and mushy, and eggs were horrible. Resident 72 stated tossed salads were served in small plastic cups making it difficult to eat. Resident 72 stated hot dogs were served instead of the planned entree two days in a row. 6. A review of Resident 26's medical record showed Resident 26 was admitted to the facility on [DATE] with diagnoses which included infectious gastroenteritis and colitis (inflammation of the digestive tract) and cerebral palsy (congenital disorder of movement and muscle tone). On 10/7/24 at 1:00 pm, an observation of the lunch meal in the dining room and concurrent interview was conducted with Resident 26. Resident 26 stated the meat was awful and the kitchen runs out of food often. 7. During a review of Resident 579's clinical record. Resident 579 was admitted to the facility on [DATE] with diagnoses that included, diabetes, anxiety (fear of unknown), Alzheimer's (a condition that permanently affects the brain), and edema (swelling). A review of Resident 579's most recent MDS, dated [DATE], indicated, Resident 579's cognition was severely impaired. During an interview on 10/07/24 at 3:21 pm, with Resident 579, Resident 579 stated, The food is not good. I circle what I want on the menu the day before. But I never receive what I actually order. 8. A review of Resident 86's clinical record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses that included anxiety, thyroid disease, unspecified severe protein-calorie malnutrition (poor nutrition, commonly caused by not eating enough of the right nutrients), depression, and heart disease. A review of the most recent MDS for Resident 86, dated 8/20/24, indicated that Resident 86 had a moderate cognitive deficit, with a BIMS score of 8 out of 15, but Resident 86 could verbalize needs. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/7/24 at 3:31 pm, Resident 86 stated, I have a complaint about all the meals. The oatmeal is not cooked all the way, and it is cold at times. The staff does heat it up, but it is an ongoing problem. They never bring the condiments like syrup I use for the oatmeal, and there are not enough straws. My wife fills out the menu, but I never get what I want. 9. During a review of Resident 580's clinical record. Resident 580 was admitted to the facility on [DATE] with diagnoses that included, diabetes, sleep apnea (periods of not breathing when sleeping), high blood pressure, and a left knee fracture. A review of Resident 590's most recent MDS, dated [DATE], indicated Resident 580 was cognitively intact. During an interview on 10/08/24 at 9:18 am, with Resident 580, Resident 580 stated, Sometimes the hot food is cold. 10. Review of Resident 119's medical record indicated that Resident 119 was admitted on [DATE] with diagnoses that included, Traumatic Brain Injury (a head injury), Diabetes, and Acute Kidney Failure (AKF, kidney(s) cannot filter waste from blood). A review of Resident 119's most recent MDS, dated [DATE], indicated a BIMS score of 8/15, which equates to moderate cognitive impairment. Resident 119 was not their own RP and did not make their own medical decisions, but could verbalize needs and preferences. During an interview on 10/8/24 at 9:48 am, with resident 119 while in the resident's room at the bedside, Resident 119 stated, Food is terrible. They gave me a green glob to eat. I thought it was seaweed Awful food. 11. During a review of Resident 587's clinical record. Resident 587 was admitted to the facility on [DATE] with diagnoses that included, depression, diabetes, a neck fracture, below the knee left amputation (leg removed just below the knee), and left leg above the knee fracture. A review of Resident 587's most recent MDS, dated [DATE], indicated that Resident 587 was cognitively intact. During an interview on 10/08/24 at 12:20 pm, with Resident 587, Resident 587 stated, The food tastes bland and not very good. I don't always get what I pick on the menu the day before. 12. During confidential interviews conducted during Resident Council (a group of residents who discuss concerns about the facility), on 10/9/2024 at 2:30 pm, three of eight confidentially interviewed residents stated they were generally dissatisfied with the quality of their meals. All three residents stated that items were often missing from their trays, both food and condiments. All three residents stated that food served was not always the correct temperature, and food was not hot enough. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/8/24 at 3:31 pm, an interview was conducted with the Certified Dietary Manager (CDM). The CDM was asked how he ensured the residents were happy with the facility food. The CDM stated he had a great relationship with the residents and attended resident council meetings monthly. The CDM also stated he handed out food satisfaction questionnaires monthly to 10% of the census (total number of residents), with a 1-5 rating system with 5 being excellent. The CDM stated 3 was the threshold for satisfaction of meals.