STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056304	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Carmichael Healthcare Center	3630 Mission Avenue Carmichael, CA 95608

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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 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. 38528 Based on observation, interview, and record review, the facility failed to ensure the right for privacy and dignity was promoted to maintain the resident's self-worth for one of 43 sampled residents (Resident 33), when the privacy curtains were not pulled, or the door not closed during resident care. This failure resulted in not attaining or maintaining the resident's highest practicable physical, mental, emotional, and psychosocial well-being. Findings: Resident 33 was admitted to the facility in early 2023 with diagnoses which included memory impairment and muscle weakness. During a review of Resident 33's Nursing Care Plan (NCP), dated 11/24/23, the NCP indicated, [Resident 33] is dependent on staff for meeting emotional, intellectual, physical, and social needs. During a review of Resident 33's Minimum Data Set (MDS, an assessment tool), dated 2/21/24, the MDS indicated Resident 33 had severe memory impairment and had been totally dependent on staff for all activities of daily living (ADLs). During an observation on 3/21/24 at 10:18 a.m. in Resident 33's room, two staff members provided care to Resident 33 with the door opened and the privacy curtains not pulled and the procedure visible to the outside hallway. Resident 33's lower body was exposed and had no sheet to cover the resident. During a concurrent observation and interview on 3/21/24 at 10:20 a.m. with the Medical Record Assistant (MRA), the MRA passed by the hallway and noticed the two staff providing care to Resident 33, verified the observed situation, entered the room, and stated, Do you guys pull the curtains while you're doing something with the patient? The MRA then stated, I think they are from hospice. There is no privacy for the resident. During an interview on 3/21/24 at 10:35 a.m. with the Director of Nursing (DON), the DON stated, When providing care to the residents, dignity and privacy should always be maintained. To make sure dignity and provide privacy for the patient, the door should be closed, or the curtains be pulled. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 10:40 a.m. with Licensed Nurse 12 (LN 12), LN 12 confirmed he provided care to Resident 33 with another staff, and stated, I was just assessing the patient and the other staff was helping me. I know the curtain was not pulled and the door was not closed .I just probably forgot to pull the curtain or something like that, but I know we've got to maintain the privacy and the dignity of the resident. During a review of the facility's policy and procedure (P&P) titled, Patient Privacy, revised 12/22, the P&P indicated, During skilled therapy treatment and transport, all patients will be clothed or be draped through appropriate draping techniques. During a review of the facility's P&P titled, Provision of Quality Care, revised 12/22, the P&P indicated, Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being.

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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** 38528 Based on observation, interview and record review, the facility failed to accommodate the needs for two of 43 sampled residents (Resident 588, Resident 28) when: 1. Resident 588's call light button was not within reach; and 2. Resident 28 was not assessed and provided with the appropriate call light type to call staff when needed. These failures resulted in the residents' not attaining their needs and not maintaining their highest practicable physical, mental, emotional, and psychosocial well-being. Findings: During a review of an Admission Record, Resident 588 was admitted to the facility on [DATE] with diagnoses of Malignant Neoplasm of lung (lung cancer) and Secondary malignant neoplasm of brain (brain cancer). During a review of Resident 588's Nursing Care Plan (NCP) titled, Falls/ADLs/Mobility, dated revision of 3/18/24, the care plan indicated Place the resident's call light within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During a review of Resident 588's Minimum Data Set (MDS, an assessment tool), dated 3/7/24, the MDS indicated Resident 588 had moderate cognitive abilities and required partial/moderate assistance with activities of daily living (ADLs). During a concurrent observation and interview on 3/18/24, at 11:53 a.m. in room [ROOM NUMBER]A, resident 588 was in bed, with eyes closed, and yelling for help. Resident 588 stated, .I need help with breathing, and I am in pain .I don't know where my call light is. The call light was observed on the floor and not reachable. During a concurrent observation and interview on 3/18/24, at 11:55 a.m., Certified Nursing Assistant 4 (CNA 4) verified the call light was on the floor and stated, It shouldn't be on the floor. During a concurrent observation and interview on 3/19/24, at 9:30 a.m., Resident 588 was in bed, with eyes closed. Observed the call light was on the floor and not reachable to resident. Minimum Data Set Coordinator (MDSC) verified the call light was on the floor and stated that the call light is on the floor. During an interview on 3/21/24 at 10:30 a.m., with the Director of Nursing (DON), the DON stated staff should make sure and place the call light within reach for the resident. (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 review of the facility's policy and procedure (P&P), titled Call Lights: Accessibility and Timely Response, revised 12/19/22, the P&P indicated Staff will ensure the call light is within reach of resident and secured, as needed. During a review of an Admission Record, Resident 28 was admitted to the facility on [DATE] with diagnoses of traumatic subdural hemorrhage (brain bleed), right and left hand contracture (contracture, a condition of shortening and hardening of muscles, tendons, and other tissue leading to deformity and rigidity of joints) and major depressive disorder (feelings of sadness and/or loss of interest in daily activities). During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 had moderate cognitive abilities and required dependent with ADLs. During an observation and concurrent interview on 3/18/24 at 9:39 a.m., in room [ROOM NUMBER]A, Resident 28 was in bed, awake and alert, verbally responsive. Resident 28's bed was in low position and call light button within reach. Resident 28 appeared upset and loudly stated, I had a bowel movement. I need somebody to clean me up. I cannot see my call light. I have no phone to call somebody. I have been here for a while During an observation and concurrent interview on 3/18/24 at 9:40 a.m., At 9:44 a.m. MDSC entered the room, and stated, He (Resident 28) just came back from the hospital, and he was able to do a lot for himself, basically, but now since he came back from the hospital there is like a decline. He is not able to use the call light. During an interview on 3/18/24 at 9:45 a.m., CNA 5 stated .He (Resident 28) is totally dependent though, so I have to do a lot of the work for him He is not able to turn on the call light. He doesn't know how. His hands are contracted. During a review of the facility's policy and procedure (P&P), titled Call Lights: Accessibility and Timely Response, revised 12/19/22, the P&P indicated .3. Each resident shall, as much as possible, be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system. 4. Special accommodations will be identified on the resident's person-centered plan of care and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.) .

