STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056231	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lassen Nursing & Rehabilitation Center	2005 River Street Susanville, CA 96130

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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 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. The facility failed to store, prepare, and serve food in a safe and sanitary manner when:1.Meat was not thawed appropriately.2.Water from thawing meat splashed onto ready to eat vegetables causing possible cross contamination (transfer of harmful bacteria, viruses, or allergens from one surface, food, or object to another between raw meat thawing and cooked vegetables).3.Staff did not wash hands after handing dirty items on the dirty side of the dish machine and before touching clean items such as eating utensils, water pitchers, and food storage tubs.Staff did not wash hands upon entering the kitchen and before starting kitchen tasks.4.Cooking pans were in poor condition.5.The can opener blade and holder was not clean.6.Cutting boards were in poor condition.7.The standing mixer was not clean.8.The knife holder was not clean.9.Thickener (a powder used to thicken liquids) was not covered, labeled, or dated.10.Dry food located in the food storage room was not stored appropriately.11.A scoop was stored directly on top of a bin of dried rice.12.Sugar was contaminated.13.Water cups were not covered.14.Cold food was not stored appropriately.15.Range (stove) hood filters were not clean.16.Swamp cooler ceiling vents and surrounding surfaces were not clean.17.Two kitchen fans were not clean.18.One floor tile was not intact.19.Kitchen walls were not clean.20.Hairnets and beard covers were not worn in the kitchen.These findings placed the 89 residents who receive food from the kitchen at risk for receiving contaminated food and/or contaminated eating utensils, out of a census of 90.Findings: 1.A review of the facility's Food Preparation and Service policy, dated 10/2017, under Thawing Frozen Food, Line 1 indicated, Thawing procedures include: b. Submerging the item in cold running water (70 degrees Fahrenheit or below). Line 4 indicated, Potentially hazardous foods, including raw meats which might contaminate other foods or the food preparation area, will be prepared in specified areas using appropriate measure to prevent cross contamination. During an observation in the kitchen on 6/22/26 at 11:05 AM, two slabs of pork shoulder were in a clear bucket in the food preparation sink. Half of both pork shoulders were not submerged in water, and water was running to the side of the meat. An observation on 6/22/26 at 12:02 PM, showed the pork shoulder continued to be half submerged in the two-compartment preparation sink, under running water. During an interview on 6/22/26 at 2:42 PM, with the Dietary Manager (DM), DM stated running water should be flowing right over the meat. DM stated, No wonder it was taking so long to thaw the meat because the water wasn't running over the meat. During a concurrent observation and interview on 6/23/26 at 8:41 AM, with DM, Surveyor observed a white bag in a container with water running into the container on the right side on the two-compartment preparation sink. The white bag had at least 3 inches of the bag sticking up above the water and water was running onto the bag. DM stated the white bag contained ground turkey that was being thawed for tonight's supper. 2. During an observation on 6/23/26 at 11:43 AM, with [NAME] A, [NAME] A removed a pan of vegetables from the steamer and poured the vegetables into a large colander in the left side of the two-compartment sink (compartment 1). The adjacent sink compartment had packaged ground turkey thawing in a container with water running over the package. Water splashed from the ground turkey package into the cooked vegetables draining in the colander. During a concurrent observation and interview on 6/23/26 at 11:45 AM, with the DM, (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor asked DM regarding the thawing meat and cooked vegetables being close to each other and if it was a concern. DM confirmed water splashed from the thawed meat into the cooked vegetables in the colander and stated that they should be placed further apart. DM removed the thawed meat package and placed it in a pan. Surveyor observed red fluid accumulated in the bottom of the pan from the meat package. When the surveyor asked DM their thoughts on the safety of the vegetables, DM confirmed the vegetables were not safe to eat. 3.A review of the facility's, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy, dated 10/2017, indicated on Line 6, Employees must wash their hands: Line C indicated, Whenever entering or re-entering the kitchen. Line D indicated, Before coming in contact with any food surfaces. Line F indicated, After handling soiled equipment or utensils. During an observation on 6/23/26 at 11:37 AM, Dietary Aide (DA) B washed dishes and organized silverware from a dish machine crate and placed them in the silverware holder on the dirty side of the dishwashing area. DA B handled the water sprayer at the dirty side of the dish machine. DA B put the silverware holder in the dish machine, then grabbed the handle on the dirty side of the dish machine to pull the door down to start the cleaning cycle. Then DA B went to the clean side of the dish machine, where clean utensils and equipment were stored and touched pitchers, tubs, utensils including a whisk, tongs, and a large potato masher. Next, DA B proceeded to handle clean silverware and placed the silverware in a clean storage area next to the tray line. DA B did not wash their hands between handling items on the dirty side of the dish machine and touching the clean items used for food preparation, food storage, and food service. During an interview on 6/23/26 at 11:42 AM, with the DM, DM confirmed hand hygiene should be done between handling dirty items and moving on to clean items when washing items in the dish machine. During an observation on 06/23/26 at 11:56 AM, [NAME] B entered the kitchen, did not wash their hands, and walked across the kitchen to the food preparation area near the mixer and microwave where he placed a hair net on his head. [NAME] B then touched the food preparation table and handled the recipe binder. 4.A review of the facility's, Sanitization policy revised 10/2008, Line 2 indicated, All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Line 16. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. During an observation in the kitchen on 6/22/26 at 11:02 AM, nine cooking pans were hung above a two-compartment preparation sink and ready for use. Each of the nine pans had dark black buildup on the cooking surfaces with a significant amount of pitting and scratches. During a concurrent observation and interview on 6/23/26 at 9:40 AM, with the DM, DM confirmed that pitting scratches were on multiple hanging pans. DM confirmed that two fry pans had lost their protective coating on the cooking surface. DM stated the pans were not usable. DM stated, It has been on the back of my mind to replace the pans but hadn't ordered them yet. 5. During an observation on 6/22/26 at 10:54 AM, in the kitchen, the industrial can opener attached to the food preparation table had brown residue on the cutting blade and on the surface. During a concurrent observation and interview on 6/23/26 at 9:40 AM, with the DM, DM stated the can opener should be cleaned after each use. DM stated the can opener, Was definitely not cleaned after each use. DM stated that when food residue is left on food equipment there is a risk of cross contamination to food. DM stated the can opener holder should be cleaned off every night and that it did not look like it was being cleaned every night. 6.During an observation on 6/22/26 at 10:57 AM, three large plastic cutting boards and five small plastic cutting boards had significant scratch marks, a coating of white flakes, chipped surfaces, and black discolorations. During a concurrent observation and interview on 6/23/26 at 9:40 AM, with the DM, DM confirmed the above observations of the cutting boards and stated the cutting boards needed to be replaced. 7.During an observation on 6/22/26 at 10:55 AM, a standing mixer was not covered. The metal guard and metal plate shield had yellowish residue that appeared to be food residue on the surface. During a concurrent observation and interview on 6/23/26 at 9:40 AM, with DM, the standing mixer was covered with plastic. DM stated the standing mixer was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	white granulated substance in the unlabeled container was sugar and confirmed the sugar had black things in it which the DM could not identify. 13.A review of the facility's, Refrigerators and Freezers policy, dated 12/2014, indicated under, Policy Statement, the facility will observe food expiration guidelines. Line 7 indicated, All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dated (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dated indicated once food is opened. A review of the facility's, Food Receiving and Storage policy, dated 7/2014, showed all foods in the refrigerator or freezer will be covered, labeled, and dated by use-by date. During an observation in the kitchen on 6/22/26 at 10:43 AM, the Nourishment refrigerator had a tray of uncovered cups filled with water. During an observation and interview on 6/22/26 at 9:01 AM, with the DM, surveyor discussed observation of water cups being stored in the nourishment refrigerator uncovered. DM stated they ran out of lids for the cups that day but the cups should have been covered to prevent air germs from getting into the water. 