STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555035	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Anaheim Healthcare Center	3435 W Ball Road Anaheim, CA 92804

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the care was provided in a manner which promoted dignity and respect for one of four final sampled residents (Resident 84) reviewed for indwelling urinary catheter and one of 24 final sampled residents (Resident 71) reviewed for privacy. * The facility failed ensure Resident 84's indwelling urinary drainage bag was fully covered. * Resident 71's body parts were exposed while being transferred to a shower bed. These failures have the potential to negatively affect the resident's emotional well-being. Findings: 1. Review of the facility's P&P titled Dignity revised 2/2021 showed the staff are expected to promote dignity and assist the residents; for example: helping resident to keep urinary bags covered. The P&P also showed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Medical record review for Resident 84 was initiated on 3/11/25. Resident 84 was readmitted to the facility on [DATE]. Review of Resident 84's MDS dated [DATE], showed Resident 84 was cognitively intact. Resident 84 needed extensive assistance from the staff with his ADL care. Review of Resident 84's Physician Order Summary dated 3/13/25, showed a physician's order dated 2/3/25, for the indwelling urinary catheter to attached to the bedside drainage bag. On 3/11/25 at 0829 and 1430 hours, and 3/13/25 at 0809 hours, Resident 84 was observed in bed. Resident 84 was observed to have the urinary drainage bag hanging to the left side of his bed. The urinary drainage bag was not fully covered and observed to have light yellow liquid. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 0821 hours, an observation and concurrent interview was conducted with the IP. The IP verified the above findings. The IP stated the urinary drainage bag had to be fully covered to protect the resident's dignity. The IP verified the urinary drainage bag for Resident 84 was not fully covered. On 3/14/25 at 0946 hours, the DON was informed and acknowledged the above findings. 49324 2. Medical record review for Resident 71 was initiated on 3/11/25. Resident 71 was readmitted to the facility on [DATE]. Review of Resident 71's H&P examination dated 5/25/24, showed the resident had the capacity to understand and make decisions. Review of Resident 71's Order Summary Report dated 3/12/25, showed Resident 71 had a diagnosis of unspecified depression. On 3/11/25 at 1016 hours, an observation was conducted on Resident 71. Resident 71 was observed to be seated on a hoyer lift, being transferred from the bed to shower bed with his abdomen and bilateral legs exposed. Resident 71's transfer to the shower bed done by CNA 3 and the SLP could be seen from the hallway with Resident 71's door wide open. On 3/11/25 at 1020 hours, an interview was conducted with the SLP. The SLP stated she was helping CNA 3 and verified Resident 71's door should have been closed to provide privacy. On 3/11/25 at 1111 hours, an interview was conducted with LVN 3. LVN 3 verified the door should have been closed and respected Resident 71's right of dignity and privacy. On 3/11/25 at 1145 hours, an interview was conducted with Resident 71. Resident 71 was asked how he felt when the care was not provided with privacy. Resident 71 stated he felt it was disappointing and got used to it. On 3/14/25 at 1045 hours, an interview was conducted with the DON. The DON verified Resident 71's body parts should have not been exposed and Resident 71's door should have been closed to provide privacy.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the informed consents for four of 24 final sampled residents (Residents 10, 44, 72, and 85) and one nonsampled resident (Resident 20) were completed as per the facility's P&P. * The facility failed to ensure the informed consents for Residents 10, 20, 72, and 85 were signed and dated by the physician. * The facility failed to ensure Resident 44's informed consent for the use of the Abilify (antipsychotic medication) was signed and dated by the physician. These failures posed the risk of residents and their responsible parties not to be informed of their treatments and the potential side effects. Findings: Review of the facility's P&P titled Informed Consent dated 12/2024 showed to ensure the residents and/or their representatives are fully informed of the benefits, risks, frequency/duration and alternatives before initiating the administration of the psychotherapeutic drugs or physical restraints. The physician and/or prescriber must sign an informed consent form after explaining all necessary information to the residents or representatives. 1. Medical Record review of Resident 10 was initiated on 3/11/25. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 5/25/24, showed the resident had the capacity to understand and make decisions. Review of Resident 10's Informed Consents form dated 2/18/25, showed the physician had confirmed giving the information of the resident proposed treatment and nature and seriousness of illness, reasonable alternative treatment and/or possible non-pharmacological approaches and the rationale for the recommended treatment, nature of procedures involved in the proposed treatment, including probable frequency and duration, probable degree, duration and probability of significant risks commonly known by health professionals in person for the following:. - proposed treatment (non-restraint) for out of the bed to the gerichair as tolerated for the resident had poor trunk control. The resident benefits from being up in the gerichair for socialization, stimulation, and activities, and - proposed treatment (non - restraint) for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. Further review of the informed consents failed to show the date and signature of the physician who had obtained the informed consents. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical Record review of Resident 72 was initiated on 3/11/25. Resident 72 was readmitted to the facility on [DATE]. Review of Resident 72's H&P examination dated 10/18/24, showed the resident had no capacity to understand and make decisions. Review of Patient 72's Informed Consent forms showed the physician had confirmed that he/she had given information to the resident's representative by telephone call regarding the reason for the treatment and nature and seriousness of the illness, nature of procedures to be used in the proposed treatment, including probable frequency and duration, probable degree and duration of improvement or remission, nature, degree, duration and probability of known side effects and significant risks commonly known by health professionals, reasonable alternative treatment and risks and why the particular treatment is recommended and that the resident or resident's representative has the right to accept or refuse the proposed treatment and if/she consents, has the right to revoke his/her consent for any reason at any time for the following consents: - dated 10/28/24, for the left hand mitten for the prevention of pulling out of the life sustaining tubes per family preference. - dated 10/16/25, for out of the bed to the gerichair for socialization, stimulation, activities and shower days; - dated 10/16/24, for the bilateral upper side rails up for positioning due to gravity related to the involuntary movements secondary to the head of bed elevated for the management of the tracheostomy and GT feeding; and - dated 10/16/24, for the low bed with the floor pads/mats to minimize the potential for injury from the spontaneous/involuntary movement from bed to the floor mats/pads. Further review of the informed consents failed to show the dates and signature of the physician who had obtained the informed consents. On 3/14/25 at 0930 hours, an interview and concurrent medical record review for Residents 10 and 72 was conducted with RN 2. RN 2 verified the above findings. 