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on observation, interview and record review, the facility failed to ensure a comprehensive assessment was performed in accordance with the regulatory time frame for one of 43 sampled residents (Resident 681), when the admission MDS (Minimum Data Set, an assessment tool) was not completed. This failure had the potential to result in the resident not attaining the highest practicable physical, mental and psychosocial well-being. Findings: Resident 681 was admitted in late 2018 with diagnoses which included stroke, muscle weakness, malnutrition, and difficulty swallowing. During a review of Resident 681's MDS, dated [DATE], the MDS indicated the assessment was incomplete, still in progress, and overdue. During a concurrent observation and interview on 3/18/24 at 10:23 a.m., Resident 681 was in bed, alert and verbal but minimally responsive, and stated, I am just new here. Let me go back to sleep. During a concurrent observation and interview on 3/19/24 at 7:15 a.m., Resident 681 was in bed, awake and verbally responsive, and stated, I'm glad I survived yesterday. During an interview on 3/21/24 at 7:14 a.m. with Licensed Nurse 11 (LN 11), LN 11 verified and confirmed Resident 681's MDS was not completed, and stated, The MDS was due on 3/5/24. During an interview on 3/21/24 at 7:17 a.m. with the MDS Coordinator (MDSC), the MDSC verified Resident 681's admission MDS was late, and stated, The MDS should have been completed by 3/14/24. During an interview on 3/21/24 at 7:39 a.m. with the MDS Director (MDSD), the MDSD stated, So when I set up the ARD (assessment reference date), the last day of assessment, all the pertinent departments would have to have their assessments in by that ARD and should be completed by 14 days .I believe [Resident 681's] MDS was due on the 14th [March, 2024] and is not completed. This is an IDT (interdisciplinary team) assessment (used to create an individual care plan, that is managed on a daily basis), and I was waiting for social services .I agree that it was not completed. During a review of the undated Resident Assessment Instrument (RAI, the MDS process), the RAI indicated, The RAI process is a means of ensuring that residents receive the highest quality of care and can maintain the highest quality of life. The process helps nursing professional and staff assess a resident's strengths and needs to create an individualized care plan. This allows for a holistic approach to care for each resident. This assessment is completed initially and periodically and is comprehensive, accurate, and standardized. It is a reproducible assessment of each resident's functional capacity.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on interview and record review the facility failed to develop and implement a baseline care plan (BCP, document that outlines initial care needs) for two of 43 sampled residents (Resident 681 and Resident 6) when the BCP was not completed within 48 hours after the resident's admission. This failure had the potential to place the residents at risk for unmet care needs. Findings: 1. Resident 681 was admitted in late 2018 with diagnoses which included stroke, muscle weakness, malnutrition, and difficulty swallowing. During a review of Resident 681's Nursing Care Plan (NCP), dated 3/4/24, the NCP indicated, Malnourished . complete mini nutritional evaluation. Evaluate for signs of impaired swallowing. During a review of Resident 681's Minimum Data Set (MDS, an assessment tool), dated 3/5/24, the MDS indicated the assessment was incomplete, still in progress, and overdue. During a review of Resident 681's Baseline Care Plan (BCP), dated 3/15/24, the BCP indicated the Dietary/Nutritional Status section had no assessment and the Social Services section was not completed. During a concurrent observation and interview on 3/18/24 at 10:23 a.m., Resident 681 was in bed, alert and verbal but minimally responsive, and stated, I am just new here. Let me go back to sleep. During a concurrent observation and interview on 3/19/24 at 7:15 a.m., Resident 681 was in bed, awake and verbally responsive, and stated, I'm glad I survived yesterday. During an interview on 3/19/24 at 12:23 p.m. with the MDS Coordinator (MDSC), the MDSC stated, Yesterday, we had a little, you know like meeting, not a care plan meeting, just a requested meeting by a family member .she just wanted to do an intense rehab for the resident. During an interview on 3/21/24 at 7:14 a.m. with Licensed Nurse 11 (LN 11), LN 11 stated, [Resident 681's] [family member] is involved and I think they did a care conference the other day .He fell on e time. During an interview on 3/21/24 at 7:17 a.m. with the MDSC, the MDSC verified the BCP was not completed, and stated, Dietary Services did not have an assessment and Social Services did not complete their assessment. 2. Resident 6 was admitted in late 2018 with diagnoses which included hip joint surgery aftercare, left artificial knee joint and infection, anxiety, depression and need for continuous supervision. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had mild memory impairment and needed partial assistance with activities of daily living (ADLs). During a review of Resident 6's NCP dated 3/17/24, the NCP indicated, [Resident 6] has unwitnessed fall with no injury. During a review of Resident 6's BCP dated 3/4/24, the BCP indicated the Social Services section was not completed and the limb prosthesis was not checked. During a concurrent observation and interview on 3/18/24 at 10:03 a.m. in Resident 6's room, Resident 6 was lying in bed, awake, alert and verbally responsive, with fall mat at the side of the bed, and stated, I fell yesterday from my chair .The food is lousy. I have never had food that's just horrible in my life. I mean the food is always cold and they need to improve on. During a concurrent observation and interview on 3/19/24 at 10:30 a.m. in the facility hallway, Resident 6 sat in a wheelchair pushed by staff holding a device, and Resident 6 stated, That is my prosthesis. During an interview on 3/21/24 at 8:25 a.m. with the MDSD, the MDSD verified the BCP of Resident 6 was not completed, and stated, The social services section was not done and the BCP was not signed. During an interview on 3/21/24 at 10:20 a.m. with the Director of Nursing (DON), the DON stated, On the baseline care plan, we try and make sure it's completed within 48 to 72 hours .all IDT members have to put in their information as soon as they can, so the BCP has to be completed on time. During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, revised 12/19/22, the P&P indicated, The baseline care plan will be developed within 48 hours of a resident's admission .include the minimum healthcare information necessary to properly care for a resident .

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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. 47197 Based on observation, interview, and record review, the facility failed to ensure three out of 43 sampled residents (Resident 91, Resident 4, and Resident 46) were assisted with nail care as part of their Activities of Daily Living (ADLs- normal daily functions required to meet basic needs) when; 1. Resident 91 had long fingernails with blackish substance underneath the fingernails; 2. Resident 4 had long fingernails with brownish substance underneath the fingernails; and, 3. Resident 46 had jagged fingernails with sharp edges with blackish substance underneath the fingernails. These failures had the potential for Resident 91, Resident 4, and Resident 46 to sustain injury and/or for the residents to acquire an infection. Findings: 1. A review of Resident 91's clinical record indicated Resident 91 was admitted August of 2021 and had diagnoses that included atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls causing obstruction of blood flow), diabetes mellitus (a chronic condition causing too much sugar in the blood which inhibits the body's natural wound-healing capabilities), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 91's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 2/1/24, indicated Resident 91 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 3 out of 15 which indicated Resident 91 had a severe impairment on cognition. A review of Resident 91's MDS Functional Abilities and Goals, dated 2/1/24, indicated Resident 91 required setup or clean-up assistance with eating and substantial/maximal assistance with personal hygiene. During a concurrent observation and interview on 3/18/24 at 9:43 a.m. with Resident 91, in Resident 91's room, Resident 91 had fingernails that were long and with blackish substance underneath the fingernails. Resident 4 stated he wanted his fingernails to be trimmed and cleaned. During a concurrent observation and interview on 3/18/24 at 9:48 a.m. with Certified Nurse Assistant (CNA) 1, in Resident 91's room, CNA 1 confirmed that Resident 91 had long fingernails and with blackish substance underneath the fingernails. CNA 1 stated he would expect that resident's fingernails to be checked, trimmed, and cleaned as needed during their scheduled baths. CNA 1 further stated the blackish substance underneath the fingernails could cause infection to Resident 91. During a concurrent interview and record review on 3/20/24 at 9:55 a.m. with Licensed Nurse (LN) 9, Resident 91's clinical records were reviewed. LN 9 confirmed that Resident 91 had no care plan of refusing ADL care and had no documented refusals of ADL care- including nail care, in the progress notes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 4's clinical record indicated Resident 4 was admitted October of 2023 and had diagnoses that included chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body) and need for assistance with personal care. A review of Resident 4's MDS Cognitive Patterns, dated 1/30/24, indicated Resident 4 had a BIMS score of 13 out of 15 which indicated Resident 4 had an intact cognition. A review of Resident 4's MDS Functional Abilities and Goals, dated 1/30/24, indicated Resident 4 required setup or clean-up assistance with eating and partial/moderate assistance with personal hygiene. During a concurrent observation and interview on 3/18/24 at 11:03 a.m. with Resident 4, in Resident 4's room, Resident 4 had fingernails that were long and with brownish substance underneath the fingernails. Resident 4 stated he would want his fingernails to be trimmed and the brownish substance underneath the fingernails to be removed. During a concurrent observation and interview on 3/18/24 at 11:11 a.m. with CNA 1, in Resident 4's room, CNA 1 confirmed that Resident 4 had fingernails that were long and with brownish substance underneath the fingernails. During a concurrent interview and record review on 3/20/24 at 9:55 a.m. with LN 9, Resident 4's clinical records were reviewed. LN 9 confirmed that Resident 4 had no care plan of refusing ADL care and had no documented refusals of ADL care- including nail care, in the progress notes. A review of Resident 4's SKIN INTEGRITY/ SHOWER SHEET, dated 3/15/24, indicated Resident 4's nails were not clipped on 3/15/24. LN on duty signed the sheet on 3/15/24. 