14.During an observation in the kitchen on 6/22/26 at 11:12 AM, of a freezer located in the dry food storage room, two opened packages of what appeared to be cookie dough were sealed in a plastic bag with no open or expiration dates on the bag and no label to indicate what the food was. The freezer contained frozen angel food cake with an expiration date of 5/24/26. A large box of pizza dough was labeled 12/18/25. During an observation and interview on 6/23/26 at 9:01 AM, with the DM, DM confirmed the opened package of cookie dough was not labeled and they were not able to determine the open and expiration dates from the original box. DM stated they would not feel safe serving them to residents because the cookie dough was susceptible to frost bite. DM confirmed pizza dough and the angel food cake in the freezer had expired. 15.Review of the facility's, Sanitization policy and procedure, dated 2008, showed the food service area shall be maintained in a clean and sanitary manner. All kitchens and kitchen areas shall be kept clean. Kitchen surfaces not in contact with food shall be cleaned on a regular schedule frequently enough to prevent an accumulation of grime. According to the 2022 Federal Food Code, indoor floors under conditions of normal use are to be smooth and easily cleanable for areas where food establishment operations are conducted. During an observation on 06/22/26 at 12:01 PM, the range hood filters had gray fuzzy build-up on them and the light fixture under the hood had gray fuzzy residue on the surface. During an observation and interview on 6/23/26 at 9:10 AM, with the DM, DM confirmed the range hood filters appeared fuzzy. DM stated they were in need of cleaning. DM stated, They could use a wipe down, but they are not terrible when discussing the condition of the lights inside the range hood. 16.During an observation on 6/22/26 at 10:51 AM, the swamp cooler vents above two refrigerators had dark gray fuzzy build-up present in between the slats and there was dark gray fuzzy build-up on the ceiling around the vents and on the wall below toward the refrigerators. During an observation and interview on 6/23/26 at 9:10 AM, with the DM, DM acknowledged the swamp cooler vents on the ceiling in the kitchen had fuzzy dust and black residue. DM acknowledged that the swamp cooler above two refrigerators had fuzzy dust and black residue on the cooler vent slats and black residue was on the wall toward the refrigerators. DM acknowledged the swamp coolers need to be cleaned and stated maintenance services these coolers but was unsure of when they are cleaned or if this service is on a schedule. DM stated they needed to be wiped down. During an observation and interview on 6/24/26 at 9:32 AM, with the Maintenance Technician (MT), MT confirmed that they cleaned the swamp cooler vents last month and they are supposed to be cleaned monthly or every other month. MT stated they were behind with cleaning the vents. MT did not know what the dark material was on and around the swamp cooler vents but confirmed it was there. 17.During an observation on 6/23/26 at 8:53 AM, in the kitchen, a large, black fan next to ice machine had black fuzzy particles on the blades and blade guards. A grey fan near the tray line had a grey fuzzy substance on the blade and blade guards. During an observation and interview on 6/23/26 at 10:02 AM, with the DM, DM confirmed that the grey standing floor fan near the tray line had gray fuzzy (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	substances on the wire blade guards and on fan blades. DM confirmed the large black fan by the ice machine was dusty. DM stated they had recently started using the fans in the kitchen. 18.During an observation and interview in the kitchen on 6/24/26 at 9:10 AM, a tile adjacent to a floor sink drain behind the ice machine, was cracked and missing a large chunk creating a rough floor surface. Water was leaking onto the floor around the floor sink creating pooling water on the tiles. DM stated they were not aware of the broken tile and had not reported it to maintenance. During an observation and interview on 6/24/26 at 10:40 AM, with the DM, DM acknowledged that the floor sink drain was leaking onto the floor and a tile was broken that needed repair. He acknowledged the presence of black residue around the plastic pipe entering the floor sink drain. 19.During an observation on 6/23/26 at 9:59 AM, two walls above the work desk in the kitchen had orange residue that looked like food had splattered on them. During an observation and interview on 6/23/26 at 9:40 AM, with the DM, DM stated they had not noticed this discoloration on the wall before. DM stated, It looks like soup. Like something exploded but wasn't sure. 20.A review of the facility's policy, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, dated 10/2017, Line 12 indicated, Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens. During an observation on 6/22/26 at 10:57 AM, DM was not wearing a hairnet to cover the hair on their head. During an observation on 6/22/26 at 2:45 PM, DM had no hairnet on, and their beard net did not cover their beard completely. During an observation on 6/23/26 at 8:43 AM, DM was not wearing a hairnet. MT was on a ladder placing a light cover on a ceiling light above the refrigerators in the back of the kitchen. MT had mustache and beard and was not wearing a beard net. During a concurrent observation and interview on 6/23/26 at 9:10 AM, with the DM, DM ?s beard net was not covering their mustache and beard completely. Surveyor asked what the expectations for maintenance workers was when entering the kitchen. DM confirmed that all hair must be covered. Surveyor discussed an observation of a MT not wearing a beard net on 6/22/26. DM stated he had not noticed this yesterday and had not communicated to the MT that hair covers are required. During an interview on 6/23/26 at 10:02 AM, with the DM, DM stated in the kitchen it is the expectation that all employees wear hair coverings for their hair and beards when going beyond the red line (tape boundary) on the kitchen floor. DM confirmed that they forgot to wear a hair net yesterday. DM stated their beard cover keeps falling down and it was hard to fully cover their mustache and beard because it had grown.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility policy and procedure (P&P) review, the facility failed to ensure call lights were answered timely for 8 of 19 sampled residents (Residents 73, 98, 3, 85, 74, 57, 6, 93) and four of seven confidentially interviewed residents.This failure resulted in dependent residents (residents not able to help themselves to the bathroom, out of bed, or out of their wheelchairs) not receiving the assistance they needed. Findings: Review of a facility procedure titled, Answering the Call Light revised October 2023 indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs.1. Answer the resident call system immediately. Review of Resident 73's medical record indicated that she was admitted to the facility on [DATE] with diagnoses which included muscle weakness, and need for assistance with personal care. During an interview on 6/22/26 at 11:00 AM, Resident 73 indicated staff were slow to answer call lights at night. Review of Resident 98's medical record indicated that she was admitted to the facility on [DATE] with diagnoses which included a wound on her left leg, an abscess (a localized, enclosed pocket of pus that forms in the body's tissues in response to an infection) of her right foot, and weakness. During an interview on 6/22/26 at 11:28 AM, Resident 98 indicated that call lights take too long and it would take a long time to get help. During an interview on 6/22/26 at 3:30 PM, the Director of Nursing (DON) confirmed that her expectation was that call lights be answered by staff and resident needs be met within a reasonable timeframe. A review of Resident 3's medical record indicated that Resident 3 was admitted on [DATE] with diagnoses that included Acute Congestive Heart Failure (CHF, Heart does not pump blood adequately), Atrial Fibrillation (A-fib, Irregular heart beat), and Acute Respiratory Failure with Hypoxia (Inadequate oxygenation of the blood). During an interview on 06/22/2026 11:30 AM, with Resident 3, in their wheelchair in the resident's room, Resident 3 stated, Call lights can take a very long time. I have waited for an hour. I think nights are a problem, weekends are a problem, and holidays are a problem. Staffing definitely seems to be an issue. It takes way too long to get pain medications. I can have my light on and just have to wait for the medication to be administered. It can be a very long wait. It isn't every time but it does happen frequently. Night shift is the longest, I know I have waited an hour. My roommate has actually had an accident because it took so long. There have been times in the day, especially on weekends or holidays that it has taken a very long time to get around to the call lights. A review of Resident 85's medical record indicated that Resident 85 was admitted on [DATE] with diagnoses that included Cerebral Infarction (Stroke), Hemiplegia and Hemiparesis following Cerebral (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infarction