3. Medical Record review of Resident 20 was initiated on 3/11/25. Resident 20 was readmitted to the facility on [DATE]. Review of Resident 20's Informed Consent forms dated 9/13/24, showed the physician had confirmed that he/she had given the information to the resident's representative by telephone call regarding the reason for the treatment and nature and seriousness of illness, nature of procedures to be used in the proposed treatment, including probable frequency and duration, probable degree and duration of improvement or remission, nature, degree, duration and probability of known side effects and significant risks commonly known by health professionals, reasonable alternative treatment and risks and why the particular treatment is recommended and that the resident or resident's representative has the right to accept or refuse the proposed treatment and if/she consents, has the right to revoke his/her consent for any reason at any time for the following: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- for the bilateral upper side rails up for positioning due to the gravity related involuntary movements secondary to the head of the bed elevated for the management of the tracheostomy and GT feeding; - for out of the bed to the geri-chair as tolerated during shower days. The resident is immobile and had no ability to transfer independently and the resident would benefit from being up in geri-chair for socialization, stimulation and activities; and - for the low bed with the floor pads/mats to minimize the potential injury from spontaneous/involuntary movement from bed to floor mats/pads. Review of Resident 20's H&P examination dated 9/17/24, showed the resident had no capacity to understand and make decisions. Further review of the informed consents failed to show the date and signature of the physician who had obtained the informed consents. 4. Medical Record review of Resident 85 was initiated on 3/11/25. Resident 85 was readmitted to the facility on [DATE]. Review of Resident 85's H&P examination dated 12/19/24, showed the resident had no capacity to understand and make decisions. Review of Resident 85's Informed Consent forms dated 12/19/25, showed the physician had confirmed that he/she had given information to the resident by telephone call regarding the reason for the treatment and nature and seriousness of illness, nature of procedures to be used in the proposed treatment, including probable frequency and duration, probable degree and duration of improvement or remission, nature, degree, duration and probability of known side effects and significant risks commonly known by health professionals, reasonable alternative treatment and risks and why the particular treatment is recommended and that the resident or resident's representative has the right to accept or refuse the proposed treatment and if/she consents, has the right to revoke his/her consent for any reason at any time for the following: - for the bilateral upper side rails up for positioning due to gravity related to the involuntary movements secondary to HOB elevated for the management of the tracheostomy and GT feeding; - for the low bed with the floor pads/mats to minimize the potential injury from spontaneous/involuntary movement from bed to floor mats/ pads; and - for the out of the bed to the gerichair as tolerated during shower days. The resident is immobile and had no ability to transfer independently and the resident would benefit from being up in the gerichair for socialization, stimulation and activities. Further review of the informed consents failed to show the date and signature of the physician who had obtained the informed consents. On 3/14/25 at 0945 hours, an interview and concurrent medical record review for Residents 20 and 85 was conducted with RN 5. RN 5 verified the above findings. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 1554 hours, an interview was conducted with the DON. The DON verified all of the above the findings. 47474 4. Medical record review for Resident 44 was initiated on 3/11/25. Resident 44 was admitted to the facility on [DATE], and reamitted on 7/14/23. Review of Resident 44's Quarterly MDS dated [DATE], showed Resident 44 had a BIMS score of 12 which meant the resident was moderately cognitively impaired. Review of Resident 44's Order Summary Report for March 2025 showed a physician's order dated 10/29/24, for Abilify 5 mg one tablet via GT at bedtime for Bipolar disorder manifested by angry outburst. Review of Resident 44's Informed Consent for the Abilify nedication dated on 10/29/24, showed no documented evidence the physician had signed or dated the informed consent. On 3/13/25 at 1356 hours, a concurrent interview and medical record review was conducted with LVN 3. LVN 3 verified Resident 44's physician's order for the Abilify medication. LVN 3 further verified the resident received Abilify 5 mg at 2100 hours from 3/1 to 3/12/25, as documented on Resident 44's MAR for March 2025. Moreover, LVN 3 verified the informed consent for the use of the Abilify medication was not signed or dated by the physician. LVN 3 stated the informed consent should have been signed and dated by the physician. On 3/14/25 at 1320 hours, an interview was conducted with the Administrator and DON with the Regional Director of Operations present. The Administrator and DON were made aware and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, and facility P&P review, the facility failed to maintain a copy of an advance directive in the medical record for one of six final sampled residents (Resident 34) reviewed for advance directives. This failure had the potential for Resident 34's decisions regarding his healthcare and treatment options to not be honored. Findings: Review of the facility's P&P titled Advance Directive revised 9/2022 showed prior to or upon admission of a resident, the Social Service Director or designee will inquire of the resident, his/her family members and /or his or her legal representative about the existence of any written Advance Directives. Further review of the P&P showed if the resident or the resident's representative has executed one or more advanced directives, or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents' medical record and are readily retrievable by any facility staff. Medical record review for Resident 34 was initiated on 3/11/25. Resident 34 was readmitted to the facility on [DATE]. Review of Resident 34's POLST dated 2/24/25, showed Resident 34 had an advance directive. Review of Resident 34's H&P examination dated 5/2/24, showed Resident 34 had the capacity to understand and make decisions. Review of Resident 34's Advance Directive Acknowledgement dated 2/24/25, showed Resident 34 had executed an advance directive. Review of Resident 34's medical record failed to show a copy of the advance directive was maintained in Resident 34's medical record. On 3/12/24 at 1019 hours, an interview and concurrent medical record review for Resident 34 was conducted with the SSD. The SSD verified there was no copy of Resident 34's advance directive in the medical record, nor was it uploaded in Resident 34's EMR. The SSD stated Resident 34 had an advance directive, and the copy of the advance directive should have been maintained in the Resident 34's medical record and should be readily retrievable by the facility staff. On 3/14/25 at 0946 hours, the DON was informed and acknowledged the above findings.