3. A review of Resident 46's clinical record indicated Resident 46 was admitted February of 2020 and had diagnoses that included cerebral infarction (pathological condition resulting from a damage to a part in the brain due to a disrupted blood flow), and dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities). A review of Resident 46's MDS Cognitive Patterns, dated 2/19/24, indicated Resident 46 was rarely/never understood. A review of Resident 46's MDS Functional Abilities and Goals, dated 2/19/24, indicated Resident 46 was dependent with eating and personal hygiene. During a concurrent observation and interview on 3/18/24 at 11:34 a.m. with LN 1, in Resident 46's room, Resident 46 had jagged fingernails with sharp edges and with blackish substance underneath the fingernails. LN 1 confirmed the observation. LN 1 stated that Resident 46 could get skin injury because of the sharp edges on her fingernails. LN 1 further stated that resident's fingernails should be clean because it would be an infection control issue. During a concurrent interview and record review on 3/20/24 at 9:55 a.m. with LN 9, Resident 46's clinical records were reviewed. LN 9 confirmed that Resident 46 had no care plan of refusing ADL care and had no documented refusals of ADL care- including nail care, in the progress notes. A review of Resident 46's SKIN INTEGRITY/ SHOWER SHEET, dated 3/16/24, indicated Resident 46's nails were not clipped on 3/16/24. LN on duty signed the sheet on 3/16/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/24 at 12:30 p.m. with the Infection Preventionist (IP), the IP stated, .Nail care [for residents] are done depending on their [residents] medical diagnosis .If they [residents] don't have DM [diabetes mellitus], CNA's can do it [nail trimming] .If the resident is diabetic, they [staff] would refer them to the nurse . The IP further stated she would expect that all resident's (both diabetic and non-diabetic residents) fingernails should be cleaned because it could be a source of infection. During an interview on 3/20/24 at 3:15 p.m. with the Director of Nursing (DON), the DON stated, I expect that residents nails should be at least clean .We have residents who are demented . It's [clean fingernails] for infection control and hygiene . A review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), revised 12/19/22, indicated, .3. Residents who are unable to carry out activities of daily living will receive the necessary services to maintain good .grooming and personal .hygiene .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47197 Based on interview, and record review, the facility failed to provide appropriate treatment and services to maintain or improve mobility and prevent decline in range of motion (ROM) for two out of 43 sampled residents (Resident 107 and Resident 44) when Resident 107 and Resident 44's restorative nursing program (RNA program- interventions that actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning) frequency was not followed. This failure had the potential for Resident 107 and Resident 44 to experience decline in range of motion or impairment in mobility. Findings: 1a. A review of Resident 107's clinical record indicated Resident 107 was admitted October of 2023 and had diagnoses that included wedge compression fracture of vertebra (collapse of a bone in the front of the spine which can lead to loss of strength, sensation, and/or reflexes), multiple fractures on bilateral (both sides) ribs, and muscle weakness. A review of Resident 107's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 1/13/24, indicated Resident 107 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 107 had an intact cognition. During an interview on 3/18/24 at 10:04 a.m. with Resident 107, Resident 107 stated he has not had his therapy exercises for a week now and he would like to have more exercises. A review of Resident 107's care plan intervention, revised 1/23/24, indicated, .Restorative Nursing Program . Site: Active Range of Motion [AROM]- Lower Extremity. AROME [sic] of BLE [bilateral lower extremities- both legs] hip flexion [bending]/abduction [movement away from the body]/adduction [movement towards the body], knee extension [extending]/flexion, ankle pumps x [for] 10 reps [repetitions] x 2 sets in sitting position. Frequency: .3x/week [3 times per week] as tolerated. A review of Resident 107's care plan intervention, revised 1/23/24, indicated, .Restorative Nursing Program . Transfers. Sit to stand x 5 reps [repetitions] with Minimal assistance using gait belt, WBAT [weight bearing as tolerated] on Left LE [lower extremity- leg]. Transfer patient from bed to Wheelchair with Min [minimal] assist so patient can sit on his Wheelchair for at least 1-2 hours as tolerated. Frequency: 3x/week as tolerated. During a concurrent interview and record review on 2/18/24 at 11:16 a.m. with the Director of Rehabilitation (DOR), Resident 107's clinical records were reviewed. The DOR confirmed that in the past 30 days, Resident 107 only had exercises for both AROM of BLE and Transfer exercises on 2/22, 2/26, 2/29, 3/10, 3/11, 3/17, and 3/18. The DOR confirmed that Resident 107 did not get his exercises in accordance with the ordered RNA program frequencies which were three times a week. The DOR stated, .the [RNA program] frequency should be followed . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/19/24 at 9:55 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 107's clinical records were reviewed. The MDSC confirmed that Resident 107 was not provided with three times a week RNA exercises. The MDSC stated, .That [not following the RNA program frequency] can possibly result to muscle weakness and decline in range of motion .or mobility, if [the RNA program frequency was] not followed. 1b. A review of Resident 44's clinical record indicated Resident 44 was originally admitted May of 2021 and had diagnoses that included paraplegia (loss of the ability to move of the legs and lower body), malignant neoplasm of frontal lobe (cancerous brain tumor that may cause changes in personality, weakness in one side of the body and loss of smell), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 44's MDS Cognitive Patterns, dated 2/7/24, indicated Resident 44 had a BIMS score of 15 out of 15 which indicated Resident 44 had an intact cognition. A review of Resident 44's MDS Functional Abilities and Goals, dated 2/7/24, indicated Resident 44 had impairment on both sides of lower extremity (hip, knee, ankle, foot) and would normally use wheelchair. During an interview on 3/18/24 at 10:24 a.m. with Resident 44, Resident 44 stated she has not had her standing-up therapy exercises for about three weeks now and she would like to have more standing-up exercises. A review of Resident 44's care plan intervention, revised 2/11/24, indicated, .Restorative Nursing Program - Transfer: Sit to stand using parallel bars or transfer pole with Max [maximum] assist 2 person (front and back avoiding left foot to excessively rotate in and assist pt [patient] to bring hips forward 3x/wk . During a concurrent interview and record review on 2/18/24 at 11:16 a.m. with the DOR, Resident 44's clinical records were reviewed. The DOR confirmed that in the past 30 days, Resident 44 only had Transfer exercises on 2/19, 2/20, 2/27, 3/4, and 3/11. The DOR confirmed that Resident 44 did not get her transfer exercise in accordance with the ordered RNA program frequency which was three times a week. The DOR stated, .It [RNA program frequency] should be followed . The risk [if the RNA program frequency is not followed] is the patient [resident] might have a decline in functioning and might impair her mobility . During a concurrent interview and record review on 3/18/24 at 11:46 a.m. with Restorative Nursing Aide (RNA) 1, Resident 44's clinical records were reviewed. RNA 1 stated there were no documentations that Resident 44 was refusing her RNA exercises. RNA 1 further stated, .Most of the time, there's only 1 RNA [available], we need 2 [RNAs] for the sit-to-stand [exercises] . During an interview on 3/20/24 at 3:15 p.m. with the Director of Nursing (DON), the DON stated, .It's [RNA exercises] not done if it's not documented .if the patient is not able to tolerate it [RNA exercises], [it]should be documented in [the resident's] progress notes . [RNA program frequency should be followed] To make sure the patient doesn't decline in function . A review of the facility's policy and procedures titled, Restorative Nursing Program, revised 12/19/22, indicated, 10. A resident's Restorative Nursing plan will include: .c. Frequency of activities .12. Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting on the electronic health record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49849 Based on observation, interview, and record review, the facility failed to ensure the environment was free from accident hazards, for one of 43 sampled residents (Resident 57), when there was an uneven pathway leading to, from and inside the designated smoking area. This failure resulted in Resident 57 feeling unsafe navigating the pathway to the smoking area and had the potential to result in accidents and injuries. Findings: Resident 57 was admitted to the facility in late 2019 with diagnoses of Spinal Stenosis (narrowing of the spinal canal), abnormalities of gait and mobility and Major Depressive Disorder (feelings of sadness and/or loss of interest in daily activities). Review of the clinical record for Resident 57 included: A Minimum Data Set (MDS- an assessment tool), dated 12/25/23, indicated Resident 57 had no memory impairment. A smoking safety assessment, dated 1/3/24, indicated safety concerns for Resident 57 included her impaired gait and balance. During an interview with Resident 57, on 3/18/24 at 12:01 p.m., she stated, I feel unsafe with the cracks in the sidewalks and smoking area .I am in this wheelchair and it's dangerous. Resident 57 stated she had reported her concerns to the Activities Director (AD) a few months ago. During an interview on 3/19/24 at 9 a.m., the AD, stated she was aware of the cracks in the sidewalks, but not aware of any plans to repair them. The AD confirmed the cracks could cause accidents and injuries to residents who go out to the smoking area. During a concurrent observation and interview on 3/19/24 at 9:10 a.m., the Maintenance Supervisor (MS) stated he was not aware of any cracks in the sidewalks of the smoking area and had not received any requests for repairs. The MS reviewed photos of the smoking area sidewalks and confirmed they needed repair. During a concurrent observation and interview on 3/20/24 at 2:57 p.m. with the MS, he confirmed he observed multiple areas of uneven sidewalks and cracked concrete in the smoking area and that it was a safety concern for the residents that smoke. During an interview on 3/20/24 at 3:05 p.m., with the Director of Nursing (DON), she stated that it was her expectation that the smoking area was maintained in a safe manner and agreed multiple areas of uneven sidewalks and cracked concrete could be unsafe for the residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Smoking Agreement, undated, stipulated, The safety of ALL residents is paramount and supersedes any right to smoke. Whenever a safety concern is evident, the facility staff shall take IMMEDIATE necessary steps to mitigate the risk. A review of the facility's policy, Resident Smoking, revised on 12/19/22, indicated, The facility would provide a safe environment for residents. A review of the facility's policy, Accidents and Supervision, revised on 12/19/22, indicated, The resident's environment would remain free of accident hazards as is possible.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47197 Based on observation, interview, and record review, the facility failed to ensure proper delivery of respiratory care was consistent with the facility's policy and procedures (P&P) and the professional standards of practice for one out of 43 sampled residents (Resident 18) when Resident 18's physician's order for oxygen therapy was not followed. This failure had the potential to result in unsafe delivery of oxygen to Resident 18 that could lead to respiratory problems. Findings: A review of Resident 18's clinical record indicated Resident 18 was originally admitted March of 2016 and had diagnoses that included chronic obstructive pulmonary disease (COPD- a group of diseases that causes airflow blockage and breathing-related problems), respiratory failure (a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), and dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities). A review of Resident 18's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 2/29/24, indicated Resident 18 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 10 out of 15 which indicated Resident 18 had a moderately impaired cognition. A review of Resident 18's MDS Special Treatments, Procedures, and Programs, dated 2/29/24, indicated Resident 18 had oxygen therapy while he is a resident in the facility. During an observation on 3/18/24 at 8:57 a.m. in Resident 18's room, Resident 18 was observed lying on bed and was using oxygen delivered using a nasal cannula (NC- a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils) with an an oxygen concentrator set at 5 liters per minute (LPM- unit of measurement for oxygen administration flow rate). During a concurrent observation and interview on 3/18/24 at 12:25 p.m. with the Assistant Director of Nursing (ADON) in Resident 18's room, Resident 18 was observed lying on the bed and was using oxygen delivered using a nasal cannula with oxygen concentrator still set at 5 LPM. The ADON confirmed the observation. A review of Resident 18's active physician's order, dated 8/1/23, indicated, Oxygen at 2L/min [LPM] via nasal cannula continuously. may titrate [continuously measure and adjust] O2 [oxygen] to maintain SPO2 [Oxygen saturation- measurement of how much oxygen the blood is carrying as a percentage] greater or equal to 90 % [percent- measurement of one part in every hundred]. every shift related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED .when in bed. A review of Resident 18's care plan intervention, initiated 6/4/20, indicated, .OXYGEN SETTINGS: Oxygen at 2L/min via nasal cannula continuous per MD order . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/20/24 at 10:10 a.m. with Licensed Nurse (LN) 9, Resident 18's clinical records were reviewed. LN 9 stated, .We [staff] document in the progress note [of the resident] if we titrate the oxygen . LN 9 confirmed that Resident 18 had no documented notes that his oxygen was titrated to maintain oxygen saturation greater or equal to 90% on 3/18/24. LN 9 also stated she would expect that Resident 18 should be getting 2 lpm on 3/18/24 because there was no progress note indicating it was titrated. LN 9 further stated that physician's orders for oxygen therapy should always be followed. During an interview on 3/20/24 at 3:15 p.m. with the Director of Nursing (DON), the DON stated, .we should administer 2 liters [per minute] if that's the doctors order .there should be documentation why it is being titrated that time .[the] patient should be thoroughly assess if [resident] needs oxygen titrated . The DON further stated that not following the physician's order for oxygen therapy is not safe and might result to respiratory problems of the resident. A review of the facility's P&P titled, Oxygen Administration, revised 2/23/24, indicated, 1. Oxygen is administered under orders of a physician . 3. The resident care plan shall identify the interventions for oxygen therapy, based upon the resident's .orders, such as .c. Equipment setting for the prescribed flow rates . 9. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations .associated with the use of oxygen.

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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. 49950 Based on observation, interview, and record review, the facility failed to ensure that pharmacy services were maintained when controlled drug (medication that may be abused or cause addiction) record forms were inaccurately signed for a census of 126. The failure had the potential to result in diversion of the residents' medication. Findings: During a review of the controlled drug record forms for five discharged residents, under the section titled Disposition of Remaining Doses, there were two sections that the nurse who received the controlled medications could sign. The first section indicated, Doses Disposed and the second section indicated Doses discharged with Patient. Further review of the controlled drug forms indicated that the nurse received the controlled medications and signed the section indicating Doses discharged with Patient. During a concurrent observation and interview on 3/19/24 at 10:31 a.m., of the controlled medication storage in the Director of Nursing's (DON) office, the DON verified that the controlled drug record forms were signed in the wrong section for five discharged residents. The DON stated that the signed controlled drug forms suggested that the controlled drugs were given to the residents at discharge. The DON further stated that controlled drugs are not given to residents at discharge but are destroyed by the nurse. The DON acknowledged that controlled drug record forms that are incorrectly signed could result in controlled drugs being diverted. Review of the facility policy titled, Controlled Substance Administration and Accountability dated 12/19/22, indicated, .the entire amount of controlled substances obtained or dispensed is accounted for .two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record, Controlled Drug Record .any discrepancies which cannot be resolved must be reported immediately .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49950 Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled correctly, when: 1. Loose pills and were found in the South wing medication cart one. 2. Opened vials and one bottle of perishable medications were not dated with open or expiration dates in the North wing medication room. 3. Packets of medicated powder did not have an expiration date in the North wing treatment cart three. 4. Opened inhaler and glucose strips were not dated with open or expiration dates in the North wing medication cart three. 5. Expired and discontinued medications were in the North wing medication cart three. 6. A bag containing medications for a resident was found in the nursing office closet. 7. Prescription eye ointment was found in a resident's room at the bedside and was not labeled with an open date. These failures had the potential for medication misuse, drug diversion, and diminish the medication effectiveness. Findings: 1. During an inspection of medication cart one on the South wing with Licensed Nurse 1 (LN 1) on 3/18/24 at 12:40 p.m., LN 1 verified there were six loose pills in the medication cart. LN 1 stated that the medication carts should be cleaned monthly, and any loose pills should be destroyed. During an interview with Director of Nursing (DON) on 3/19/24 at 11:20 a.m., the DON acknowledged that having loose pills in the medication cart was an issue. Review of facility policy titled Labeling of Medication and Biologicals dated 12/29/22, indicated, .All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices . 2. During an inspection of North Wing medication room on 3/19/24 at 9:04 a.m., LN 2 verified there were two vials of influenza vaccine, one bottle of lanosterol eye drops, and one vial of Aplisol without an open date written on them. LN 2 verified that one vial of influenza had expired from open date (more than 28 days). LN 2 stated that not having open dates on vials and eye drops can result in residents receiving expired medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 3/19/24 at 11:20 a.m., the DON acknowledged that not having an open date on perishable medications and expired medications in the medication room was an issue. Review of the facility policy titled Labeling of Medications and Biologicals dated 12/19/22, indicated, .Labels for multi-use vials must include the date the vial was initially opened or accessed (needle punctured) .all opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for the opened vial .Labels for each floor/unit's stock medications must include the expiration date when applicable . 