Affecting Left Non-Dominant Side (Paralysis and weakness that affects one side of the body), and Abdominal Pain. During an interview on 06/22/26 11:46 AM, with Resident 85 in their bed while in the resident's room, Resident 85 stated, The call light takes an hour, pain meds take a long time to get. It seems like there is not enough staff. It takes a long time to get help when I use the call light. During an interview on 6/23/26 at 3:00 PM, with Certified Nursing Assistant (CNA) F in the hall outside room [ROOM NUMBER], CNA F stated the residents in room [ROOM NUMBER] (Resident 3 and Resident 85) use the call light a lot, we do our best to answer it timely even when we are short staffed. During an interview with 6/25/26 at 1:15 PM, with CNA G on the back patio entering the building, CNA G stated we could use another CNA position, it would help with things like call lights. During a review of Resident 93's admission record indicated that Resident 93 was admitted on [DATE] with diagnoses that included aftercare following surgery on the digestive system, atrial fibrillation (a cardiac condition), high blood pressure, diabetes, heart failure and sleep apnea (disrupted breathing during sleep). During an interview on 6/22/26 at 10:56 AM, resident 93 stated that staff take a long time to respond to call lights and that the wait time is often well over 30 minutes. Resident 93 stated they have had to wait for assistance with bed changes and to use the bathroom. Resident 93 stated they have come to accept that this is just the way it is but that the delays are embarrassing and make them feel that they are being a bother. During a review of Resident 74's record indicated that Resident 74 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), retention of urine, heart failure, anxiety disorder, and muscle weakness. During an interview on 6/22/26 at 11:30 AM, Resident 74 stated they regularly wait more than 30 minutes after activating the call light. Resident 74 stated the call light is usually used to request assistance to the restroom and that staff have taken so long to respond that they have experienced episodes of incontinence (lost control of bowels or bladder) before assistance arrived. Resident 74 stated the delays occurred during both the day and the night shifts and made them feel upset, angry, and undignified when waiting for assistance to use the restroom. During a review of Resident 6's admission record indicated that Resident 6 was admitted on [DATE] with diagnoses that chronic obstructive pulmonary disease (COPD), colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body), diabetes, obesity, artificial openings of urinary tract, and muscle weakness. During an interview on 6/22/26 at 12 PM, Resident 6 stated that they often wait a long time for staff to respond after activating the call light, especially during the night. Resident 6 stated they have a urinary drainage bag that requires routine emptying at night. Resident 6 stated that on a couple of occasions during the previous two weeks, they woke up in the morning to find the bag full, which the resident stated only happens if it was not emptied during the night. Resident 6 stated they typically wait more than one hour after activating the call light and that, at times during the night, the call light is not answered at all. Resident 6 stated these delays make them feel forgotten. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 57's admission record indicated that Resident 57 was admitted on [DATE] with diagnoses that included metabolic encephalopathy (brain disfunction caused by a problem in the body rather than an injury), epilepsy (a brain disorder that causes recurring seizures), high blood pressure, diabetes, and muscle weakness. During an interview on 6/22/26 at 3:24 PM, Resident 57 stated there are times when the call light is not answered during the night and that they have often waited more than an hour for assistance. Resident 57 recalled a recent night when they had a bowel movement in the middle of the night, activated the call light, and did not receive assistance until the morning staff arrived and cleaned them up. Resident 57 stated they informed the morning staff that they had waited all night. Resident 57 stated the delays are worse at night, make them feel uncomfortable, and have caused them to think about leaving the facility. Resident 57 further stated they try to avoid using the call light during busy times because they know it will take longer to receive assistance, which sometimes results in waiting longer to be changed. During a confidential interviews on 7/24/26 at 10:10 AM, four of seven confidentially interviewed residents it takes staff 45 minutes or longer to answer their call lights. One of one confidentially interviewed resident stated they don't get their pain medication on time. They put their call light on at 11:00 AM and at 11:30 AM, no one answered the call light so they had to get out of bed and go find someone, only to be told the nurse was at lunch and they had to wait until she got back to get the pain medication. One of one confidentially interviewed resident stated they had an accident (peed the bed) because her call light was not answered in time. During a review of the, Resident Council Minutes (RCM), dated January 2, February 6, March 6, April 3, May 1, and June 5, 2026, the RCM indicated that call lights are being turned off and no one comes back to assist the resident with what they need. Residents are having to wait 20 to 30 minutes for their call light to be answered.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and facility document review, the facility failed to ensure Food and Nutrition Services (FNS) staff had the appropriate competencies and skills sets to carry out the functions of the FNS department when:1.Two staff did not know manual dishwashing procedures;2.One staff did not follow the recipe for pureed food;3.One staff used expired test strips for testing sanitizer strength; and4.Two staff did not follow proper hand hygiene procedures (Cross Reference F812).The failure to ensure FNS staff competency and skills sets resulted in 4 of 10 FNS staff not appropriately carrying out tasks related to their jog duties which had the potential to lead to contamination of food and food service equipment, and decreased quality of food for a census of 90.Findings: 1.Review of the policy and procedure titled, Food and Nutrition Services Staff dated 2001, showed the food and nutrition services staff, under the supervision of the Dietitian and/or the food and nutrition services manager, will safely and effectively carry out the functions of the food and nutrition services department.During an interview on 6/22/26 at 11:50 AM, the Dietary Manager (DM) stated he was the DM for about a year.During an interview on 6/23/26 at 9:01 AM, DM explained he had nine kitchen staff and six of those staff were new, less than a month.During an interview on 6/24/26 at 9:02 AM, when DM was asked for documentation of inservice training for kitchen staff regarding their job duties and performed tasks, DM stated he did not have any documented inservices. DM explained a Dietary Assistant who was experienced, trained the dietary aides on their job duties and he (the DM) trained cooks on their job duties. DM stated he did on-the-job training because he was too busy trying to keep up. DM stated due to staff turnover, he did not have enough time to provide documented training or competency assessments. DM stated he also did not have any records of kitchen staff training from the previous kitchen manager.During an interview on 6/24/26 at 11:15 AM, the Director of Staff Development (DSD) B stated she provided onboarding training for all staff, but DSDs did not provide kitchen specific training. Review of the Personal File Checklist dated 6/1/24 provided by DSD B as the checklist used for newly hired employees included competency check-off list for items applicable to all staff at the facility, and some nursing specific competencies, but did not include competencies for kitchen specific job duties and tasks.During an interview on 6/23/26 at 11:26 AM, Dietary Aide (DA) B stated her position was a dishwasher.During an observation in the kitchen and interview on 6/23/26 at 12:45 PM, DA B stated she had to manually (wash by hand) wash dishes sometime last year because the dish machine (dishwasher) was not working. DA B described and demonstrated how she would use the two-compartment manual sink to wash dishes by hand, if the dish machine was out-of-order. DA B stated the first step was to sanitize the items in the first sink, the second step was to rinse the items well in the second sink, the last step was to place the items on the counter to air dry. DA B stated she would not use soap to wash the dishes on any of the steps.During an observation in the kitchen, interview, and document review on 6/24/26 at 9:02 AM, the DM described manual dish washing procedures using the two-compartment manual dish washing sink. DM stated the first sink was for washing items (dishes, utensils, etc.), the second sink was for sanitizing the items, then they were rinsed with a sprayer adjacent to the two-compartment sink. Then DM stated he needed to look at the posted directions if he needed to manual dishwash. DM confirmed the undated laminated poster titled Dishwashing 2 sink method for pots, pans and cooking utensils showed first to wash, then to rinse, then sanitize. DM stated according to the directions on the poster for the two-compartment sink, the first step was to fill the first sink with to wash items with detergent, then empty the first sink to rinse items, then fill the second sink with sanitizer to sanitize. DM stated the directions were normally posted on the wall above the two-compartment sink, but the directions were removed at some point. 