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate restraint use, including skin assessment, removal of restraint, and ROM exercises for three of three final sampled residents (Residents 41, 72, and 100) reviewed for the use of the restraints. * Resident 100 did not have a physician's order and consent for the use of the elbow restraint, and no documentation of the restraint removal, and if the arm was assessed and exercised every two hours. * Residents 41 and 72's medical records failed to show their hand mitten restraints were removed, and if their hands were assessed and exercised every two hours. These failures had the potential for the increased risk of resident's skin and soft tissue injury as well as the decrease in the ROM functions related to restraint use. Findings: Review of the facility's P&P titled Use of Restraints revised April 2017 showed the following: - Restraints will only be used with a physician's order and after consent is obtained, - The opportunity for motion and exercise for a period of not less than 10 minutes every two hours while the restraint is in use, and - Documentation will include the observations, range of motion and repositioning flowsheets. 1. On 3/11/25 at 0854 hours, an observation and concurrent interview was conducted at Resident 100's bedside. Resident 100 was observed lying in bed, with oxygen tubing connected to his tracheal tube. The resident had an elbow splint on his left arm, keeping the left arm extended and preventing the arm from bending. Resident 100's family member (Family Member 1) entered the room and went to the resident's bedside. Family Member 1 stated Resident 100 had the elbow splint to prevent him from pulling out his respiratory tubing. Family Member 1 stated she came in daily and would remove the resident's elbow splint when she was with him. Medical record review for Resident 100 was initiated on 3/11/25. Resident 100 was readmitted on [DATE]. Review of Resident 100's medical record failed to show for a physician's order and consent were obtained for an elbow splint. The record also failed to show documentation of an elbow splint removal, splint site observations and exercises performed as per the faiclity's P&P. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 0754 hours, Resident 100 was observed lying in bed, with the eyes closed; and the elbow splint was observed applied to the resident's left arm, keeping it extended. There were no visitors observed at the resident's bedside. On 3/13/25 at 0812 hours, an interview was conducted with CNA 6. CNA 6 stated Resident 100 had the elbow splint prior to the resident's readmission to the facility. CNA 6 stated the elbow splint was usually in placed every morning when he came in, and the resident's family would take it off when they were at the resident's bedside and put it back on when they leave. On 3/13/25 at 0823 hours, an interview and concurrent record review was conducted with the ADON and RN 3. The ADON stated Resident 100 had a previous order from a prior admission for the elbow splint. RN 3 verified there was no current physician's order and consent for the use of the left elbow splint, and no documentation to show the splint was removed every two hours. 2. Medical record review for Resident 41 was initiated on 3/11/15. Resident 41 was readmitted to the facility on [DATE]. Review of Resident 41's Order Summary Report showed the following physician's orders: - dated 2/1/25, for a right hand-mitten restraint to prevent from pulling out life sustaining tubes, and - dated 2/4/25, to release the restraint every two hours for 15 minutes for comfort, circulation, ROM exercises, repositioning, and monitoring of the skin integrity. Review of Resident 41's MAR for March 2025 showed the entry for the order to release the restraint every two hours for 15 minutes for comfort, circulation, ROM exercises, repositioning, and monitoring skin integrity and it was signed off per shift; however, it did not show what time it was performed, including the findings and outcome. On 3/13/25 at 1039 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 stated they would remove the splint every two hours and document on the MAR, with only one entry for the entire eight-hour shift. LVN 6 stated they did not document it anywhere else. LVN 7 further stated they used to document every two hours on a flowsheet, but the facility did not use the flow sheet anymore. 47474 3. Medical record review for Resident 72 was initiated on 3/11/25. Resident 72 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 72's annual MDS dated [DATE], showed Resident 72's cognitive skills for the daily decision making was severely impaired. Review of Resident 72's Order Summary Report for March 2025, showed the following physician's orders: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 12/2/24, to monitor the episodes of pulling out the life sustaining tubes, tracheostomy or GT/NGT (nasogastric tube) and tally with hashmarks, and - dated 1/24/25, for the restraint left hand mitten for the prevention of pulling out the life sustaining tubes per the family's preference, and restraint may be released every two hours for 15 minutes to check for the circulation, movement, sensation, and skin integrity. Multiple observations of Resident 72 were conducted in the resident's room. Resident 72 was observed wearing the left hand mitten restraint on the following dates and times: - 3/11/25 at 0841, and 1010 hours; and - 3/12/25 at 1201, and 1525 hours. On 3/13/25 at 1039 hours, a concurrent interview and medical record review was conducted with LVN 13. LVN 13 verified Resident 72 had a physician's order for the left hand restraint. LVN 13 stated the restraint was to be removed every two hours to ensure the resident's skin was assessed for any skin breakdown. Further review of Resident 72's MAR for March 2025 showed no documented evidence for the removal of the hand mitten restraint was documented every two hours as per the facility's P&P. LVN 13 stated the MAR only showed the total number of times Resident 72 attempted to remove the hand mitten restraint during the shift. LVN 13 verified the MAR did not show when the left hand mitten restraint was removed. On 3/13/25 at 1049, 1300, and 1500 hours, a follow-up observation was conducted for Resident 72. Resident 72 was observed wearing the left hand mitten restraint. On 3/13/25 at 1527 hours, a concurrent interview and medical record review was conducted with RNA 1. RNA 1 verified Resident 72 wore the left hand mitten restraint. RNA 1 stated the documentation were electronically entered on the EMR. When RNA 1 was asked if the RNA documentation included when the left hand mitten restraint was released, RNA 1 stated she did not document the times when the left hand mitten restraint was released. RNA 1 further stated the left hand mitten restraints should be removed every two hours. On 3/14/25 at 1300 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 72 had a physician's orders for the left hand mitten restraint. The DON further verified the facility did not have the paper medical record or documentation to show the left hand mitten restraint was released every two hours. The DON stated her expectations of the nurses were to remove the left hand mitten restraint every two hours to ensure hand circulation and assess the skin for dryness, infection, or discoloration. On 3/14/25 at 1320 hours, an interview was conducted with the Administrator and DON with the Regional Director of Operations present. The Administrator and DON were made aware and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, and medical record review, the facility failed to develop and implement the plan of care for one of 24 final sampled residents (Resident 100). * Resident 100's care plan failed to address the resident's ventilator use at night and left elbow restraint use. This failure had the potential for the resident's plan of care not being communicated to the interdisciplinary team. Findings: Medical record review for Resident 100 was initiated on 3/11/25. Resident 100 was readmitted on [DATE]. a. On 3/11/25 at 0854 hours, an observation was conducted at Resident 100's bedside. The resident had an elbow splint on his left arm, keeping the arm extended and preventing the arm from bending. On 3/12/25 at 0754 hours, Resident 100 was observed lying in bed, with their eyes closed. The elbow splint was observed applied to the resident's left arm, keeping it extended. On 3/13/25 at 0812 hours, an interview was conducted with CNA 6. CNA 6 stated Resident 100 had the elbow splint prior to the resident's readmission. CNA 6 stated