3. During an inspection of treatment cart three on the North wing with LN 3 on 3/19/24 at 9:45 a.m., LN 3 verified there were packets of DermaFungal powder without expiration dates in the treatment cart. LN 3 stated that if she were on vacation and another nurse was using her treatment cart, the covering nurse would not know which box the DermaFungal powder came from and what the expiration date would be. During an interview with the DON on 3/19/24 at 11:20 a.m., the DON acknowledged that not having an expiration date on medicated powder in the treatment cart was an issue. Review of the facility policy titled Labeling of Medication and Biologicals dated 12/19/22, indicated, .Labels for over-the-counter (OTC) medications must include the expiration date when applicable . 4. During an inspection of medication cart three on the North Wing on 3/19/24 at 9:58 a.m., LN 4 verified there was an open Breo inhaler and an open bottle of Assure glucose strips without an open date written on them. LN 4 stated that she was not sure of manufacturer recommendations for when the Breo inhaler expires after it was opened. LN 4 further stated that residents could have an adverse effect on expired medications. During an interview with the DON on 3/19/24 at 11:20 a.m., the DON acknowledged that not having an open date on perishable medications was an issue. Review of the facility policy titled Labeling of Medications and Biologicals dated 12/19/22, indicated, .All medications and biological will be labeled in accordance with applicable federal and states requirements and current accepted pharmaceutical principles and practices .labels for individual drug containers must include the expiration date when applicable . 5. During an inspection of medication cart three on the North Wing on 3/19/24 at 9:58 a.m., LN 4 verified there were two expired medications and three discontinued medications in the medication cart. LN 4 stated that residents could have adverse effects from expired medications. During an interview with the DON on 3/19/24 at 11:20 a.m., the DON acknowledged that expired and discontinued medications was an issue. Review of the facility policy titled Medication Storage dated 12/19/22, indicated, .Unused Medications: The pharmacy and all the medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medication are destroyed in accordance with facility policy . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During a concurrent observation and interview on 3/19/24 at 10:31 am., the DON verified that there was a bag of medications in her office closet. The DON stated that medications were for a resident that was in the hospital and expected to return to the facility. The DON verified that her office closet was not temperature controlled. Review of the facility policy titled Medication Storage dated 12/19/22, indicated, .All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medications rooms) under proper temperature controls . 7. During a concurrent observation and interviews on 3/18/24 at 10:45 a.m., with the Minimum Data Set (an assessment tool used to guide care) Coordinator (MDSC) and Resident 47, MDSC verified that Resident 47's eye ointment was left in Resident 47's room without an open date. Resident 47 stated They already gave my eyedrops this morning. I don't know why they left the medication at the bedside. During a concurrent observation and interview with LN 7 on 3/18/24 at 10:52 a.m., LN 7 entered Resident 47's room and indicated she was the nurse who left the medication, verified there was no open date, and stated, I forgot to take it back to my cart. Medications are not supposed to be left at the bedside. There is no open date that I see for the erythromycin. During an interview with LN 5 on 3/21/24 at 10:42 a.m., LN 5 verified that an open date was not written on Resident 47's eye ointment. LN 5 stated that prescription eye ointment should be kept in the medication cart and not bedside. Review of the facility policy titled Medication Storage dated 12/19/22, indicated, .All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls . Review of the facility policy titled Labeling of Medications and Biologicals dated 12/19/22, indicated, .All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices .labels for individual drug containers must include the expiration date when applicable .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on observation, interview and record review, the facility failed to hire a Director of Food and Nutrition Services who had the qualifications required. This had the potential of leading to food borne illness for the 124 residents eating facility prepared meals. Findings: During the initial kitchen tour on 3/18/24 at 8:38 a.m., there was not a certificate or degree in the Food and Nutrition Services office. In a subsequent interview with the Dietary Manager (DM) at 8:45 a.m., she stated that she had worked as the Food and Nutrition Services manager for the past year. She further explained that she had not yet completed the process to become a Certified Dietary Manager, nor had she received the required six hours of Title 22 instruction. During an interview on 3/19/24 at 9:08 a.m. with the Consultant Registered Dietitian (CRD) , she stated that her usual schedule was 35 hours per week. These hours were split between clinical nutrition and being a resource for the kitchen. She further explained that she does not hire or supervise dietary staff. Her involvement in the kitchen was a monthly audit, conducting test trays, and providing monthly in-services for dietary staff on occasion. Review of the provided job description for the Registered Dietitian (Healthcare Services Group, Inc., undated) indicated that the CRD Responsibilities include planning, organizing, developing and directing the nutritional care of the resident . Acts as a resource to the Director of Dining Services . this is not a supervisory function . Review of the facility provided Director of Food and Nutrition Services Department ([NAME] Corporate Dietitians, 2022) indicated in bullet b: In States that have established standards . meets State requirements for Directors of Food and Nutrition Services; . Review of the State of California - Health and Safety Code 1265.4 indicated that: . (b) The dietetic services supervisor shall have completed at least one of the following educational requirements: (1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility. (2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration. (3) A graduate of a dietetic assistant training program approved by the American Dietetic Association. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Carmichael Healthcare Center	3630 Mission Avenue Carmichael, CA 95608

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(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. (5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management 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. (6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision. (7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6).

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38528 Based on observation, interview and record review, the facility failed to prepare foods that conserved nutritive value, flavor, and appearance; and served food at unappetizing temperatures. This had the potential of leading to poor intake, malnutrition and weight loss for the 124 residents eating facility prepared meals when: 1. Vegetables were heated for over 2 hours, 2. Pureed meals were prepared without measuring ingredients, and 3. Pureed food was prepared in a dirty food processor bowl. Findings: 1. During the initial kitchen tour on 3/18/24 at 9:12 a.m., the steamer doors were opened, and a large pan of green beans were being heated. During the dining observation on 3/18/24 at 12:08 p.m. the first cart of lunch trays exited the kitchen. Review of John Hopkins Medicine website on How to Keep the Nutrients in your Veggies indicated, Cooking decreases some of the nutrients in vegetables. Higher temperatures and longer cooking times are the two variables that can cause more nutrient loss. 2. During a return visit to the kitchen on 3/19/24 at 9:57 a.m. Cook 1 (CK 1) filled a pot with hot water and placed on the stove to boil, and adding a bag of frozen zucchini. After boiling the zucchini, CK 1 drained off excess water and added an unmeasured amount of zucchini to the food processor bowl (which had not been cleaned from the pureeing of bread). CK 1 next added an unmeasured amount of broth (no margarine was added as required for the regular Butter Zucchini recipe). Review of facility provided Pureed Vegetables Recipe ([NAME], undated) indicated in the directions to: 1. Remove portions required from regular prepared recipe .Process until smooth. 2.If necessary add a small amount of reserved cooking liquid. During a return kitchen visit on 3/19/24 at 11:20 a.m., CK 1 was observed pureeing tortellini. CK 1 added an unmeasured amount of water to the food processor bowl along with the tortellini and pureed until jiggly. A Surveyor test tray conducted on 3/19/24 at 1:13 p.m. found the pureed tortellini to be bland when compared to the regular product. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility provided Pureed Casseroles Recipe ([NAME], undated) indicated in the ingredient list to include casserole, hot broth or hot 2% milk, and thickener (if needed). No water was included. During an interview on 3/20/24 at 10:52 a.m. with the Consultant Registered Dietitian (CRD) and Dietary Manager (DM), the CRD stated that broth or milk were added in order to help maintain flavor or add nutrition. Adding water would potentially dilute the flavor and nutrition. 3. After boiling the zucchini, CK 1 drained off excess water. She then brought the zucchini over to the food processor which had a bowl with a tan residue covering the internal surfaces. When asked what the residue was, CK 1 stated she had used the bowl to puree bread and proceeded to add the zucchini to be processed. During an interview on 3/20/24 at 10:52 a.m. with the CRD and DM, the CRD stated the food processor bowl should have been cleaned before preparing another recipe as there was a risk that residents with sensitivities (such as gluten) might eat the pureed zucchini. Review of facility provided Pureed Vegetables recipe ([NAME], undated) indicated in the Critical Control Points (for food safety) that Clean and sanitized equipment must always be used.