2.Review of the policy and procedure titled, ?Kitchen Weights and Measures dated 2001, showed Food Services staff will be trained in proper use of cooking and serving measurements.Review of the policy and procedure titled, Food and Nutrition (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Services dated 2001, showed each resident is provided with a palatable diet.Review of the menu spreadsheet titled, [Facility Name] Spring 2026 Therapeutic Spreadsheets dated week 3 Tuesday, showed Pork Roast with gravy as the main entree for Regular diets and pureed (liquified) pork roast with gravy for the pureed diets.During an observation and interview on 6/23/26 at 10:25 AM, [NAME] A blended pork in a food processor. [NAME] A stated he was making the pureed pork for the upcoming lunch meal. [NAME] A stated he was making enough portions for four residents who were on pureed diets. After [NAME] A added pork to the food processor, [NAME] A poured in water from a plastic pitcher. [NAME] A confirmed he did not measure the water poured in with the pork and he did not know exactly the amount but stated it was more than one cup. [NAME] A proceeded to blend the pork and water, then added more pork, then poured in a powdered thickening agent without measuring the thickening agent.During an observation and document review of lunch tray line food service on 6/23/26 starting at 12:05 PM, showed four pureed diets were served to residents with a tray ticket dated, Noon Meal - Tuesday, June 23, 2026 and indicated, Pureed/Level 4 Texture as part of the diet order.During an observation and interview on 6/23/26 at 1:59 PM, a test tray for pureed and regular textured food was conducted in the presence of DM as soon as the last lunch tray was passed to a resident in the dining room. When the food was tasted, the regular textured pork was very flavorful. However, the pureed pork did not have much flavor. DM tasted the pureed pork and stated it was bland. During an interview and document review on 6/24/26 starting at 12:35 PM, the recipe titled, Pot Roast/Grvy [Gravy] dated Spring 2026 for the pork pot roast served for lunch on 6/23/26 was reviewed with DM. The recipe showed for puree, to place portions needed from the regular prepared pot roast into a food processor and process to a fine texture. Add thickener and process until smooth. If the product is too thick, add one tablespoon of hot liquid at a time, and re-process. DM stated [NAME] A did not follow the recipe for the pureed pot roast if he added over a cup of water without measuring. DM stated he guessed the pureed pork was bland for lunch on 6/23/26 because the recipe was not followed and too much water was added. 3. During an observation on 6/23/26 at 11:00 AM, DA B demonstrated how to check the sanitizer strength of the chemical sanitizing/low temperature dish machine. DA B removed a test strip from a test strip container and dipped the strip in the dish machine sanitizer solution after the dish machine completed the cycle. DA B compared the test strip to the test strip color chart on the container to assess the strength of the sanitizer. Review of the sanitizer test strip container titled, [Manufacturer Name] Chlorine Test Papers showed an expiration date of 10/1/25. During a concurrent interview and observation on 6/23/26 at 11:00 AM, the test Chlorine Test Paper container was shown to DM. DM stated he did not know there was an expiration date for the test strips and no wonder they were getting unexplainable test strip readings when they tested the sanitizer strength. An observation and interview on 6/24/26 at 8:57 AM, showed [NAME] A demonstrated how to test the sanitizer in the red bucket used for sanitizing food contact surfaces in the kitchen. [NAME] A showed the container of sanitizer from which the sanitizer was from and showed it was a, [Brand Name] Multi-Quat Sanitizer (also known as Quaternary Ammonium, or Quat). Review of the test strip container titled, QAC QR Test Strips which [NAME] A stated were the test strips used to test the Quat sanitizer had an expiration date of 5/2026. In a concurrent interview and observation on 6/24/26 at 8:57 AM, DM confirmed the Quat test strips were expired and again stated he was unaware the test strips expired. 4.An observation on 6/23/26 at 11:37 AM, showed DA B touched dirty items then clean food service and food preparation items without washing her hands in between. During an observation on 06/23/26 at 11:56 AM, [NAME] B did not wash his hands upon entering the kitchen, touched his hair to put on a hair net, touched a food preparation surface and a recipe binder without washing his hands. Review of the Facility's, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy, dated 10/2017, showed employees must wash their hands: Line C indicated, Whenever entering or re-entering the kitchen, before coming in contact with any food surfaces, and after handling soiled equipment or utensils. During an interview on 6/24/26 at 9:46 AM, with the DM, DM stated there was no documentation regarding cross contamination, dishwashing, or hand hygiene.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation and interview, the facility failed to provide alternate entrees of equal nutritive value to the entree served. This failure had the potential to result in decreased nutrient intake leading to food related medical issues for 11 out of 11 residents who requested an egg salad sandwich alternate entree for a lunch meal out of a census of 90. Findings: Review of the policy and procedure titled, Menus dated 2001, showed menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board. Menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal. If a food group is missing from a resident's daily diet, the resident is provided an alternate means of meeting his or her nutritional needs. Review of the menu spreadsheet titled, [Facility Name] Spring 2026 Therapeutic Spreadsheets dated week 3 Tuesday, showed Pork Roast with gravy as the main entree. Other items on the menu included mashed potatoes, Italian blend vegetables, and a roll with margarine.An observation of tray line food service and concurrent interview on 6/23/26 starting at 12:05 PM, showed 11 residents who requested an egg salad sandwich, versus what was served on the menu, received an egg salad sandwich and potato chips. These residents did not receive any of the other menu items on their tray, such as vegetables. The Dietary Manager (DM) explained residents could choose an alternate entree if they wanted. DM explained that residents are given menus once a week for the entire week, and the residents circle or write in on the menu, what they want to eat off the menu for the week and only receive what they mark on the menus. During an observation and interview on 6/23/26 at 1:08 PM, [NAME] A prepared an egg salad sandwich to serve as an alternative during the tray line lunch service. [NAME] A removed egg salad from a pan with a metal spatula and placed the egg salad between two pieces of bread. When asked how much egg salad he placed on the sandwich, [NAME] A stated he prepared enough to give each residents two eggs per sandwich, but he did not measure the amount he placed on the sandwich. During an interview on 6/24/26 at 12:35 PM, DM stated he or the Registered Dietitian (RD) did not look into the nutritional value of alternate entrees provided to residents, to ensure the alternate was of equal nutritive value to what the alternate was substituted for. DM confirmed the egg salad sandwich was the alternate just for the entree. DM stated in the past, he offered food items such as salads, but the residents did not want the salad, so he stopped asking. DM stated the other menu items should be served in addition to the alternate entree and stated, for example, the residents should still receive vegetables or a salad as a substitute for the vegetables. DM stated he did not know the protein content of the egg salad sandwich and he did not know if the egg salad sandwich was of equal nutritive value to what was served. When the egg salad sandwich recipe was requested, DM stated there was not an egg salad sandwich recipe. DM stated he thought staff must be Googling the recipe. [NAME] A stated he looked at YouTube videos to learn how to make the egg salad sandwiches. [NAME] A showed a variety of YouTube videos on his phone but did not specify which video he watched to make egg salad sandwiches. During an interview on 6/25/26 at 8:27 AM, when RD was asked the process for determining the nutritive value of alternates for menu items, RD stated she was not 100 percent sure. RD stated she relayed resident preferences, but she did not compare nutritive values when meal planning. When asked if she observed resident dining, RD stated she observes dining when she visits the facility by sitting at the nurse's station across the hall from the entry to the dining room. RD stated she did not observe alternate meals. When asked about residents being served alternate meals but not receiving all of the food that is not the entree, she stated the residents should be receiving the rest of the meal.