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observation, interview and facility record review, the facility failed to ensure one of 116 resident's (Resident 48) received the appropriate textured diet when chopped meats were not the appropriate size. This failure had the potential for residents who received chopped meats to not receive the appropriate texture which could lead to chewing and/or swallowing concerns. Findings: Review of the facility document titled, Therapeutic Spreadsheet Week 2 Monday dated 10/7/24, showed Easy to Chew diets should have received chopped meat for the lunch meal. Review of the facility Diet Manual, revised September 2024, showed, Mechanical Soft diet Recommendations: All meat (such as beef, fish, poultry and pork), should be ground or chopped. Definition of Menu Terms: Chopped was defined as 1/4 inch to 1/2 inch pieces. A review of Resident 48's clinical record showed Resident 48 was admitted to the facility on [DATE] with diagnoses which included fracture of left humerus (upper arm), unspecified dementia, and major depression. Review of the facility meal ticket for Resident 48 showed Fat/Cholesterol Restricted Diet Regular Chopped meat texture, thin liquid consistency. During a lunch meal observation on 10/7/24 at 1:00 pm, in the dining room, Resident 48 was observed with her lunch meal tray. The lunch meal contained cut up pork in approximately one to one and a half inch pieces. One piece of pork had been chewed and spit out on the plate. Resident 48 stated she did not like the meat. On 10/8/24 at 3:31 pm, an interview was conducted with the Certified Dietary Manager (CDM). The CDM was asked to define a Regular chopped meat diet. The CDM confirmed a Regular chopped meat diet was not on the therapeutic spreadsheet (describes how much and what type of food each diet type should be served). The CDM was asked to define the size of chopped meats. The CDM stated he did not know the specific size for chopped meats but would check the diet manual for specifics on the appropriate size of chopped meats.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observation, interview, facility document, and policy and procedure review, the facility failed to ensure seven of 116 resident's (Resident 577, 61, 579, 580, 69, 587 and 114) food preferences were honored. This failure posed the potential for facility residents to not be satisfied with their meals which could contribute to decreased intake and further lead to unintentional weight loss. Findings: Review of the facility policy titled, Resident Food Preferences updated May 12, 2021, showed nutritional assessments will include an evaluation of individual food preferences. 1. During a review of Resident 577's clinical record. Resident 577 was admitted to the facility on [DATE] with diagnoses that included, numbness of feet and hands, irregular heart rate, and wounds to right foot and left foot. The most recent Minimum Data Set, (MDS, an assessment tool), dated 09/27/24, indicated that Resident 577 was cognitively intact. During an interview on 10/07/24 at 12:28 pm, with Resident 577. Resident 577 stated, I fill out my menu the day before but, I do not get what I ordered. When I don't get what I ordered on the menu, my tray card comes blank. I do not like ham, but I get ham with some of my meals. The meat is sometimes hard as a rock, and I cannot cut it up to eat it. I have open wounds on both of my feet and I need the protein to help heal my feet but if the meat is to hard I don't eat it. 2. A review of Resident 61's clinical record indicated Resident 61 was admitted to the facility on , d+[DATE]//24 with diagnoses which included fall with nasal fracture, fracture of left index finger, and a fracture of the left hand. Review of the facility document titled, Therapeutic Spreadsheet dated 10/7/24, showed the lunch meal for regular diets were to be served polish sausage, german potato salad, sauerkraut, bavarian roll, and apple strudel. Review of the lunch meal ticket for Resident 61 showed she had selected a pork chop for the main entree. During the lunch meal observation on 10/7/24 at 12:55 pm, in the main dining room, Resident 61 was observed eating soup. Resident 61's meal tray consisted of soup, polish sausage, sauerkraut, and german potato salad. Resident 61 stated the soup was too spicy and usually soup was the only food she liked of the meals served at the facility. Resident 61 did not eat the other food served with her meal. Resident 61 was questioned about her meal ticket. Resident 61 stated she had selected the pork chop by circling it on the lunch menu the previous day. When asked why she received polish sausage, Resident 61 stated, It's a crapshoot with meals, you never know what you will get. On 10/8/24 at 10:33 am, an interview was conducted the Certified Dietary Manager (CDM) regarding resident menu selections. The CDM explained menus were handed out each day on the breakfast trays and collected at 2:00 pm, the following day. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/08/24 at 3:31 pm, an interview was conducted with the CDM. The CDM was unable to explain why the menu Resident 61 received did not match the menu served on 10/7/24, but confirmed Resident 61 should have received what she ordered. 3. During a review of Resident 579's clinical record. Resident 579 was admitted to the facility on [DATE] with diagnoses that included, diabetes, anxiety (fear of unknown), Alzheimer's (a condition that permanently affects the brain), and edema (swelling). The most recent MDS, dated [DATE], indicated, Resident 579 was severely cognitively impaired. During an interview on 10/07/24 at 3:21 pm, with Resident 579, Resident 579 stated, The food is not good. I circle what I want on the menu the day before. But I never receive what I actually order. 4. During a review of Resident 580's clinical record. Resident 580 was admitted to the facility on [DATE] with diagnoses that included, diabetes, sleep apnea (short periods of not breathing during sleep), high blood pressure, and left knee fracture. The most recent MDS, dated [DATE], indicated that Resident 580 was cognitively intact. During an interview on 10/08/24 at 9:18 am, with Resident 580, Resident 580 stated, I asked for a ham sandwich but was told they did not have ham. I then asked for a turkey sandwich with cheese, and I was told they did not have cheese. Sometimes the hot food is cold. 5. During a review of Resident 69's clinical record. Resident 69 was admitted to the facility 9/27/2020 with diagnoses that included chronic pain and adult failure to thrive (decline in function that includes weakness and loss of appetite). Her most recent MDS, dated [DATE], indicated she had a moderate cognitive impairement. Resident 69 was her own responsible party and made decisions about her care independently. During an interview on 10/08/24 10:40 am, with Resident 69 she expressed generalized food complaints. Resident 69 stated she fills out her menu daily but does not always recieve what she ordered, as the kitchen staff make subsititutions. During an interview on 10/10/24 at 10:15 am, with Resident 69 and her daughter, her daughter stated she has also observed that what the resident ordered and what she recieves on her meal tray do not always match. Resident 69's daughter stated she visits most often on Sunday during meals when she's noted substitutions. Both the resident and her daughter expressed discomfort about complaining to the staff, and their understanding that the kitchen had run out of the requested item.

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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. 49859 Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation guidelines were followed when: 1. The cool down process for time, temperature control, and safety of food (TSC, foods that need to be kept at specific temperatures to prevent bacteria growth and foodborne illness), was not monitored. 2. Dish machine wash and rinse temperatures did not meet manufacturer's guidelines. 3. Hair restraints were not worn. 4. Food preparation equipment was not in proper working order. 5. Kitchen equipment was not clean. 6. Food preparation equipment and silverware were not air dried. 7. Food was not stored properly in the kitchen. 8. Kitchen cleaning supplies were not stored properly. 9. Non-functioning kitchen equipment was not discarded. These failures had the potential of causing foodborne illness in 115 of 116 residents who consumed food prepared in the facility's kitchen. Findings: A review of the facility Matrix (a list of residents and thieir care needs), showed that 115 of 116 residents consumed food prepared in the kitchen. 