the elbow splint was usually in place every morning when he came in, and Resident 100's family member took it off when they were at the facility and put it back on when they were leaving. On 3/13/25 at 0823 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified there was no care plan to address Resident 100's use of the elbow splint. b. Review of Resident 100's Order Summary Report showed the following physician's orders: - dated 1/22/25, for the resident to be on a ventilator at night, and specified the ventilator settings. - dated 1/22/25, for the resident to receive oxygen at 3 LPM via a tracheal piece/collar during AM and PM shifts, and to be on a ventilator at night. Review of Resident 100's plan of care failed to show the resident was being weaned off from the ventilator during the day and evening shifts, and on a mechanical ventilator during the night shift. On 3/12/25 at 1111 hours, an interview and concurrent record review was conducted with the Respiratory Lead. The Respiratory Lead stated Resident 100 was previously on a ventilator 24 hours a day, but the resident was currently only on the ventilator during the night shift from 2200 to 0600 hours, and was off from the ventilator and on supplemental oxygen for the rest of the day. The Respiratory Lead reviewed the resident's care plan and verified it did not address the resident being on the ventilator every night.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51539 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of 24 final sampled residents (Resident 47) remain free from accident hazards. * The facility failed to apply the tab alarm (a fall prevention device designed to alert caregivers when a person attempts to get out of the bed, chair, or wheelchair) for Resident 47 as ordered by the physician. This failure had the potential to place Resident 47 at risk for serious injuries. Findings: Review of the facility's P&P titled Alarm Monitor (undated) showed the licensed nurse will complete the physical restraint assessment to determine whether the resident is a candidate for alarm monitor. The assessments will include but are not limited to : - The medical symptoms warrant the use of alarm monitor. - The less restrictive measures attempted prior to the alarm. - The type of alarm to be used: - Tab alarm; - Pad alarm (a fall prevention device designed to alert caregivers when a person attempts to get out of the bed, chair or wheelchair); - Alarm in wheelchair; and - Alarm in bed. The P&P further showed the staff will apply the alarm to the resident, following the manufacturer's instructions, to ensure its functionalists. Medical record review for Resident 47 was initiated on 3/11/25. Resident 47 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 47's Order Summary Report dated 3/14/25, showed a physician's order dated 1/14/25, to monitor the placement of the pad/tab alarm every shift. Review of Resident 47's Standard Assessments-Falls showed Resident 47 had fallen on the following dates: - on 10/16 and 10/20/24; and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 1/8 and 1/14/25. Review of Resident 47's Change of Condition assessment dated [DATE], showed Resident 47 had lost her balance and fell backwards, hitting her head on the floor while trying to get up to go to the bathroom unassisted. Review of Resident 47's plan of care showed a care plan problem dated 1/14/25, addressing Resident 47's status post fall. The interventions included to apply the tab alarm in the bed and wheelchair. On 3/11/25 at 0906 hours, Resident 47 was observed in her room sitting in the wheelchair without the tab alarm. On 3/13/25 at 1004 hours, an observation and concurrent interview was conducted with LVN 1 for Resident 47. Resident 47 was observed in the dining room sitting in the wheelchair. Resident 47 was observed sitting on the tab alarm device and the tab alarm clip was not clipped onto the resident's clothing. When LVN 1 was asked if the resident should be sitting on the tab alarm device, LVN 1 stated the tab alarm should be hung on the wheelchair handle and the tab alarm clip should be clipped onto Resident 47's clothing. LVN 1 verified Resident 47's tab alarm was not properly applied on Resident 47. On 3/13/25 at 1056 hours, an observation and concurrent interview was conducted with CNA 5. Resident 47 was observed sitting in the wheelchair inside the bathroom. CNA 5 was observed wheeling Resident 47 out of the bathroom and handing the resident a cardigan sweater to wear. CNA 5 was asked if she had clipped the tab alarm onto Resident 47 after wheeling the resident out of the bathroom. CNA 5 verified she did not clip the tab alarm onto Resident 47 after assisting her. CNA 5 stated she knew Resident 47 was a high fall risk resident who benefited from the proper use of the tab alarm.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, medical record review, and facility P&P review, the facility failed to verify the GT placement, patency, and gastric residuals prior to starting an enteral tube feeding for one of four residents investigated for tube feeding (final sampled resident, Resident 100). This failure had the potential for adverse outcome related to a dislodged GT or increased gastric residuals. Findings: Review of the facility's P&P titled Enteral Tube Feeding via Continuous Pump revised March 2023 showed to verify placement of the GT, and when placement has been verified, flush the tubing with at least 30 ml of water. Medical record review for Resident 100 was initiated on 3/11/25. Resident 100 was readmitted to the facility on [DATE]. Review of Resident 100's Order Summary Report showed the following physician's orders: - dated 1/3/25, to check the GT feeding residual every shift and hold the enteral feeding for one hour if the residuals are more than 100 ml. - dated 1/3/25, to run 40 ml of water every hour to provide 800 ml/day. - dated 2/18/25, for Peptamen AF 1.2 (feeding formula) to be administered at 70 ml/hr for 20 hours daily via GT. On 3/11/25 at 1302 hours, an observation and concurrent interview was conducted with LVN 5 at Resident 100's bedside. LVN 5 was observed connecting the enteral feeding formula and water flush tubing to the resident's GT, and then starting the feeding pump. LVN 5 was not observed checking the GT for placement, checking for patency or for gastric residuals prior to starting the enteral feeding formula and water flush. LVN 5 verified they did not check the GT for placement, patency, or residuals; and stated the staff checked them earlier in the shift when administering the morning medications. On 3/11/25 at 1310 hours, an interview was conducted with the ADON. The ADON stated when starting a GT feeding, the protocol was to check the tube placement using a stethoscope and an air bolus into the GT to check for the placement and check gastric residuals before starting the feeding and hold if needed as per the physician's order.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure three of three final sampled residents (Residents 52, 82, and 712) reviewed for respiratory care were provided the appropriate respiratory care. * The facility failed to ensure Residents 82 and 712's oxygen tubings were labeled and dated. * The facility failed to ensure Resident 52 was administered the oxygen as per the physician's order. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: Review of the facility's P&P titled Oxygen Administration dated 10/2010 showed for the oxygen administration preparation, to verify that there is a physician's order for this procedure, review the physician's orders or facility protocol for oxygen administration, review the resident's care plan to assess for any special needs of the resident, and assemble the equipment and supplies as needed. Review of the facility's P&P titled Departmental (Respiratory Therapy) - Prevention of Infection dated 11/2011 showed to change the oxygen cannula and tubing every seven days or as needed. 