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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** Based on observation, interview, and record review the facility failed to provide basic safety measures for three of 19 residents (Resident 1, 64, and 93) when call lights were not easily accessible as they were not placed within the resident's reach.This failure placed residents at risk for avoidable complications, including incontinent issues and falls, associated with the inability to urgently communicate with staff for needs and safety issues, which could result in physical and emotional decline and reduced quality of life. Findings: During a review of the facility's policy and procedure titled, Answering the Call Light, dated October 2023, the policy indicated, The purpose is to ensure timely responses to the resident's requests and needs.Ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. During a review of a facility document titled, New Employee Orientation Checklist, First 8 Hours, undated, indicated, Employees are oriented and trained to manage resident care through the following subject matter: Orientation Topic.Use of Equipment.Resident's Unit/Call Lights. During a review of a facility document titled, Inservice Lesson Plan and Attendance Record, dated 6/10/26, indicated the Weekly CNA (Certified Nursing Assistant), RNA (Restorative Nursing Assistant) .Meeting topics included, Gentle Reminder.Call light is in reach. A review of Resident 1's medical record indicated that Resident 1 was admitted on [DATE] with diagnoses that included, Acute Respiratory Failure with Hypoxia (Lungs cannot supply enough oxygen to bloodstream), Anxiety Disorder (Excessive, uncontrollable worry), and Heart Failure (Heart cannot pump enough blood). During a concurrent observation and interview on 6/22/26 at 2:05 PM, with Resident 1, who was sitting in their wheelchair by their bedside closest to the door, the call light is observed hanging from the far-side of the bed onto the floor. Resident 1 stated I want to go back to bed, I have been sitting here for 30 minutes, I don't have the call light. Surveyor turned on Resident 1's call light for her. During a concurrent observation and interview on 6/22/26 at 2:20 PM, with Certified Nursing Assistant (CNA) E outside Resident 1's room, CNA E was observed to go in and out of Resident 1's room three different times following the call light being initiated by surveyor, each time CNA E interacted with Resident 1. The first two interactions the call light was left out of the resident's reach, on the third interaction CNA E placed the call light in Resident 1's hand. CNA E stated, I always check that the call light is within the residents' reach when I go into rooms.I just missed it. During an interview on 6/22/26 at 3:30 PM, with Director of Nursing (DON), in the DON office, DON stated, the expectation is that call lights are placed within residents' reach. A review of Resident 64's medical record indicated that Resident 64 was admitted on [DATE] with diagnoses that included, Cancer, Coronary Artery Disease (heart disease), high blood pressure, diabetes (high blood sugar), and Alzheimer's (loss of memory). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/22/26 at 3:05 PM, with Resident 64 in their room, Resident 64 was up in the wheelchair on the left side of the bed facing the wall and the call light was at the bottom of her bed out of reach. Resident 64 stated, I can not reach my call bell. During a review of Resident 93's admission record indicated that Resident 93 was admitted on [DATE] with diagnoses that included aftercare following surgery on the digestive system, atrial fibrillation (a cardiac condition), high blood pressure, diabetes, heart failure and sleep apnea (disrupted breathing during sleep). During a concurrent observation and interview on 6/22/26 at 8:56 AM, with Resident 93, the call light was observed stretched from the wall to the bed rail, extending to approximately knee level on the bed. The call light obstructed the walkway between the bed and the nightstand and would become detached if the bed rail was lowered. Resident 93 stated the call light had been in this condition for three days and frequently became detached from the bed rail. Resident 93 stated that on one occasion, after the call light became detached from the bed rail while he was in bed, he attempted to use dishes from the bedside table to reach the call light but was unsuccessful. Resident 93 stated he had to wait for assistance to use the bathroom and for a bed change, which he described as embarrassing and made him feel like he was being a bother.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and facility document review, the facility failed to ensure professional standards of quality were met when one of the Registered Dietitians (RD) was not onsite to complete timely and comprehensive nutrition assessments. This failure had the potential to result in delayed nutrition care for residents leading to an increased risk for nutritionally related clinical decline.Findings:Nutrition-focused physical findings are a fundamental part of a comprehensive nutrition assessment. Registered dietitian nutritionists are uniquely trained to evaluate physical examination data to correctly evaluate nutrient-specific physical findings and analyze the role of nutritional status in health maintenance as well as recovery from injury or disease. The physical assessment is used to evaluate for malnutrition and other nutritional related factors. Physical examination techniques include gathering data via observation and touch. (Academy of Nutrition and Dietetics. Nutrition Care Manual. Nutrition Focused Physical Findings. https://www.nutritioncaremanual.org. Accessed July 5, 2026.)Review of the policy and procedure titled Nutritional Assessment dated 2001, showed as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The dietitian shall, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition. Review of the job description titled Dietitian dated 2001, showed the dietitian may be full time or part time depending on the current requirements of the facility. These requirements are based on assessments and care plans of resident nutritional needs and the overall facility assessment of the number, acuity and diagnosis of the resident population.Review of the document titled Consultant Agreement and signed by RD and Admin on 10/20/25, showed the consultant shall provide consulting services to the Facility weekly, both in house and remotely. Consultant and Facility may increase Consultants visits as needed per agreement of both Consultant and Facility. Consultant shall provide the following services within the scope of the dietitians professional credentials, in accordance with Federal, State, and County laws, rules, regulations and current professional standards of practice. The Consultant shall actively participate in Facilities overall patient care evaluation programs. Review of the Document titled Requirements of Participation [Facility name and address] with a completion date of 1/12/26, showed the facility must employ sufficient staff with appropriate competencies and sills sets to carry out the functions of the food and nutrition services, taking into consideration resident assessments, individual plans of care, and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. The facility assessment showed the average daily census was approximately 86-92 residents. Average admissions were 1 per weekend and 2-4 average weekday weekly. It was noted the facility assessment did not include the staffing needs for Food and Nutrition services or Registered Dietitians. During an interview on 6/25/26 at 8:27 a.m., the Registered Dietitian (RD) stated she started working for the facility as their Registered Dietitian nine to twelve months ago. RD described her role as providing clinical nutrition services. RD stated she worked remotely about one day a week and worked on site about once every three to four weeks. RD stated she did her resident assessments remotely unless she was at the facility, then she did the assessments when she was on site. When asked if there was a physical component to her assessments, RD stated yes. When asked how she did the physical portion of her assessments remotely, RD stated she did not do the physical portion of the assessment remotely. RD stated she guessed she would do the physical part later when she was on site. RD stated initial assessments are done within a week of a resident's admission.During an interview on 6/25/26 at 10:49 a.m., the Administrator (Admin) confirmed RD worked remotely and was on site about once a month.