1. A review of the USDA Food Code 2022, Section 3-501.14 Cooling. (B) indicated Time/temperature control for safety food shall be cooled within 4 hours to 41 degrees Fahrenheit (F) or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna. A review of the facility's policy titled, Cooling Policy, dated 2/27/2020, indicated that using the One-stage Method, Food must be cooled to 41 degrees F or lower in less than four hours. A review of the facility's menu titled, Cycle 3 2024, indicated that in week 2 Tuna Salad/Croissant was served, week 3 Seafood Salad/Croissant and Chicken Salad/Sandwich was served. (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 with [NAME] 1 on 10/8/24 at 8:41 am, [NAME] 1 stated that he does not make the tuna or chicken salad at the facility and that he was not sure if they used a cooling log to monitor the temperature of the tuna or chicken salad while cooling. During an interview with the Certified Dietary Manager (CDM) on 10/8/24 at 3:31 pm, in the empty resident dining room the CDM confirmed that the facility does not use a cool down log to ensure safe temperatures for ambient (room temperature) food items such as tuna or chicken salad prepared with mayonnaise and that he avoids using cooling logs. 2. A review of the instruction signage plate on the front of the dishwasher titled, NSF Data Plate located on the dish machine indicated, Hot water sanitizing - final sanitizing rinse minimum temperature: 180 degrees F and Wash tank minimum temperature: 150 degrees F. During an interview and observation with Diet Aid 1 (DA) 1 on 10/8/24 at 9:09 am, DA 1 stated that the wash temperature for the dishwasher should be 150 degrees F and the rinse cycle should be180 degrees F. The temperature gauges on the dishwasher indicated 142 degrees F for the wash temperature and 146 degrees F for the rinse cycle. During an interview and observation with the Plant Operations Manager (POM) on 10/8/24 at 9:16 am, the POM stated that the dishwasher had a dish machine booster (an extra water heater) that ran automatically and that the booster raised the temperature to 190 degrees F. After the POM adjusted the dish machine booster, the rinse cycle then registered 170 degrees F. The POM stated that the dishwasher also had a chemical back up to ensure the dishes in the dishwasher were sanitized. As the POM left the kitchen, he told the staff in the dishwashing area to let him know if the dishwasher did not maintain the correct temperatures. During an interview with DA 1 on 10/8/24 at 9:18 am, DA 1 stated that the sanitizer is automatic and confirmed she did not check the sanitizer for the correct parts per million (ppm), of chlorine. During an interview with the CDM on 10/8/24 at 9:31 am, the CDM confirmed that the facility did not have chlorine test strips to test the chemicals used in the dishwasher to ensure the dishes were sanitized. The CDM stated that the dishwasher booster (extra water heater) should be on at all times and that the dishwasher booster needed to be fixed by maintenance every other day. The CDM also stated that the chemical sanitizer for the dishwasher was a backup for the dishwasher booster. 3. A review of the facility's policy titled, Employee Cleanliness, dated 2/27/20, indicated that, A hairnet, hat or bouffant disposable cap must be worn and must cover hair completely including bangs and Facial hair must be completely covered with a beard net. During an observation on 10/7/24 at 10:40 am, DA 2 was not wearing a hair net in the kitchen. During an observation on 10/7/24 at 10:41 am, [NAME] 1 was not wearing a hair net or beard net in the kitchen. During an observation on 10/7/24 at 10:42 am, the CDM was not wearing a beard net in the kitchen. During an interview on 10/7/24 at 10:45 am, CDM stated that they don't have beard nets and that staffs' hair needed to be covered by a hat. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. According to the USDA Food Code 2022, Section 4-501.11 Good Repair and Proper Adjustment, (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. During a kitchen observation on 10/7/24 at 11:20 am, the can opener blade was worn. During an interview with the CDM on 10/7/24 at 11:23 am, the CDM confirmed that the can opener blade needed to be replaced. According to the USDA Food Code 2022 Annex Chapter 4. Equipment, Utensils, and Linens, 4-101.11 Characteristics. Multiuse equipment is subject to deterioration because of its nature, i.e., intended use over an extended period of time. Certain materials allow harmful chemicals to be transferred to the food being prepared which could lead to foodborne illness. In addition, some materials can affect the taste of the food being prepared. Surfaces that are unable to be routinely cleaned and sanitized because of the materials used could harbor foodborne pathogens. Deterioration of the surfaces of equipment such as pitting may inhibit adequate cleaning of the surfaces of equipment, so that food prepared on or in the equipment becomes contaminated. Inability to effectively wash, rinse and sanitize the surfaces of food equipment may lead to the buildup of pathogenic organisms transmissible through food. Studies regarding the rigor required to remove