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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. 38528 Based on observation, interview and record review, the facility failed to accommodate food allergies and food preferences for six of 43 sampled residents (Resident 100, Resident 26, Resident 34, Resident 57, Resident 97, and Resident 89). This had the potential of leading to allergic reactions (including death), as well as lead to poor intake and weight loss in the 124 residents receiving facility prepared meals. Findings: 1. Resident 100 was admitted in the middle of 2022 with diagnoses which included failure to thrive. During the lunch meal observation on 3/18/24 at 12:32 p.m., Resident 100 was unable to get coffee with his meal. He stated, As an American, usually we drink coffee and it has been scarce. The resident added, Sometimes I don't get ice cream. I prefer ice cream. Noted on the resident's meal tray was a piece of cake for dessert. On the meal card it indicated the resident's preference was ice cream. Licensed Nurse 13 (LN 13) brought Resident 100 two small cups of ice cream, and stated, So, the kitchen staff are supposed to know your preference for ice cream because it says on your meal card. They are supposed to put it in there right away. During an Interview with Consultant Registered Dietitian (CRD) on 3/19/24 at 8:45 a.m., the CRD stated that staff were being trained to check the food preference area (instead of the note section) as this was a recent change implemented from corporate. 2. Resident 26 was admitted in late 2023 with diagnoses which included diabetes (abnormal blood sugar levels) and malnutrition. During an interview on 3/18/24 at 3:29 p.m., Resident 26 complained of having a sensitive stomach requiring several food preferences. Resident 26 stated her system did not tolerate garlic but she had received food items containing garlic. Resident 26 also stated they had not allowed her to receive sausage which she really liked and missed. During an interview with the CRD on 3/19/24 at 8:45 a.m., the CRD stated that Resident 26's food preferences included no garlic as well as no sausage. The CRD stated she would remove sausage from the food dislikes. 3. Resident 34 was admitted in late 2021 with diagnoses which included stroke and malnutrition. During an interview on 3/18/24 at 3:48 p.m. with Resident 34, Resident 34 stated she received green beans for 12 meals in a row (excluding breakfasts). Res 34 stated she disliked carrots and salads which may be the reason she gets green beans so often, but now she is tired of them. During dining observations, green beans were given at lunch on both 3/18/24 (as the main vegetable) and 3/19/24 (as the alternative vegetable). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/24 with Cook 1 (CK 1), CK 1 stated that she tried to remember what the alternative was from the previous meal or would ask other employees. They stated the facility did not have a system for rotating the alternative items. During the same interview on 3/18/24 at 3:48 p.m. with Resident 34, she also stated that the food was too salty at times. During an observation on 3/19/24 at 10:48 a.m., CK 1 was observed adding unmeasured amounts of salt to burgers and fries being prepared for the lunch meal. CK 1 explained that she had a sensitive stomach and did not taste test the food prepared. During an interview on 3/20/24 at 10:52 a.m. with the Dietary Manager (DM) and CRD, the DM stated they were not aware of the use of salt by CK 1 and will educate and monitor. 4. Resident 57 was admitted in early 2023 with diagnoses which included diabetes and muscle weakness. During an interview on 3/18/24 at 4:04 p.m., Resident 57 stated that the consistent carbohydrate diet did not receive the best options for them (such as whole wheat bread instead white, sweet potatoes instead of white potatoes). Resident 57 also reported that she received chicken tenders often, when she disliked the entree on the menu, and preferred to have more variety. Chicken tenders were given as an alternative on the 3/19/24 lunch meal. 5. Resident 97 was admitted in late 2022 with diagnoses which included diabetes. During an interview on 3/18/24 at 4:10 p.m., Resident 97 stated that alternative items are not always available though not removed from the alternative menu, and that the soup is often watery. Interview with the CRD on 3/29/24 at 8:45 a.m., the CRD stated that they use canned soups as well as well as house made soups. She did not believe that the cook's alter the recipes, but that they have new recipes which may not be as well received as the previous menus. 6. Resident 89 was admitted in late 2023 with diagnoses which included stroke, diabetes and difficulty swallowing. During an interview on 3/18/24 at 4:28 p.m., Resident 89 stated hot food is often cold or lukewarm. Surveyor test tray conducted on 3/19/24 at 1:13 p.m. found the zucchini temperature measured at 104 degrees F (Fahrenheit, a unit of measurement) which had a lukewarm mouth feel. Res 89 also stated she received green beans too frequently. Res 89 lastly stated that she has a seafood allergy but had received shrimp and tuna fish on her meal trays during her stay. (Note sign behind bed to warn staff not to give seafood due to allergy). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the CRD on 03/19/24 at 8:45 AM, she stated that seafood allergy is listed in chart and on the tray tickets. She was unsure how seafood was served to the resident twice. She also stated that she nor the DM go to resident council meetings as they believed they were not allowed to. Review of facility provided resident council notes included the following: 10/24/23: Food really bad, diabetic diets not being followed, special diets (no pork, vegan, protein) not being followed, meals running late (45 minutes to 1 hour), food is cold, kitchen runs out of certain items .allergy not honored . 2/27/24: Soup too diluted, still getting a high carb (carbohydrate) diet. Review of facility's policy and procedure (P&P) titled, Menus and Adequate Nutrition, (The Compliance Store, LLC., 2022), the P&P indicated, in bullet 5: Menus shall reflect input from residents and resident groups: a. Resident preferences, including likes and dislikes will be documented in the resident's chart and shall be reviewed when planning menus. i. Alternatives shall be available for residents if they dislike the primary menu choice. ii. Each resident's plan of care will reflect interventions to accommodate nutritional needs . b. The resident council will be included periodically in menu planning and efforts will be made to accommodate requests.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48445 Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for a total of 124 residents who received facility prepared foods when: 1. Proper food labeling was not followed, 2. Expired foods were not discarded, 3. Perishable salads were not kept in safe food temperature range, 4. Foods were not kept covered while in storage, 5. Freezer had an ice drip from the fan onto the food box, 6. Cutting boards were found with debris on the cutting surface, and 7. Can opener tip was found rusted and missing metal. These failures had the potential to lead to food borne illness. Findings: 1. During the initial kitchen tour on [DATE] beginning at 8:38 a.m., the following items were observed not having proper labeling: - a container of graham crackers without year, label indicated, Prep Date ,d+[DATE], Use by ,d+[DATE] - two whipped toppings without year, labels for both items indicated, Prep Date ,d+[DATE], Use Date , d+[DATE] - a tray of butterscotch pudding without year, label indicated, Prep Date ,d+[DATE], Use By ,d+[DATE] - a bag of cabbage without a year, label indicated, ,d+[DATE], ,d+[DATE] -a box of croissant without a year, label indicated, Prep Date ,d+[DATE], Use by ,d+[DATE] - one whipped topping without label and date - one bag of opened spaghetti noodles wrapped in plastic without a label and date - a blue plastic bag of vegetable burgers without a label and date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on [DATE] at 9:10 a.m. with the Dietary Manager (DM) in the dry food storage room in the kitchen, the DM confirmed the observed items did not have the proper labels and stated, They should be dated because it's a food item, it should not go past the use by date .it can cause food illnesses. When asked about the items without year on dating, the DM stated, There is no year, so it is unclear if the food products are still safe. The dating is improper without the year included. During an observation on [DATE] at 10:27 a.m. in the kitchen, Cook 1 (Ck 1) was observed cooking chicken tenders. After placing the desired amount of chicken tenders in the oven, Ck 1 wrapped the excess chicken tenders with plastic, placed a label on the package and wrote ,d+[DATE]-,d+[DATE] without indicating the year. During a review of the facility policy and procedure (P&P) titled, Food Safety Requirements, dated [DATE], the P&P indicated, 3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage .Practices to maintain safe refrigerated storage include: .iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded . During a review of the facility P&P titled, Date Marking for Food Safety, dated 2022, the P&P indicated, 2. The food shall be clearly marked to indicate the date or day by which food shall be consumed or discarded . 4. The marking system shall include the date of opening, and the date the item must be consumed or discarded . 