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, the facility failed to ensure two Residents (26, 30) received assistance with their meal in a timely manner. This failure had the potential to result in decreased quality food and/or decreased intake of food leading to weight loss for 2 of 13 residents who received their lunch during the assisted dining.Findings:A review of Resident 26's admission Report, dated 6/24/26, indicated Resident 26 was admitted on [DATE] with diagnoses including dysphagia (difficulty swallowing), seizures (a sudden, temporary burst of uncontrolled electrical activity in the brain), and dementia (a decline in mental ability affecting daily life).A review of Resident 26's Annual Minimum Data Set (MDS) (yearly comprehensive assessment), dated 9/8/25, indicated under the Swallowing and Nutrition Status Assessment that resident had significant weight loss.Review of Resident 26's Quarterly MDS, dated [DATE], indicated partial/moderate assistance was required with eating.A review of Resident 26's Care Plan Report showed Resident 26 has potential nutritional problems related to underweight/unintended weight loss, dementia, increased depression. Interventions included assist with meals dated 2/5/26.Review of Resident 30's admission Report, showed Resident 30 was admitted on [DATE] with diagnoses including Alzheimer's Disease (a form of dementia, slowly destroying memory, thinking skills, and eventually the ability to perform simple daily tasks), unspecified dementia with mild agitation, lack of coordination, cognitive communication deficit (occurs when brain disruptions make it difficult it understand, express or process information), and adult failure to thrive (a syndrome of progressive physical and mental decline. It is characterized by unexplained weight loss, poor appetite, malnutrition, fatigue, and reduced ability to perform daily tasks).Review of Resident 30's Care Plan Report showed Resident 30 had and had the potential for nutritional problems, including unintended weight loss, food intake fluctuations. Interventions included assist with meals as needed dated 9/3/25.Review of Resident 30's Quarterly MDS, dated [DATE], indicated Partial/moderate assistance with eating was required.During an observation on 6/22/2026 at 12:59 PM, the second dining group for residents who needed assistance with meals started being brought into dining room. Three staff were in the dining room helping residents to their table. There were eight tables in the room and Residents were sat at each table.During an observation on 6/22/26 at 1:03 PM,, thirteen residents were sitting in the dining room ready for lunch. A cart containing lunch meal trays arrived at the dining room. During an observation on 6/22/26 from 1:10 PM to 1:15 PM, staff passed resident food trays from the food cart to residents sitting at tables. When the trays were passed, staff set up the meal in front of the resident. Part of the set up included removing the residents' hot food from an insulated cover, so the plate of hot food was uncovered on the table in front of the resident.An observation on 6/22/26 at 1:16 PM, showed Resident 26 in a wheelchair, slumped over, with her eyes closed (at table 5 according to the posted Assisted Dining seating chart). A couple times Resident 26 vocalized, oh, oh, oh. A staff member in the dining room asked Resident 26 how she was doing. Resident 26, continued to sit at the table with her food in front of her, but was not eating. Resident 26's plate of hot food was untouched and not covered. An observation on 6/22/26 from 1:16 PM to 1:31 PM, showed Resident 30 sat in her wheelchair at the same table as Resident 26. Resident 30 had her eyes closed and her hot food was on the table in front of her, untouched, and not covered. It was noted another resident (there were three residents total at this table) who was seated at this table with Resident 26 and Resident 30 was eating and was able to eat independently.An observation on 6/22/26 at 1:25 PM, showed Certified Nursing Assistant (CNA) K feeding a resident at a table adjacent from the table for Resident 26. CNA K stood up and walked over to Resident 26's table, sat down and assisted Resident 26 with several bites of food. Then CNA K walked back to the adjacent table to continue feeding the resident she was originally feeding. When CNA K left Resident 26, Resident 26 did not eat anymore. Five minutes later CNA K went back to Resident 26 to assist her with her meal again and Resident 26 began eating with assistance.An observation on 6/22/26 at 1:31 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, showed CNA H entered the dining room and sat next to Resident 30 to begin assisting Resident 30 with her lunch. Resident 30 began to eat with assistance.During an interview on 6/24/26 10:20 AM, when CNA J was asked what the process was for assisting residents with feeding in the dining room, CNA J stated there was a list at the nurse's station that showed CNA assignments. She stated the facility usually assigned one CNA per table in the dining room. When CNA J was asked why there were not 8 CNAs in the dining room on 6/22/26 for lunch service, (8 tables in dining room, 1 CNA per table=8 CNAs total), she stated there were call offs. CNA J stated that Administration helped out if asked, but she did not think to ask on Monday. Then CNA J stated she did not want to get up to leave the resident she was assisting, to go ask for help. During an interview on 6/24/26 at 1:02 PM, CNA K stated there was supposed to be one staff per table to assist residents with eating during dependent dining. However, lately there were usually 4 CNAs or less to assist dependent eating residents in the dining room, and that was how it usually was lately. CNA K stated there were call-offs on Monday 6/22/26 which is why there were not enough CNAs to attend to each dining table. CNA K explained for lunch on 6/22/26, she assisted her assigned resident with eating but noticed Resident 26 was not eating and felt bad for her, so she left her assigned resident to give Resident 26 a couple bites of food before going back to her assigned resident. CNA K stated she wants to feed residents at other tables when she sees them sitting there with food in front of them and the food would probably get cold. During an interview on 6/25/26 at 10:08 AM, when CNA H was asked about entering the dining room at 1:31 PM, on 6/22/26 to assist Resident 30 with her lunch meal, CNA H stated he got pulled away for something but could not recall what it was. CNA H stated sometimes he was pulled away to answer call lights or for resident care. CNA H acknowledged he was assigned to the dining room for lunch on 6/22/26 and he was late getting to the dining room to assist Resident 30. CNA H stated there were usually about four staff assisting in the dining room and it was dependent on how many residents had to be assisted with feeding. CNA H stated it was supposed to be one staff assisting one resident. CNA H stated even if two residents needed assistance with eating at one table, it was still one staff per resident. Review of the Nursing Daily Assignment and Sign-in Sheet dated 6/22/26 A.M. shift, showed five CNAs were assigned to the assisted dining for lunch on 6/22/26. (It was noted there were five CNAs in the dining room for assisted dining including another who showed up later). During an interview on 6/25/26 at 10:17 AM, Director of Staff Development (DSD) B stated there should be one staff to one to two residents for resident feeding assistance. DSD B stated at least eight CNAs should be in the dining room on a good day, depending on staffing. DSD B stated licensed staff were also encouraged to help with assisting residents with feeding after completing their medication pass. DSD B stated CNAs were supposed to let administrative staff know when they needed assistance in the dining room. DSD B stated if CNAs needed assistance, they should have gone to the nursing station to ask for help before starting to assist residents or use their personal cell phone to call for assistance. DSD B stated multiple administrative roles are cross-trained as CNAs to help with feeding residents. DSD B stated for lunch on 6/22/26, staff should have asked for help when they knew there were not enough assistants. DSD B also stated hot food should remain covered if CNAs cannot assist with feeding right away. DSD B stated there was not a list of residents who required assistance with feeding. DSD B stated she thought there were eight residents who required assistance with feeding. Review of the facility's policy and procedure titled Assistance with Meals revised March 2022, showed residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Facility staff will serve resident trays and will help residents who require assistance with eating.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to comprehensively assess and implement appropriate interventions to restore bladder continence following indwelling urinary catheter (a tube inserted into the bladder to remove urine), removal for one of 19 sampled residents (Resident 74).This failure placed Resident 74 at risk for missed opportunities to restore or improve bladder continence, avoidable complications associated with prolonged incontinence (loss of bladder control), and reduced quality of life.Findings: A review of Resident 74's admission record indicated that Resident 74 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), retention of urine (unable to fully empty the bladder), heart failure, anxiety disorder, and muscle weakness.During a review of Resident 74's Minimum Data Set (MDS-assessment tool) section C, dated 4/20/26, indicated Resident 74 had mild cognitive (memory and decision making ability) impairment. Section GG, dated 4/20/26, indicated Resident 74 required extensive assistance (one or two staff need to provide help) with Activities of Daily Living (ADLs) including bed mobility, transfers, and toileting.During a review of Resident 74's MDS section H, dated 4/24/26, indicated Resident 74 arrived to the facility with an indwelling urinary catheter.During a review of the facility's policy and procedure (P&P) titled, Behavioral Programs and Toileting Plans for Urinary Incontinence, dated 10/2010, indicated, the purpose of the policy was