biofilms from smooth surfaces highlight the need for materials of optimal quality in multiuse equipment. During a kitchen observation on 10/7/24 at 11:39 am, two of three rubber spatulas in a drawer under the food preparation table were chipped and discolored. During an interview with the CDM on 10/7/24 at 11:41 am, the CDM confirmed that the chipped spatulas should not be used. During a kitchen observation on 10/8/24 at 11:38 am, [NAME] 1 used a chipped spatula to scrape sweet potato puree into a holding pan. During and observation and interview with the CDM during the initial tour of kitchen on 10/7/24 at 10:40 am, four of four heavily scratched cutting boards for food preparation were observed on the food preparation table in a rack. The CDM confirmed that the cutting boards were heavily scratched, and indicated that the facility replaces them every 6 months. During a kitchen observation on 10/8/24 at 11:23 am, the CDM and [NAME] 1 used deeply scratched cutting boards to cut up vegetables and meat. 5. According to the USDA Food Code 2022, Section 4-601.11, Food Contact Surfaces, Nonfood Contact Surfaces, and Utensils (A) Equipment, food contact surfaces, and utensils shall be clean to sight and touch, (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. A review of the facility's policy titled, Knife Safety, dated 4/2020, indicated, Knife rack, knife holder, or if using a separate drawer for storage shall be kept clean from dust or debris. A review of the facility's policy titled, Floor Safety, dated 4/2018, indicated that, Floors will be kept clean and dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy titled, Shelves and Other Surfaces, dated 4/27/20, indicated, Walls, ceilings and vents must be washed thoroughly at least quarterly. Heavily soiled surfaces must be cleaned more frequently, Removable drawer should be removed and washed, Clean cabinets and drawers on a weekly basis, or more often as needed. A review of the facility's policy titled, Can Opener, dated 4/2018, regarding cleaning the can opener indicated; Use the following procedure to thoroughly clean the can opener after each use: 1. Wash the handle portion of the can opener in the dish machine or the pot and pan sink. 2. Wash the base with a brush, cloth and a detergent solution, making sure the shaft cavity is clean. 3. Rinse base with fresh water. 4. Sanitize with appropriate strength solution and allow to air dry. Note: Unbolt the base from the table as needed for deep cleaning. Wash and sanitize the base as well as the area on the table where the base rests. During the initial tour of the kitchen on 10/7/24 at 10:40 am, with the CDM, the following were observed and confirmed by the CDM: -the knife holder was not clean -the floors were not clean -the walls were not clean -the drawers under the food preparation table were not clean -the food preparation table was not clean -two cookie pans were not clean -two food storage bins were not clean -the wire shelf storing clean food service utensils was not clean -the standing fan in the kitchen was not clean -the can opener and base were not clean -the mixer and area around it were not clean -the fryer was not clean (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 observation and interview on 10/7/24 at 3:10 pm, with the POM a black substance was observed on the left side of the ice storage bin of the ice machine. The POM confirmed that the inside of the ice storage bin was not clean. During an observation and interview on 10/8/24 at 9:05 am, with the CDM dome racks (racks used to air dry the plate covers used to protect residents' food during transport from the kitchen to the dining room), were observed to have dust and debris on them. The CDM confirmed that they were not clean. During an observation on 10/8/24 at 9:05 am, with the CDM 4 large frying pans were observed with hard, black residue around the insides of the pans. During an interview on 10/8/24 at 9:24 am, the CDM confirmed that the above pans were not clean. During an observation on 10/8/24 at 12:05 pm, observed [NAME] 1 add 11 two-ounce pieces of cooked turkey and add thickener from an amber colored pitcher with visible white debris on the inside, outside, and handle of the pitcher to the Robot Coupe (RC - a device used to grind and puree foods). During an interview on 10/9/24 at 9:28 am, the CDM confirmed that the amber colored pitcher used for the thickener was only washed once per shift. 