1. Medical record review for Resident 82 was initiated on 3/11/25. Resident 82 was readmitted to the facility on [DATE]. Review of Resident 82's Order Summary Report for March 2025 showed a physician's order dated 1/23/25, to administer oxygen at a rate of 2 LPM via nasal cannula, may titrate up to 5 LPM for the oxygen saturation level less than 92% every shift. On 3/11/25 at 0923 hours, during the initial tour of the facility, an observation was conducted with Resident 82. Resident 82 was observed using the oxygen at 2 LPM via nasal cannula. The nasal cannula was unlabeled with the name and date on when it was changed. On 3/11/25 at 0926 hours, an observation and concurrent interview was conducted with LVN 3. When asked when Resident 82's nasal cannula was changed, LVN 3 stated he was not sure and would need to get a new nasal cannula tubing. LVN 3 verfied the nasal tubing should have been labeled with the name and date when it was changed for infection prevention and control. 2. Medical record review for Resident 712 was initiated on 3/11/25. Resident 712 was admitted to the facility on [DATE]. Review of Resident 712's Order Summary Report for March 2025 showed a physician's order dated 2/19/25, to administer the oxygen at a rate of 2 LPM via nasal cannula, may titrate up to 5 LPM for the oxygen saturation level less than 92% every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 0914 hours, during the initial tour of the facility, an observation was conducted with Resident 712. Resident 712 was observed receiving the oxygen at a rate of 2 LPM via nasal cannula. The nasal cannula was unlabeled with name and date when it was changed. On 3/11/25 at 0919 hours, an observation and concurrent interview was conducted with LVN 3. When asked when the nasal cannula was last changed for Resident 712, LVN 3 stated he was not able to recall when it was last changed. LVN 3 verified Resident 712's nasal cannula tubing was unlabeled with the name and date when it was changed. On 3/14/25 at 1045 hours, an interview was conducted with the DON. The DON was made aware and acknowledged Residents 82 and 712's nasal cannula tubing should have been labeled and dated on when it was changed. 50967 3. Medical record review for Resident 52 was initiated on 3/11/25. Resident 52 was readmitted to the facility on [DATE]. Review of Resident 52's H&P examination dated 5/14/24, showed Resident 52 had no capacity to understand and make decisions. Review of Resident 52's Order Summary Report showed a physician's order dated 5/28/24, for oxygen at a rate of 2 LPM continuously. On 3/11/25 at 0943 hours, during the initial tour of the facility, an observation was conducted for Resident 52. Resident 52 was observed lying in bed asleep with oxygen at a rate of 3 LPM via nasal cannula. On 3/12/25 at 1029 hours, a concurrent observation and interview was conducted with LVN 1. Resident 52 was observed lying in bed asleep with oxygen via nasal cannula. When asked to check Resident 52's oxygen rate, LVN 1 stated Resident 52's oxygen rate was set at 3 LPM. LVN 1 verified Resident 52's physician's order for the continuous oxygen was to be administered at a rate of 2 LPM. LVN 1 further stated the physician's order for Resident 52 's oxygen was not followed. On 3/14/25 at 1400 hours, an interview was conducted with the DON. The DON was asked regarding the importance of following physician's orders, the DON stated it was very important to follow physician's orders. The DON stated the licensed nurses must check the residents' oxygen saturation level, assess residents' color, and make sure to administer the oxygen as per the physician's order. The DON was informed and acknowledged the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the non-pharmacological interventions for pain management was provided when one of one final sampled resident (Resident 34) reviewed for pain management. This failure had the potential to negatively affect Resident 34's well-being. Findings: Review of the facility's P&P titled Pain - Clinical Protocol dated 3/2018 showed the physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. Further review of the P&P showed the staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, positioning/repositioning, local heat or ice, and the opportunity to talk about chronic pain. On 3/11/24 at 0904 hours, Resident 34 was observed lying in her bed. Resident 34 stated she had pain on the right side of her body. RN 1 was observed entering the room of Resident 34. Resident 34 reported having pain on the right side of her body to RN 1. RN 1 then stated she would look if Resident 34 had any pain medication. RN 1 was not observed offering the non-pharmacological interventions to manage Resident 34's pain. Medical record review for Resident 34 was initiated on 3/11/25. Resident 34 was readmitted to the facility on [DATE]. Review of the Resident 34's Care Plan Report dated 11/24/22, showed a care plan problem addressing Resident 34's pain with the goal of reducing episodes of pain or discomfort through appropriate interventions daily. The interventions included to provide non-pharmacological interventions: positioning for comfort, hot pack, cold pack, massage, and distraction. Review of Resident 34's H&P examination dated 5/2/24, showed Resident 34 had the capacity to understand and make decisions. Review of Resident 34 's Physician Order Summary showed an order dated 1/8/25, to administer tramadol (pain medicine) 50 mg one tablet by mouth every eight hours as needed for moderate to severe pain (pain level of 6-10, on a pain scale of 0 to 10, with 0 indicating no pain and 10 indicating the worst possible pain). Review of Resident 34's MAR dated 3/1- 3/31/25, showed Resident 34 had a pain level of 7 on 3/8/25 at 1700 hours, 3/9/25 at 1700 hours, 3/11/25 at 0742 hours, and 3/12/25 at 0959 hours. Further review of Resident 34's MAR showed the tramadol 50 mg medication was administered on the above dates and time. Further review of Resident 34's medical record did not show the non-pharmacological interventions were provided to Resident 34, when Resident 34 had a pain level of 7 on the above dates and times. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 at 1409 hours, an interview and concurrent medical record review for Resident 34 was conducted with RN 1. RN 1 verified the above findings and stated the non-pharmacological interventions should be provided to the residents to manage their pain. RN 1 stated there was no physician's order for the non-pharmacological interventions related to the use of the tramadol medication for Resident 34. RN 1 stated she was not able to find the documented evidence to show the non-pharmacological interventions were provided to Resident 34 when the resident had the pain level of 7 on the above dates and times. On 3/14/25 at 0946 hours, the DON was informed and acknowledged the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest physical well-being for one of one final sampled resident (Resident 10) reviewed for hemodialysis care. * The facility failed to ensure the licensed staff have the competency to assess the hemodialysis access site of Resident 10. This failure had the potential for the delay in hemodialysis site assessment and resident's poor health outcomes. Findings: Review of the facility's P&P titled Care of Resident with End-Stage Renal Disease (undated) showed the following: - Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents; and - Education and training of staff includes, specifically the nature and clinical management of ESRD, the type of assessment data that is to be gathered about the resident's condition on a daily basis or per shift basis and the care of grafts and fistulas. Medical record review for Resident 10 was initiated on 3/12/25. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's MDS dated [DATE], showed Resident 10's BIMS score was 14, indicating cognitively intact. Review of Resident 10's H&P examination dated 2/21/25, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Order Summary Report dated 3/13/25, showed the physician's order to monitor the shunt or graft for bruit (a whooshing sound heard with a stethoscope), and thrill (a buzzing vibration felt over the fistula) every shift. On 3/13/25 at 0904 hours, an interview was conducted with LVN 1. LVN 1 was asked how to check for the bruit and thrill. LVN 1 stated she would use the stethoscope to check for bruit and thrill. On 3/13/25 at 0929 hours, an interview was conducted with RN 3. RN 3 was asked how to assess Resident 10's Arteriovenous (AV) Fistula (a surgical procedure that creates a connection between an artery and a vein, typically in the forearm, to facilitate hemodialysis in patients with kidney failure) access site for dialysis and she stated check the lumen, sometimes it has two lumens. Furthermore, RN 3 stated the lumens should be intact and patent. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 1021 hours, an interview was conducted with LVN 2. LVN 2 was asked how to check for bruit and thrill on Resident 10's AV fistula access site. LVN 2 stated to listen to the flow for thrill and feel the vibrations for bruit. Review of facility's Dialysis In-Service dated 2/1/25, showed a lesson plan titled Care of Resident Receiving Renal Dialysis and licensed nurse attendees, included three out five licensed nurses who were interviewed. On 3/14/25 at 1400 hours, an interview was conducted with the DON. The DON was asked how to assess for bruit and thrill. The DON stated to listen using a stethoscope for the bruit and feel for the thrill. The DON was informed and acknowledged the above findings. Furthermore, the DON stated she would have an in-service for the licensed nurses on how to properly assess the access site of the hemodialysis residents.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure seven of eight final sampled residents (Residents 9, 45, 47, 51, 52, 89, and 99) reviewed for the side rail use remained free from the accident hazards associated with the use of the elevated side rails. * The facility failed to ensure the side rails assessment was accurate or completed, and/or the least restrictive measures were provided prior to the use of the side rails for Residents 9, 45, 47, 51, 52, 89, and 99. These failures had the potential to put the residents at risk for entrapment and serious injuries. Findings: Review of the facility's P&P titled Bed Safety and Bed Rails revised on 3/2023 showed the following: - The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for the use of bed rails have been met, including the attempts to use an alternatives, interdisciplinary evaluation, resident assessment, and informed consent; and - Alternatives to the use of side or bed rails are attempted. Alternatives may include roll guards, foam bumpers, lowering the bed and/or use of concave mattresses to reduce rolling off the bed. 1. On 3/12/25 at 0952 hours, an observation was conducted for Resident 51. Resident 51 was observed lying in bed, awake, alert, with the bilateral half upper side rails elevated. Medical record review for Resident 51 was initiated on 3/14/25. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's Order Summary Report showed a physician's order dated 10/4/23, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. Review of Resident 51's NA-Restraint-Physical (Initial Evaluation) dated 10/4/23, did not show if the alternatives were attempted prior to the application of the bilateral half upper side rails. Review of Resident 51's H&P examination dated 10/9/24, showed Resident 51 had the capacity to understand and make decisions. Review of Resident 51's MDS dated [DATE], showed Resident 51's BIMS score was 14, indicating cognitively intact. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 1019 hours, a concurrent observation and interview was conducted with CNA 2. CNA 2 verified Resident 51's bilateral half upper side rails were elevated. CNA 2 stated Resident 51 was able to hold on the side rails during the repositioning with an extensive assistance from the staff. On 3/14/25 at 1025 hours, a concurrent observation and interview was conducted with LVN 1. LVN 1 verified Resident 51's bilateral half upper side rails were elevated. LVN 1 stated Resident 51 was able to use the side rails as an enabler for repositioning with assistance from the staff. On 3/14/25 at 1029 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 verified there were no documentation to show if the alternatives were attempted prior to the application of Resident 51's bilateral half upper side rails. RN 2 verified and stated the least restrictive interventions must be attempted prior to the application of the side rails. 2. On 3/11/25 at 0943 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with CNA 2. Resident 52 was observed lying in bed asleep with the bilateral upper half side rails elevated. CNA 2 stated Resident 52's bilateral arms and hands were contracted and unable to grab or use the side rails. Medical record review for Resident 52 was initiated on 3/11/25. Resident 52 was readmitted to the facility on [DATE]. Review of Resident 52's H&P examination dated 5/14/24, showed Resident 52 had no capacity to understand and make decisions. In addition, Resident 52 had a history of Spastic Quadriplegic Cerebral Palsy (the most severe form of spastic cerebral palsy, affecting all four limbs, often the trunk and face, with increased muscle tone (spasticity) and resulting in challenges with movement, balance, and coordination), and contracture on the right wrist and both hands. Review of Resident 52's NA-Restraint-Physical (Initial Evaluation) dated 5/12/24, showed the summary of the IDT review for Resident 52 to have the bilateral upper half side rails as an enabler for repositioning and ease of mobility. Review of Resident 52's MDS dated [DATE], under the section for the Functional Abilities, showed Resident 52 had an impairment to both upper extremities and was dependent for staff assistance for the mobility. Review of Resident 52's Order Summary Report dated 3/12/25, showed a physician's order dated 5/13/24, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. On 3/12/25 at 1029 hours, a concurrent observation and interview was conducted with LVN 1. LVN 1 verified Resident 52's bilateral upper half side rails were elevated. LVN 1 stated Resident 52's bilateral upper extremities were still and contracted. In addition, LVN 1 stated Resident 52 was a total care with the ADL care and unable to use the side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 1044 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 stated Resident 52 was not appropriate to have the bilateral upper half side rails due to Resident 52 could not grab the side rails to help turn or reposition. On 3/14/25 at 1400 hours, an interview was conducted with the DON. The DON verified Resident 52 could not grab the side rails and stated she would inform the physician to obtain an order to discontinue the side rails. The DON was informed and acknowledged the above findings. 51352 3. On 3/11/25 at 0844 hours, an observation was conducted for Resident 45. Resident 45 was observed lying in bed on his back with the bilateral upper half side rails elevated. Medical record review for Resident 45 was initiated on 3/11/25. Resident 45 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 45's NA-Restraint-Physical (Initial Evaluation) dated 10/31/24, showed the following alternatives were attempted prior to the application of the side rails: - anticipating hunger, pain, heat, cold; - acceptance of risk; - normal schedule/individual routine; - medication review; and - bloodwork/labs review. Review of Resident 45's Side Rail/Entrapment Assessment/Care Plan dated 10/31/24, showed the recommendation for the bilateral upper half side rails was due to Resident 45's generalized muscle weakness. Review of Resident 45's H&P examination dated 11/2/24, showed the resident had no capacity to understand and make decisions. Review of Resident 45's Order Summary Report showed a physician's order dated 3/1/25, for the bilateral upper half side rails up when in bed for positioning and ease of mobility. On 3/12/25 at 1411 hours, a concurrent observation and interview was conducted with LVN 1. LVN 1 verified Resident 45's bed had the bilateral upper half side rails elevated. On 3/12/25 at 1429 hours, an interview and concurrent medical record review for Resident 45 was conducted with the MDS RN. The MDS RN verified Resident 45's medical record failed to show the least restrictive alternatives were attempted prior to the installation of the bilateral upper half side rails. 