2. During a concurrent observation and interview on [DATE], within the initial kitchen tour beginning at 8:38 a. m., with the DM in the dry food storage area in the kitchen, the following items were observed past their use-by dates: - a container with partially opened green lid that contained an opened bag of cake mix with label that indicated, Use by [DATE]. - a plastic container of ground cloves with a label that indicated, Use by [DATE]. - a plastic container of thyme leaves with a label that indicated, Use by [DATE]. The DM confirmed the observations and stated, Expired food may lead to food borne illness. During a review of the facility P&P titled, Date Marking for Food Safety, dated 2022, the P&P indicated, 6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. During a review of the facility P&P titled, Food Safety Requirements, dated [DATE], the P&P indicated, 1. Food safety practices shall be followed throughout the facility's entire food handling process .Elements of the process include the following: .b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an observation on [DATE], within the initial kitchen tour beginning at 8:38 a.m., in the walk-in refrigerator, the egg and tuna salad were both tested to have temperature of 42 F (degrees Fahrenheit, a unit of temperature measurement). During a concurrent observation and interview on [DATE] at 8:35 a.m. with the Registered Dietitian (RD) in the walk-in refrigerator, the tuna salad was observed to have temperature of 43.7 F. The RD verified the temperature with her own thermometer and stated it was possibly due to food delivery. During a review of the facility P&P titled, Date Marking for Food Safety, dated 2022, the P&P indicated, 1. Refrigerated, ready-to-eat, time/temperature control for safety food (i.e., perishable food) shall be held at a temperature of 41 F or less for a maximum of 7 days. During a review of the facility P&P titled, Food Storage, revised [DATE], the P&P indicated, Improper storage of Time/Temperature Controlled for Safety (TCS) foods can affect your budget or even worse, get a resident sick .a. These foods must be maintained at the proper temperature, typically 41 F of [sic] below .c. Improper storage of food is the main reason for foodborne illness. During a review of the facility P&P titled, Food Safety Requirements, dated [DATE], the P&P indicated, d. Holding - staff shall monitor food temperatures while holding for delivery to ensure hot and cold temperatures are maintained. Staff shall refer to the current Food and Drug Administration (FDA) Food Code and facility policy for food temperatures as needed. During a review of the US (United States) FDA 2022 Food Code, section ,d+[DATE].14, titled, Cooling., [DATE] version, indicated, (B) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled within 4 hours to 5 degrees C [Celsius, a unit of temperature measurement] (41 degrees F) or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna. During a review of the US FDA 2022 Food Code, section ,d+[DATE].16, titled, Time/Temperature Control for Safety Food, Hot and Cold Holding, [DATE] version, indicated, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD .shall be maintained . (2) At 5 C [degrees Celsius, a unit of temperature measurement] (41 F) or less. 4. During a concurrent observation and interview on [DATE], within the initial kitchen tour beginning at 8:53 a.m., with the DM in the dry food storage area in the kitchen, a container that contained an opened bag of cake mix was observed with partially opened lid. The DM confirmed the observation. During a concurrent observation and interview on [DATE], within the initial kitchen tour at 9:32 a.m., with the DM in the walk-in freezer, an unlabeled container was observed partially closed. The DM confirmed the observation and verified the container contained bacon. During an observation on [DATE], within the initial kitchen tour at 9:52 a.m., in the reach-in freezer, an open box that contained an open plastic bag of pork patties and an open box with open plastic bag of fish patties were observed. Ice crystals were observed on the plastic bags and freezer burn were observed on the pork and fish patties. During a review of the facility P&P titled, Dry Storage Chart, revised [DATE], the P&P indicated, Mixes . Brownie and Cake .Store in a cool, dry environment. Once opened, store in airtight container. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility P&P titled, Food Safety Requirements, dated [DATE], the P&P indicated, 1. Food safety practices shall be followed throughout the facility's entire food handling process .Elements of the process include the following: .b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms .3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage .Practices to maintain safe refrigerated storage include: .v. Keeping foods covered or in tight container. 5. During an observation on [DATE], within the initial kitchen tour at 9:32 a.m., in the walk-in freezer, ice buildup measuring approximately 4x2 inches (a unit of measurement) was observed on the boxes stored below the fan. During a concurrent observation and interview on [DATE] at 9:48 a.m., with the Maintenance Supervisor (MS) in the walk-in freezer, the MS confirmed the ice buildup inside the freezer and stated he had not been told about it but believed it was related to the door not being closed tightly. During an interview on [DATE] at 9:49 a.m. with the DM, the DM confirmed the buildup inside the freezer was under the fan and stated, I didn't know that, but it looks like it is coming from the fan. During a review of the facility P&P titled, Food Safety Requirements, dated [DATE], the P&P indicated, 3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage .Practices to maintain safe refrigerated storage include: .i. Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation. 6. During a concurrent observation and interview on [DATE], within the initial kitchen tour beginning at 8:53 a.m., with the DM in the kitchen, green and blue chopping boards were observed in storage, having white-colored debris and yellow chopping board had black-colored debris on the cutting surfaces. The DM confirmed the observations. During a review of the facility P&P titled, Food Safety Requirements, dated [DATE], the P&P indicated, 1. Food safety practices shall be followed throughout the facility's entire food handling process .Elements of the process include the following: .e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food .6. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. During a review of the US FDA 2022 Food Code, section ,d+[DATE].11, titled, Equipment Food-Contact Surfaces and Utensils., [DATE] version, indicated, Microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces. Food-contact surfaces and equipment used for time/temperature control for safety foods should be cleaned as needed throughout the day but must be cleaned no less than every 4 hours to prevent the growth of microorganisms on those surfaces. 7. During a concurrent observation and interview on [DATE], within the initial kitchen tour beginning at 8:53 a.m., with the DM in the kitchen, the DM confirmed the can opener was observed rusted and had a missing metal on blade. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34980 Based on observation, interview, and record review, the facility failed to ensure an effective infection prevention and control program was followed and maintained for a census of 126 when: 1. A clean-linen delivery cart and two clean linen storage shelves were found with a thick layer of dusts in the laundry room; 2. A nasal cannula (oxygen tubing) had no labeled date for Resident 27; 3. An empty intravenous (IV) medication bag with no administration date and licensed nurse (LN) initial hanged in Resident 682's room; 4. An IV tubing was not labeled for Resident 131; 5. A urinary bag was found on the floor in Resident 19's room. These failures had the potential to result in the transmission of infection and cross-contamination in a vulnerable population. Findings: 1. During a concurrent observation and interview on 3/20/24, at 8:39 a.m., in the Laundry Room, with Laundry Staff (LS), the clean-linen delivery cart was stocked with clean linens and was found with thick layers of dust on its side corners. LS confirmed the observation and stated they only have one clean-linen delivery cart in the facility, and they would use the cart to deliver clean beddings, towels, washcloths, and other linens that they wash in the laundry room every day. Upon request to see documentation of cleaning the cart, the LS stated they do not have a log for cleaning the cart. The LS further stated if the cart was not clean, the dust might get in contact with the clean linen and could lead to possible spread of germs to the residents. During an interview on 3/20/24, at 9:02 a.m. with the Maintenance Supervisor (MS), the MS stated, .The laundry staff should clean it [clean-linen delivery cart]. There's no schedule yet on how often the carts are cleaned . The MS further stated, . [The clean- linen delivery cart should be regularly cleaned] so it doesn't build-up with dust or anything else .Dirt can transfer to the clean linen and might spread to the residents. During a concurrent observation and interview on 3/20/24, at 9:31 a.m., in the northeast clean-linen storage room, with LS, LS was observed stocking clean linens to the storage shelves and two out of two clean linen storage shelves were found with a thick layer of dust on the side corners. LS confirmed the observation. LS stated they do not have a scheduled regular cleaning of the clean-linen storage shelves. During an interview on 3/20/24 at 12:30 p.m. with the Infection Preventionist (IP), the IP stated, . If it's [clean-linen delivery cart and clean-linen storage shelves] dirty, [there's a] possibility of transfer [of dirt or germs] to [the] clean linen and [it] can get transferred to residents . (continued on next page)