to provide guidelines for initiating and monitoring behavioral interventions for residents with urinary incontinence. The policy directed staff to conduct a comprehensive assessment to identify factors contributing to a decline in urinary incontinence, including changes in medical condition or medications. The assessment included evaluating the resident's comprehension and ability to recognize the urge to void. The policy further directed staff to monitor and document voiding patterns, including voiding times, type in frequency of incontinence, and the resident's response to interventions. Once the resident is assessed appropriate interventions such as pelvic floor rehabilitation (a strengthening exercise), toileting plans, prompting, and habit training, can be implemented. The policy indicated that bladder training is appropriate for residents with urge (sudden need to void) or mixed incontinence (both continent (able to control bladder) and incontinent episodes), who are cognitively intact.During an interview on 6/24/26 at 9 AM, in the resident's room, Resident 74 stated they sometimes have difficulty reaching the restroom in time and required staff assistance to transfer them on and off the toilet. Resident 74 stated they have had trouble controlling their bladder since removal of their indwelling urinary catheter, which was about three days after they were admitted . Resident 74 stated, at times staff took so long to respond to the call light that they had episodes of incontinence before assistance arrived. Residents 74 further stated nursing staff had not asked about their bladder control and reported that prior to hospitalization, they were continent and used the restroom normally. Resident 74 expressed concern that they may not regain continence and felt their bladder control had continued to worsen over time.During an interview on 6/24/26 at 3:00 PM, Certified Nursing Assistant (CNA) B stated the point-of-care information (electronic CNA documentation), indicated Resident 74 required one person assistance with toileting, had at least one episode of incontinence during the previous shift, and was not on any scheduled toileting program. CNA B stated that because they had not previously cared for Resident 74, they would need to ask the resident what type of toileting assistance was needed and would not otherwise know whether the resident was continent or incontinent.During an interview on 6/24/26 at 3:10 PM, Licensed Vocational Nurse (LVN) C stated that Resident 74 was admitted with an indwelling urinary catheter, which was removed three days after admission. LVN C stated a voiding (urinating) trial was completed following catheter removal, but that Resident 74 had not been evaluated for a specific individualized toileting program. LVN C further stated they were not sure who at the facility initiates bladder training (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	programs. LVN C stated resident 74 would be a good candidate for bladder training because the resident has intact cognition and continues to have episodes of incontinence.During a concurrent record review and interview on 6/24/26 at 3:19 PM, with the facility Director of Nursing (DON), Resident 74's medical record titled, POC Response History Bladder Continence, for April, May, and June of 2026 were reviewed. The DON confirmed documentation showed that in April Resident 74 had 15 episodes of incontinence and 38 episodes of continence, in May 46 episodes of incontinence and 146 episodes of continence, and in June 48 episodes of incontinence and 37 episodes of continence. The DON confirmed that documentation was not reflective of an individualized bladder training program for Resident 74. The DON stated bladder training is initiated by the interdisciplinary team (IDT) (a group of healthcare professionals who work together to manage a resident's needs) and nursing following an individualized assessment that considers the resident's medical history, cognition, medications, and physical abilities. The DON stated Resident 74 had been screened on two occasions with documentation reflecting both continent and incontinent episodes. The DON stated resident 74 was not considered for a bladder training program due to episodes of incontinence and the use of diuretic (a water pill) medication. The DON acknowledged that Resident 74 has had an increase in incontinent episodes and could have benefited from an individualized bladder training program.During an interview on 6/24/26 at 3:25 PM, Registered Nurse (RN) D stated that resident 74 was not considered for bladder training because Resident 74 was physically capable of using the toilet and episodes of incontinence were behavioral or by choice. RN D further stated that Resident 74's history of COPD, as well as the residents age, contributed to the incontinence. RN D then confirmed that urinary incontinence is not a normal part of the aging process.During an interview on 6/25/26 at 8:15 AM, RN A stated that bladder training consists of scheduled toileting, assisting the resident to the toilet, and monitoring voiding patterns. RN A stated that residents are assessed for bladder training upon admission and upon return from hospital stays, but not after the removal of an indwelling urinary catheter. RN A confirmed that Resident 74 was not assessed for bladder training following the removal of the indwelling urinary catheter, or at any point assessed for the type of incontinence they were experiencing. RN A stated that Resident 74 was not considered a good candidate for bladder training due to fluid restriction (physician ordered limited amounts of fluids), non-compliance with fluid restrictions, and having more episodes of incontinence than continence. RN A further stated that Resident 74 would now be considered a good candidate for bladder training because they have had increased episodes of incontinence and required more assistance with mobility to reach the toilet. RN A acknowledged that Resident 74 would have benefited from bladder training when the indwelling urinary catheter was first removed, on 4/21/26, but stated Resident 74, slipped through the cracks.During a review of Resident 74's medical record, dated 4/20/26, the Bowel and Bladder Screener indicated Resident 74 was having episodes of incontinence, was alert and oriented, showed willingness for bladder training, and was at risk for incontinence. During a review of Resident 74's Physician's Order, dated 4/21/26, indicated Resident 74's indwelling urinary catheter was to be removed.Record review did not show any evidence of a bladder assessment for the type or cause of Resident 74's incontinence or an individualized toileting training program.

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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. Based on interview and document review, the facility failed to ensure:1.One of one Dietary Managers received frequently scheduled consultations from a qualified dietitian; and2.One of one Dietary Managers was qualified for his position when DM did not meet a State requirement for a Dietary Manager.Failure to ensure one of one Dietary Managers received frequent consultation from the dietitian and training qualifications were met for the Dietary Manager, had the potential to result in substandard Food and Nutrition Services operations serving a census of 90. Findings:According to the California Code, Health and Safety Code - HSC S 1265.4 current as of January 01, 2025, a licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements to supervise dietetic service operations. The dietetic services supervisor shall receive frequently scheduled consultation from a qualified dietitian. One of five educational requirements to qualify for a dietetic services supervisor 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.Review of the job description titled, Dietitian dated 2001, showed a qualified, competent, and skilled Dietitian will help oversee the food and nutrition services in the facility. A Food and Nutrition Services Manager will oversee the production, storage, and delivery of food. The Dietitian will work closely with the Food and Nutrition Services Manager and clinical staff. If a dietitian is not employed full time (35 or more hours per week) a director of food service management will be designated. This individual will have at least one of five qualifications, on of which being a Certified Dietary Manager, and receive frequently scheduled consultations from a qualified dietitian. Review of the job description titled, Dietary Manager signed by DM on 6/22/2025, showed the position summary included to organize, plan and supervise the dietary department functions in accordance with applicable federal, state and local standards that govern the facility.1.During an observation and interview on 6/22/26 at 11:50 AM, DM was in the kitchen helping Food and Nutrition staff with job duties. DM introduced himself and stated he was the Dietary Manager and was a Certified Dietary Manager. DM stated he was in the position for about one year. During an interview on 6/24/26 at 9:02 AM, DM stated the Registered Dietitian (RD) worked remotely and came on site every few weeks. DM stated the RD rarely entered the kitchen.During an interview on 6/25/26 at 8:27 AM, the RD stated she started working for the facility as their Registered Dietitian from nine months to a year ago. RD described her role as mainly providing clinical nutrition services and did not provide any consultation to kitchen staff. RD stated she did not do anything in the kitchen in regard to looking at kitchen sanitation. RD also described her hours working for the facility as less than full time when she worked remotely about one day per week and was physically in the facility once every three to four weeks.During an interview on 6/25/26 at 10:49 AM, the Administrator (Admin) stated the RD oversees the kitchen manager. Admin stated RD should be doing a kitchen inspection/checklist however she did not receive any reports from RD. Admin stated the RD was supposed to check in with DM and answer his questions as needed. Admin stated she was unaware the RD and DM were not collaborating. 