6. According to the USDA Food Code 2022, 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food. During the initial tour on 10/7/24 at 10:40 am, with the CDM two steam table pans were stacked on the shelf wet. During an observation on 10/8/24 at 9:01 am, the RC and the blender were stored with the tops on and wet inside. During an observation on 10/8/23 at 9:23 am, a Diet Aide put wet glasses from the dishwasher on a tray right side up and stacked another tray on top of the glasses. During an interview on 10/8/24 at 9:35 am, the CDM confirmed that they are not air drying the glasses, the RC, or the blender. 7. According to the USDA Food Code 2022, 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(3) At least 15 cm (6 inches) above the floor. During an observation on 10/8/24 at 4:01 pm, a cooking oil container was observed on the floor by the hand washing station in the kitchen. During an interview on 10/9/24 at 9:20 am, the CDM confirmed that the cooking oil container on the floor by the hand washing station should not have been stored on the floor. 8. According to the USDA Food Code 2022 Section 6-501.113 .Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be (B)Stored in an orderly manner that facilitates cleaning the area used for storing the maintenance tools. During the initial tour of the kitchen on 10/7/24 at 10:40 am, with the CDM, a broom was observed being stored on the floor of the chemical closet of the kitchen. The CDM confirmed that the broom should have been hung up on the racks on the wall of the chemical closet. 9. According to the USDA Foor Code 2022, Section 6-501.114 Maintaining Premises, Unnecessary Items and Litter. The premises shall be free of, (A) Items that are unnecessary to the operation or maintenance of the establishment such as equipment that is nonfunctional or no longer used. A review of the facility's policy titled, Equipment Safety not dated, indicated that, Any equipment that is not functioning properly, including exposed electrical components, must not be used. Notify Director of Nutritional Services who will then notify Maintenance of the needed repair. During the initial tour of the kitchen on 10/7/24 at 10:40 am, with the CDM, two broken RCs were observed on the floor in the kitchen next to the back door. The CDM confirmed that they were there awaiting repair. During an interview on 10/9/24 at 9:20 am, with the CDM, the CDM confirmed that the broken RCs on the kitchen floor should have been discarded a year ago.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 49859 Based on observation, interview, and record review, the facility failed to dispose of garbage properly. These failures had the potential to result in attracting insects and rodents affecting all 116 residents who resided in the facility. Findings: According to the USDA Food Code 2022, Section 5-501.19 Storage Areas, Redeeming Machines, Receptacles and Waste Handling Units, Location. (A) An area designated for refuse, recyclables, returnables, and, except as specified in (B) of this section, a redeeming machine for recyclables or returnables shall be located so that it is separate from food, equipment, utensils, linens, and single-service and single-use articles and a public health hazard or nuisance is not created. According to the USDA Food Code 2022, Section 5-501.110 Storing Refuse, Recyclables, and Returnables. refuse, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. A review of the facility's policy titled, Food/Waste Disposal, dated 8/2/24 indicated, The Food and Nutrition Services Department will be free of waste and clutter at all times, Cardboard boxes are to be broken down before being placed in the dumpsite or storage area, and Dumpsters and dumpsite area to be kept clean and free of debris. 1. During the initial tour of the kitchen on 10/7/24 at 10:40 am, with the Certified Dietary Manager (CDM) greater than ten broken down cardboard boxes were observed on a kitchen cart sitting in the kitchen, and two broken down cardboard boxes were observed tucked next to the food preparation table. During an interview on 10/8/24 at 3:31 pm, with the CDM, the CDM confirmed that the boxes were collected in the kitchen then taken outside at the end of shift. 2. During a concurrent observation and interview on 10/7/24 at 11:57 am, with Plant Operations Manager (POM), outside the kitchen door, dietary carts, linen carts, mattresses, and wheelchair parts were sitting against or near a portable storage container next to the kitchen loading dock. The POM stated that as far as he knew the items around the kitchen loading dock (where food supplies are delivered), were not broken, and that nobody was assigned to pick up trash. During a concurrent observation and interview on 10/8/24 at 10:21 am, with the Central Supply Clerk (CSC), the CSC stated that maintenance took care of the loading dock area. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/24 at 8:51 am, with the Administrator (ADM), when asked who is in charge of the area outside the kitchen door, the ADM stated that there was not one person assigned, that they did rounds on the area. The ADM stated that there should not be trash there and that someone may have left equipment there and not communicated it. The ADM stated that the POM takes items that need to be discarded to the dump.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46147 Based on observation, interview, and record review, the facility failed to ensure they coordinated resident care needs with the Hospice Agency (an outside agency that specializes in end of life care), for one of four sampled residents (Resident 112). This failure caused a delay in personal care, comfort, and had the potential to result in emotional stress, feelings of neglect, and negative clinical outcomes for residents who received Hospice services. Findings: A review of the facility's policy dated 5/2010 titled, Hospice Program, indicated the facility contracts for hospice services for residents who wish to participate in such programs. A Coordinated Plan of Care between the facility, hospice agency, and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status. A review of Resident 112's clinical record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (syndrome of weight loss, poor nutrition, impaired immune system, loss of appetite and inactivity), heart disease, high blood pressure, unspecified severe protein-calorie malnutrition (poor nutrition), anxiety (a feeling of fear, dread, and uneasiness), diabetes (too much sugar in the blood), and repeated falls. Resident 112 was receiving Hospice services. A review of the most recent Minimum Data Set (MDS, a resident assessment tool), for Resident 112 dated 8/4/24, indicated that Resident 112 had a severe cognitive deficit, with a brief interview for mental status (BIMS) score of 2 out of 15, and was totally dependent for staff with all activities of daily living (ADLs, basic needs as personal hygiene, dressing, toileting, transferring, walking, and eating). During an interview on 10/8/24 at 10:33 am, Licensed Nurse (LN) 2 indicated that LN 4 had informed her that Resident 112 refused a shower that morning. During an interview on 10/8/24 at 2:59 pm, Resident Care Manager (RCM) 1 confirmed LN 4 and all nursing staff should coordinate all care with any hospice agency, and it was the facility's responsibility to make sure Resident 112 received a shower or bath at least two times weekly, and as needed. RCM 1 confirmed there was a lack of communication between the Hospice agency nurses and the facility, and that Resident 112's care plan was not updated. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 10/8/24 at 3:28 pm, the Director of Patient Care (DPC), from the Hospice agency, indicated that Resident 112 was admitted to their Hospice services on 10/2/24, and the plan for end of life care and ADL care needs had been sent to the facility in order to coordinate Resident 112's care between the Hospice agency and the facility. DPC also confirmed it was the expectation of the Hospice agency that any changes to the plan of care would be updated by the facility. DPC indicated changes would be communicated to the Hospice agency to ensure quality of care and allow for revisions in how often the Hospice agency would visit Resident 112. During a review of 112's clinical record, a document dated 10/2/24 through 12/30/24, titled, Hospice Certification and Plan of Care (POC, or Physician Orders), orders and treatments indicated Hospice nurse to coordinate plan of care with facility staff. Facility staff to provide the following daily nursing care: Medication administration, and coordination with hospice for any changes in condition. During a review of 112's clinical record a document dated 10/2/24 through 12/30/24, titled, POC [Plan of Care], goals indicated, Facility staff is knowledgeable and involved in hospice plan of care for patient through end of episode. During an interview on 10/10/24 at 10:40 am, RCM 1 stated, I confirm there was no care coordination with the Hospice agency for [Resident 112] for end-of-life care, to include symptom management and ADLs to promote comfort. I confirm there was no communication to make sure all the needs for [Resident 112] were met, and all residents with end-of-life care should be coordinated with any outside agency per our facility's policy. During an interview on 10/10/24 at 11:10 am, the Director of Nursing confirmed Resident 112 needed care coordination for end-of-life care for all needs to be identified and met, and the facility did not follow their policy for end-of-life care.