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	056304	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Carmichael Healthcare Center	3630 Mission Avenue Carmichael, CA 95608

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/24 at 3:15 p.m. with the Director of Nursing (DON), the DON stated she would expect the clean-linen delivery cart and clean-linen storage shelves to be clean to prevent possible infection of the residents. A review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, revised 12/19/22, indicated, 11. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection . 2. A review of Resident 27's clinical record indicated Resident 27 was originally admitted October of 2021 and had diagnoses that included chronic obstructive pulmonary disease (COPD- a group of diseases that causes airflow blockage and breathing-related problems), heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body). A review of Resident 27's active physician's order, dated 10/15/23, indicated, use Oxygen via N/C [nasal cannula] 2-4L [liters per minute/LPM- unit of measurement for oxygen administration flow rate] .every shift. During an observation on 3/18/24 at 3:06 p.m. in front of the south nurse's station, Resident 27 was observed sitting on her wheelchair and was using an oxygen delivered using a nasal cannula with the oxygen tank set at 3 liters per minute. The nasal cannula was not labeled with the date it was first used. During a concurrent observation and interview on 3/18/24 at 3:24 p.m. in front of room [ROOM NUMBER], with Licensed Nurse (LN) 8, LN 8 confirmed that Resident 27's nasal cannula was not labeled with the date it was first used. LN 8 stated, it should be labelled with the date it was first used so they would know when to change it. LN 8 further stated, It [nasal cannula] should be changed every 7 days .every Sunday night .it's risk of infection [if the nasal cannula is not regularly changed] . During an interview on 3/20/24 at 3:15 p.m. with the DON, the DON stated, .As soon as they [staff] change it [nasal cannula], they [staff] put the date when day change it [nasal cannula] .to make sure that it's [nasal cannula] frequently changed to prevent infection control issues . A review of the facility's P&P titled, Oxygen Administration, revised 2/23/24, indicated, 4 .Other infection control measures include: .b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated . 3. Resident 682 was admitted in early 2024 with diagnoses which included foot and ankle bone infection. During a review of Resident 682's Physician's Orders (PO), dated 3/14/24, the PO indicated, Cefazolin [IV antibiotic] .intravenously every 12 hours related to SEPSIS [infection] .for 14 days. During a concurrent observation and interview on 3/18/23 at 10:32 a.m. in Resident 682's room, Resident 682 was in bed, awake and alert and verbally responsive and at the bedside was an IV pole with an empty IV bag with no labeled date when the medication was infused and no labeled nurse initials. The IV tubing was not labeled or dated. Resident 682 stated, I need the antibiotics every day for my infection. It started since I got here. I don't know when I got here. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/18/23 at 10:34 a.m. with the Assistant Director of Nursing (ADON) in Resident 682's room, the ADON verified the IV bag hanged at the bedside was not labeled, and stated, I don't know who hung [the IV medication] and I don't know when the tube was changed. There's no date and I don't know if the label is correct. Since we don't know when the tubing was last changed, we shouldn't use the same tubing, that would be infection control .The nurse should label the bag when it was hung and who administered the medication. During an interview on 3/21/24 at 10:20 a.m. with the DON, the DON stated, When the nurse hung the IV medication, it should be labeled with date and the initial of the nurse who administered the medication. 4.Resident 131 was admitted to the facility in 2024 with diagnoses which included pleural effusion (a buildup of fluid between the lung and chest tissues). During a review of Resident 131's PO, dated 3/14/24, the PO indicated, Cefepime [IV antibiotic] .every 8 hours for possible pleural effusion. During an initial tour observation on 3/18/24 at 11:04 a.m., Resident 131's IV tubing was not labeled. During a concurrent observation and interview on 3/18/24 at 11:05 a.m., with LN 11 in Resident 131's room, LN 11 confirmed Resident 131's IV tubing was not labeled. LN 11 stated, All IV tubing that is in use should be labeled with date, time and the nurses initials when first used. During a concurrent observation and interview on 3/18/24 at 11:09 a.m., with the ADON in Resident 131's room, the ADON confirmed Resident 131's IV tubing was not labeled with date and time. The ADON stated, The IV tubing should be labeled with the date, time and the nurses initials .should be done by the nurse hanging the new tubing. During a review of the facility's P&P titled, Intravenous Therapy, dated 12/19/2022, the P&P indicated, 5. All IV tubing is to be labeled with date, time and initials. 5. Resident 19 was admitted to the facility in 2022 with a diagnoses that included benign prostatic hyperplasia (BPH - a condition in which the prostate gland is enlarged resulting in urinary retention). A review of Resident 19's Physician's Order dated 3/18/24, indicated an order for an indwelling catheter for urinary retention. During an observation on 3/20/24 at 1 p.m., Resident 19's urinary catheter drainage bag was attached to the lower portion of the bed and approximately half of the catheter bag was touching the floor. During a concurrent observation and interview with the ADON on 3/20/24 at 1:10 p.m., the ADON verified Resident 19's urinary catheter drainage bag was lying on the floor. The ADON stated, A catheter bag should never touch or be on the floor. The ADON further stated, This could cause an infection. Lastly, the ADON stated, If the bed is close to the floor, the catheter bag should be placed in a plastic container in order to keep it from coming in contact with the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 3/21/24 at 11 a.m., the DON stated, A catheter bag should never come in contact with the floor because it could result in a serious infection for the resident. The DON further stated, If the bed is close to the floor the catheter bag should be placed in a container on the floor to keep it from becoming contaminated. A review of the facility policy titled, Standard Precautions Infection Control dated 12/19/22 under soiled resident-care equipment, Handle in a manner that prevents transfer of microorganisms to others and to the environment . 5. Resident 19 was admitted to the facility in 2022 with a diagnoses that included benign prostatic hyperplasia (BPH - a condition in which the prostate gland is enlarged resulting in urinary retention). A review of Resident 19's Physician's Order dated 3/18/24, indicated an order for an indwelling catheter for urinary retention. During an observation on 3/20/24 at 1 p.m., Resident 19's urinary catheter drainage bag was attached to the lower portion of the bed and approximately half of the catheter bag was touching the floor. During a concurrent observation and interview with the ADON on 3/20/24 at 1:10 p.m., the ADON verified Resident 19's urinary catheter drainage bag was lying on the floor. The ADON stated, A catheter bag should never touch or be on the floor. The ADON further stated, This could cause an infection. Lastly, the ADON stated, If the bed is close to the floor, the catheter bag should be placed in a plastic container in order to keep it from coming in contact with the floor. During an interview with the DON on 3/21/24 at 11 a.m., the DON stated, A catheter bag should never come in contact with the floor because it could result in a serious infection for the resident. The DON further stated, If the bed is close to the floor the catheter bag should be placed in a container on the floor to keep it from becoming contaminated. A review of the facility policy titled, Standard Precautions Infection Control dated 12/19/22 under soiled resident-care equipment, Handle in a manner that prevents transfer of microorganisms to others and to the environment . 38528 45882 47197

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 38528 Based on observation, interview and record review, the facility failed to ensure essential kitchen equipment (ice machine and oven) were in safe operating conditions. This had the potential of leading to food borne illness for the 124 residents eating facility prepared meals. Findings: During the initial kitchen tour on 3/18/24 at 8:52 a.m., the Maintenance Supervisor (MS) opened the ice machine to explain the cleaning process. He stated that the ice machine had problems with randomly shutting off. During the initial kitchen tour on 3/18/24 at 9:33 a.m., the right side of the oven was not working. During a revisit to the kitchen on 3/19/24 at 9:45 a.m. to observe lunch preparation, the survey team requested to calibrate our thermometers with the facility's. Cook 1 (CK 1) stated that she would be unable to use the ice bath method as the ice machine is not working again today. During a revisit to the kitchen on 3/19/24 at 10:14 a.m., CK 1 reported she had to change meal preparation and timing due to the right side of oven not working. Review of the US Food and Drug Administration's 2022 Food Code section 4-501.11 Good Repair and Proper Adjustment indicated that (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.