2.Review of the document titled, CDM/CFPP Certified Dietary Manager Certified Food Protection Professional showed that DM was a CDM CFPP and was certified through 8/31/26. During an interview on 6/24/26 at 12:35 PM, DM stated he did not have Title 22 training and he did not know what Title 22 was. During an interview on 6/25/26 at 10:49 AM, Admin stated she was unaware the CDM/Dietary manager position required Title 22 training.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of four Residents (27 and 35) received their prescribed nutritional supplements.This failure placed Residents 27 and 35 at increased risk for malnutrition and weight loss.Findings: A review of Magic Cup definition per the manufacturer of Magic Cup; it can be eaten frozen like an ice cream or thawed like a pudding. Magic cups are a supplement option for adding nutrition, calories, and protein for those experiencing involuntary weight loss. Magic cups contain 290 calories and 9 grams of protein for a 4 ounce serving. (Magic Kitchen, Magic Cup, magickitchen.com, accessed 3/7/26)A review of the facility's, Therapeutic Diet policy, dated 10/2017, indicated, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences.A review of the facility's, Food and Nutrition Services policy, dated 10/2017, indicated, Each resident is provided with nourishing, well-balanced diet that meets his or her daily nutritional and special dietary needs.A review of Resident 27's, admission Report, dated 6/24/26, indicated Resident 27 was admitted on [DATE] with diagnoses including gastritis (inflammation of the gastrointestinal system), dysphagia (difficulty swallowing), and respiratory failure.A review of Resident 27's, Minimum Data Set (MDS, comprehensive assessment), Swallowing and Nutritional Status section, dated 4/15/26, indicated Resident 27 had unanticipated weight loss and was on a mechanically altered (chopped food) therapeutic diet.A review of Resident 27's care plan dated 5/21/26, indicated Resident 27 had weight loss, malnourishment, and the potential risk for pressure ulcers (bed sores). Care plan interventions included providing nutritional supplements as ordered by the physician.A review of Resident 27's, Physician's Order Report undated, indicated Resident 27 was prescribed Magic Cups to be given twice a day for risk of malnutrition starting 1/10/26.A review of Resident 35's, admission Report, dated 6/24/26, indicated Resident 35 was admitted on [DATE] with diagnoses including heart failure, low blood pressure, and muscle weakness.A review of Resident 35's care plan indicated Resident 35 had a history of weight loss. Care plan indicated on 5/13/26 Resident 35's weight was 132 pounds, a 13-pound weight loss from 4/30/26. Interventions on care plan included increasing Magic cup to three times a day.A review of Resident 35's, Physician's Order Report indicated Resident 35 was prescribed Magic cups with meals for malnutrition starting on 5/14/26.A review of Resident 35's, Quarterly Nutrition Assessment dated 6/17/26, indicated Resident 35 weighed 133 pounds and their ideal body weight was 178 pounds. Assessment indicated Magic Cup to be given three times a day.During a dining observation on 06/22/26 at 12:35 PM, Resident 27 and Resident 35's lunch meal ticket instructions indicated to give a Magic Cup with the meal.During a tray line observation on 6/23/26 starting at 12:00 PM, Resident 27 and 35's meal trays had no Magic Cup. During an interview on 6/23/26 at 12:45 PM, with the Dietary Manager (DM), DM stated, We are out of Magic Cups and indicated he had not known they were out. During a concurrent observation, interview, and meal ticket review on 6/23/26 at 12:50 PM, with Dietary Aide (DA) A, Resident 27 and 35's lunch meal ticket Tray Instructions, read Magic Cup with meals. A Magic Cup was not placed on either Resident's meal tray. DA A stated they were out of Magic Cups. DA A stated we substituted the Magic Cup with ice cream. During an interview on 6/24/26 at 12:30 PM, with DA A, DA A stated there were still no Magic Cups available. During an interview on 6/24/26 at 12:37 PM, with the DM, when DM was asked about the reason the facility did not have Magic Cups, DM stated they ran out yesterday. When DM was informed Magic Cups were not provided on 6/22/26, DM stated Magic Cups must have run out over the weekend. DM stated they ran out because nursing asked the DAs to give them extra Magic Cups, that were not physician ordered, and that should not have happened. DM stated the nutritional values and protein content of ice cream was not equal to a Magic Cup. During an interview on 6/25/26 at 8:25 AM, with the Registered Dietitian (RD), RD stated they make a (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendation to resident's physicians for Magic Cups to be ordered as a nutritional intervention for residents who had orders for thickened liquids, or who had weight loss, unhealed wounds, and low protein status. RD stated Magic Cups were supposed to be given to residents who had physician's order for them and should not have been given to nursing staff to give to residents who did not have a physician's order. RD confirmed ice cream was provided in place of Magic Cups and confirmed ice cream was not of the same nutritive value as the Magic Cups.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interview, the facility failed to maintain equipment located in the kitchen when there was not a system to track maintenance requests, and:1.One of seven food storage coolers was leaking;2.There was a leak from plumbing in relation to the ice machine;The failure to have a system for tracking maintenance requests and maintain leaks from two of over 13 pieces of equipment had the potential to result in delayed maintenance of equipment; attract and provide harborage for pests leading to contamination of food and equipment; and pose an electrical safety risk for a census of 90. Findings:During an interview on 6/23/26 at 9:01 AM, the Dietary Manager (DM) stated he was responsible for reporting maintenance issues for the kitchen. DM stated maintenance issues were mostly reported to maintenance verbally because maintenance was very quick to fix things, and there was not even time to put in a work order before something was fixed. It was noted there was not a way to track most maintenance requests from DM due to requests were mostly verbal. 1.An observation on 6/22/2026 at 11:56 AM, showed refrigerator number six, a tall roll-in food cart refrigerator, had water pooling under the refrigerator, and black, wet residue build-up on the floor at the edges of the refrigerator. There was also a puddle of water inside the refrigerator. During an observation and interview on 6/23/2026 at 9:35 AM, a cart holding food was inside refrigerator number 6. The Dietary Manager (DM) stated the refrigerator was used to hold desserts. The cart holding desserts was removed so the inside could be observed. There was orange residue on the bottom inside surface. DM stated the refrigerator leaked sometimes. DM stated he tried to monitor the refrigerator, but he did not put in a work order or notify maintenance about the leak. DM looked at the refrigerator and verified there was water pooled underneath and stated he thought it was worse and now it was rusty inside. During an observation and interview on 6/23/26 at 9:35 AM, Maintenance Technician (MT), confirmed there was water under refrigerator number six and stated he was unaware of the issue. 2. During an observation on 6/23/26 at 8:59 AM, water leaked onto the tile floor, from what appeared to a pipe plumbed into the wall behind the ice machine. The water leak created pooled water on the floor, and the leak was close to an electrical outlet. DM stated he was aware of the leak, but it looked worse now. DM stated he did not put in a work order but reported the water leak to maintenance verbally, so there was no way to verify the maintenance request. During an observation and interview on 6/24/26 at 9:32 AM, with MT and DM, the plumbing behind the ice machine continued to leak onto the tile floor, creating a pool of water. MT stated the leak seemed to be from the actuator (a device attached to a valve to automate opening and closing, allowing water flow to be controlled automatically). MT, who was the only maintenance staff on site on 6/24/26, stated he was not aware of the leak. DM stated an outside company was contacted yesterday (6/23/26) but the company said they were not responsible for fixing the leak, and now he needed to work with the facility maintenance to get it fixed. DM confirmed the maintenance staff he reported the issue to was not at the facility today (6/24/2026). During an interview on 6/24/26 at 12:35 PM, DM stated he was aware of the leak behind the ice machine since, last week on Friday.