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 39856 Based on observation, interview and facility document review, the facility failed to ensure the facility was free from pests. This failure posed the risk of 116 residents who resided in the facility to be exposed to pests. Findings: Review of the facility policy titled, Vermin Control dated 4/2018, showed the Food and Nutrition Services Department must be free from vermin (pests), at all times. The Food and Nutrition Services Department must be kept free of soil and clutter. Arrangements will be made by the Administrator for an effective pest control program to provide routine service. Review of the facility documents from the outside pest company dated 7/18/24, 8/13/24 and 9/19/24 showed that two fly bait stations located in the kitchen and one fly bait station located outside the facility were serviced. During the initial tour of the kitchen on 10/7/24 at 10:40 am, with the Certified Dietary Manager (CDM), one fly was observed in the kitchen near the food preparation sink. On 10/7/24 at 11:49 an, an observation of the kitchen was conducted. The air curtain, a device used to prevent flying insects from entering the kitchen, which was located above the back door of the kitchen was not operable. On 10/7/24 at 12:10 pm, an interview was conducted with the Plant Operations Manager (POM). The POM was asked how the facility prevented pests. The POM stated the facility used an outside company to control pests. The POM stated the kitchen had two bug lights and one air curtain to control flying pests. The POM added the bug lights were located near the back door and in the dish room. One fly was observed flying around the kitchen then landed on the meal tray line. When asked about the air curtain, the POM stated the air curtain above the back door of the kitchen was not turned on and should be turned on all the time. The POM turned the air curtain on from the circuit breaker located in the dry storeroom and stated that should make a big difference in the number of flying pests. During an observation on 10/7/24 at 12:35 pm, in the Assisted Dining Room, residents were still awaiting trays. Multiple flies were noted darting throughout the dining area. During an observation on 10/8/24 at 9:24 am, a fly was observed flying in the dish room. During an observation on 10/8/24 at 10:00 am, multiple fruit flies and one fly were observed in the dry storeroom. During an observation on 10/8/24 at 10:28 am, a fly was observed in the hall outside the dining room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/8/24 at 10:33 am, an interview was conducted with the CDM. The CDM was asked how he ensured the air curtain used to prevent flying insects from entering the kitchen, was always turned on. The CDM stated the morning crew were responsible to turn the air curtain on and the evening crew were responsible to make sure the air curtain was turned off. When asked if the CDM ever turned on the air curtain, he stated he had never turned the air curtain on. The CDM confirmed he had not noticed the air curtain was not functioning on 10/7/24. On 10/8/24 at 11:05 am, one fly was observed in the kitchen in the food preparation area. On 10/8/24 at 11:07 am, during an interview with Diet Aid 5, a fly was observed on the CDM's desk. On 10/8/24 at 11:10 am, an interview was conducted with Diet Aid 1. Diet Aid 1 stated her shift started at 5:30 am. When asked if she was responsible to turn on the air curtain above the back door of the kitchen, Diet Aid 1 stated she did not touch the air curtain. On 10/8/24 at 11:18 am, an interview was conducted with [NAME] 1. [NAME] 1 stated his shift started at 4:30 am. When asked if he turned the air curtain on, [NAME] 1 stated he did not turn on the air curtain because it is was always on. [NAME] 1 stated he had worked at the facility for two years and had never touched the air curtain. On 10/8/24 at 11:19 am, an interview was conducted with Diet Aide 3. Diet Aid 3 stated she didn't touch anything mechanical and had never turned the air curtain on in the morning. On 10/8/24 at 12:05 pm, a fly was observed in the food preparation area of the kitchen. During a test tray audit on 10/8/24 at 12:54 pm, on the 400 unit, a fly was observed to land on the resident lunch meal tray cart. On 10/9/24 at 9:20 am, an interview was conducted with the CDM. The CDM stated pest control was completed monthly. The CDM stated the POM was responsible for the facility pest control. The CDM was asked if flies were an issue in the kitchen could he contact the outside pest control company. The CDM stated he would contact the POM if flies were an issue in the kitchen. The CDM confirmed he had not contacted the POM regarding the flies seen in the kitchen. During an observation on 10/10/24 at 2:08 pm, flies were noted in the conference room.