51539 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Medical record review for Resident 47 was initiated on 3/11/25. Resident 47 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 47's NC-Side Rail/ Entrapment Assessment/Care Plan dated 4/13/24 and 1/11/25, showed the reason for Resident 47's use of the bilateral upper half side rails was due to the resident's generalized weakness. Review of Resident 47's Order Summary Report dated 3/14/25, showed a physician's order dated 1/12/25, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. On 3/14/25 at 1308 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated Resident 47 should have an assessment completed for the physical restraint in her medical record prior the use of the bilateral upper half side rails. RN 2 was asked if a physical restraint assessment was initiated for Resident 47, RN 2 stated she did not see it in her medical record. Furthermore, RN 2 stated the least restrictive measure should have been implemented and tried for Resident 47 prior to ordering the bilateral upper half side rails for the resident. On 3/14/25 at 1335 hours, an interview and concurrent medical record review was conducted with the MDS RN. The MDS RN was asked if Resident 47 had a physical restraints assessment completed before the physician ordered the bilateral upper half side rails. The MDS RN stated, no and verified there was no physical restraint assessment documented for Resident 47. The MDS RN was asked if the least restrictive measures regarding the restraints were used for Resident 47. The MDS RN stated there was no way to know since the physical restraint assessment was not completed for Resident 47. 5. Medical record review for Resident 9 was initiated on 3/11/25. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's NA-Restraint-Physical (Initial Assessment) dated 1/29/25, the section for the History/Alternatives Attempted failed to show any alternative measures were attempted prior to Resident 9's use of the bilateral upper half side rails. Review of Resident 9's Order Summary Report dated 3/13/25, showed a physician's order dated 1/30/25, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. On 3/14/25 at 1314 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was asked what alternative measures were attempted and documented for Resident 9 prior to the use of the bilateral upper half side rails. RN 2 stated the restraint-physical assessment had no documentation if any alternative measures were provided prior to the use of the bilateral upper half side rails for Resident 9. On 3/14/25 at 1407 hours, an interview and concurrent medical record review was conducted with the MDS RN. The MDS RN was asked what alternative measures were attempted for Resident 9 prior to the use of the bilateral upper half side rails. The MDS RN stated the NA-Restraint-Physical assessment had no documented evidence if any alternative measures were provided prior to the use of the bilateral upper half side rails for Resident 9. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Medical record review for Resident 99 was initiated on 3/11/25. Resident 99 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 99's Order Summary Report dated 3/13/25, showed a physician's order dated 2/24/25, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. Review of Resident 99's NA-Restraint- Physical (Initial Assessment) dated 2/24/25, the section for the History/Alternatives Attempted failed to show any alternative measures were attempted prior to Resident 99's use of the bilateral upper half side rails. On 3/14/25 at 1316 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was asked what alternative measures were attempted prior to the use of the bilateral upper half side rails for Resident 99. RN 2 stated there was no documented evidence if any alternative measures were provided prior to the use of the bilateral upper half side rails for Resident 99. On 3/14/25 at 1350 hours, an interview and concurrent medial review was conducted with the MDS RN. The MDS RN was asked what alternative measures were attempted prior to the use of the bilateral upper half side rails for Resident 99. The MDS RN stated there was no documented evidence if any alternative measures were provided prior to the use of the bilateral upper half side rails for Resident 99 and detailed reason for the use of the side rails. 7. Medical record review for Resident 89 was initiated on 3/11/25. Resident 89 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 89's NA-Restraint-Physical (Initial Assessment) dated 8/27/24, the section for the History/Alternatives Attempted failed to show any alternative measures were attempted prior to Resident 89's use of the bilateral upper half side rails. Review of Resident 89's Order Summary Report dated 3/13/25, showed a physician's order dated 8/27/24, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. Review of Resident 89's NA-Restraint-Physical (Initial Assessment) dated 8/27/24, the section for the History/Alternatives Attempted failed to show any alternative measures were attempted prior to Resident 89's use of the bilateral upper half side rails. On 3/14/25 at 1321 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was asked what alternative measures were attempted and documented prior to the use of the bilateral upper half side rails for Resident 89. RN 2 stated there was no documentation if any alternative measures were provided prior to the use of the bilateral upper half side rails for Resident 89. On 3/14/25 at 1405 hours, an interview and concurrent medial review was conducted with the MDS RN. The MDS RN was asked what alternative measures were attempted prior to the use of the bilateral upper half side rails for Resident 89. The MDS RN stated there was no documentation if any alternative measures were provided prior to the use of the bilateral upper half side rails for Resident 89.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the physician's orders matched the medication label provided by the pharmacy and medication was administered as ordered by the physician for two of three residents (nonsampled residents, Residents 18 and 48) reviewed during the medication administration as evidence by the following: * The facility failed to ensure Resident 18's physician's order for the digoxin (heart medication) matched the instructions shown on the medication label of the bubble pack provided by the pharmacy. * The facility failed to ensure Resident 48's metoprolol tartrate (blood pressure medication) medication was administered with food as ordered by the physician. These failures posed the risk for negative health outcomes to the residents. Findings: Review of the facility's P&P titled Administering Medications revised 3/2023 showed the medications are administered in a safe and timely manner, and as prescribed. The medication are administered in accordance with prescriber orders, including any required time frame. Review of the facility's P&P titled Medication Orders revised 3/2023 showed when recording orders for the medication, to specify the type, route, dosage, frequency, and strength of the medication ordered. 1. Medical record review for Resident 18 was initiated on 3/11/25. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 18's H&P examination dated 6/18/24, showed Resident 18 had no mental capacity to understand and make decisions. Review of Resident 18's Order Summary Report for March 2025 showed a physician's order dated 6/17/24, for digoxin 125 mcg two tablets (250 mcg) via GT one time a day for atrial fibrillation (an abnormal heartbeat) and hold if the HR less than 60 beats per minute. Review of Resident 18's MAR for March 2025 showed Resident 18 was administered with two tablets of digoxin 125 mcg medication at 0900 hours, from 3/1 to 3/12/25. Review of Resident 18's digoxin medication label on the bubble pack provided by the pharmacy showed the instructions to administer one tablet of digoxin 250 mcg via GT one time a day for atrial fibrillation and hold if the HR less than 60 beats per minute. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 0914 hours, a concurrent medication administration observation and medical record review for Resident 18 was conducted with LVN 8. LVN 8 verified the medication label on the bubble pack from the pharmacy showed to administer one tablet of digoxin 250 mcg tablet medication. LVN 8 further verified he administered one tablet of digoxin 250 mcg to Resident 18. On 3/12/25 at 1409 hours, a follow-up interview and concurrent medical record review was conducted with LVN 8. LVN 8 verified Resident 18's physician's order for the digoxin medication showed to administer two tablets of the digoxin 125 mcg; however, the medication label on the bubble pack provided by the pharmacy showed to administer one tablet of digoxin 250 mcg medication. LVN 8 acknowledged the orders and instructions did not match and verified there was no evidence a change of direction label was placed on Resident 18's digoxin medication bubble pack. LVN 8 stated the instructions should match with the physician's orders to ensure the right dose of the medication was administered. 2. Medical record review for Resident 48 was initiated on 3/11/25. Resident 48 was admitted to the facility on [DATE]. Review of Resident 48's Order Summary Report for March 2025 showed a physician's order dated 2/3/25, for metoprolol tartrate 50 mg one tablet by mouth two times a day for hypertension (elevated blood pressure), hold if the SBP less than 110 mmHg or HR less than 60 beats per minute, and to administer with food. Review of Resident 48's H&P examination dated 2/6/25, showed Resident 48 had the capacity to understand and make decisions. On 3/12/25 at 1015 hours, a medication administration observation was conducted for Resident 48 with LVN 1. LVN 1 was observed administering the metoprolol tartrate medication to Resident 48 without food instead of with food as ordered by the physician. On 3/12/25 at 1346 hours, an interview was conducted with LVN 1. LVN 1 verified she did not administer Resident 48's metoprolol tartrate medication with food as ordered by the physician. LVN 1 stated she should have provided Resident 48 with food as instructed in the physician's order. LVN 1 further stated she could have provided Resident 48 with food such as crackers or pudding. On 3/14/25 at 1320 hours, an interview was conducted with the Administrator and DON with the Regional Director of Operations present. The Administrator and DON were made aware and acknowledged all of the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49324 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage and disposal of the medications. * The facility failed to store the external and internal medications separately in Medication Storage Room A and Medication Cart G. * The facility failed to ensure seven out of eight sampled Medication Carts (Medication Carts A, B, C, D, E, G, and H) were maintained in a clean and sanitary manner. * The facility failed to ensure Residents 19 and 98's Assure Platinum Meter Serial Number in the blood glucose monitoring system record were accurately documented. These failures had the potential to negatively impact the residents' well-being, and the potential for the medications to lose the stability and effectiveness. Findings: Review of the facility's P&P titled Storage of Medications dated 3/2023 showed the facility stores all the drugs and biologicals in a safe, secure, and orderly manner. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. 1.a. On 3/12/25 at 0926 hours, an inspection of Medication Storage Room A and concurrent interview was conducted with RN 1. Boxes of bisacodyl stimulant laxative suppository (medication to relieve constipation) were observed being stored together with the boxes of artificial tears lubricant eyedrops (medication to moisten dry eyes) on the second shelf. RN 1 acknowledged the rectal medications and eyedrops medications should not be stored together. b. On 3/12/25 at 1200 hours, an inspection of Medication Cart G and concurrent interview was conducted with LVN 6. An open box of loperamide hcl 2 mg tablets (medication to relieve diarrhea), an open spray bottle of fluticasone propionate 50 mg nasal spray (medication to reduce inflammation of nasal passages) and three boxes of artificial tears lubricant eyedrops were stored together in the left middle drawer of Medication Cart G. LVN 6 verified the medications should not be stored together. 2.a. On 3/12/25 at 1024 hours, an inspection of Medication Cart A and concurrent interview was conducted with RN 1. The following was observed: - A bag of disinfecting caps for intravenous ports had sticky yellow residue. - The top drawer compartment had a streak of sticky yellow brown residue. RN 1 verified the above findings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 3/12/25 at 1033 hours, an inspection of Medication Cart B and concurrent interview was conducted with RN 1. The following was observed: - The drawer compartment containing the tuberculin syringes was not clean and had dried brown medication residue. - The drawer compartment containing scissors and tape for labeling had dried yellow brown medication residue. RN 1 verified the above findings. c. On 3/12/25 at 1047 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 7. The following was observed: - The top drawer compartment was not clean and had dried brown residue. - A bottle of Lactulose Solution (medication to relieve constipation) medication had spilled medication residue on the top part of the bottle. LVN 7 verified the above findings and stated the cart should be clean for infection prevention and control. d. On 3/12/25 at 1108 hours, an inspection of Medication Cart D and concurrent interview was conducted with LVN 8. The following was observed: - The bottom drawer was not clean and had spilled dried yellow brown residue. - A bottle of liquacel concentrated liquid protein (protein supplement) had spilled sticky medication residue on the upper part of the bottle. - A bottle of milk of magnesia (medication to relieve constipation) medication had spilled medication residue on the upper part of the bottle. - A bottle of lactulose Solution medication had spilled medication residue on the upper part of the bottle. LVN 8 verified the above medication bottles should be clean for infection prevention and control. e. On 3/12/25 at 1135 hours, an inspection of Medication Cart E and concurrent interview was conducted with LVN 3. The following was observed: - The top drawer compartment was not clean and had dried brown residue. - The bottom drawer compartment was not clean and had dried brown medication residue. LVN 3 verified the medication cart drawers should be clean for infection prevention and control. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. On 3/12/25 at 1200 hours, an inspection of Medication Cart G and concurrent interview was conducted with LVN 6. The following was observed: - A bottle of milk of magnesia medication had spilled medication residue on the upper part of the bottle. - A bottle of liquacel concentrated liquid protein had spilled sticky medication residue on the upper part of the bottle. - A bottle of Lactulose Solution medication had spilled medication residue on the upper part of the bottle. - The bottom drawer was not clean and had brown residue. LVN 6 verified the above findings. g. On 3/12/25 at 1330 hours, an inspection of Medication Cart H and concurrent interview was conducted with LVN 9. The following was observed: - The top drawer compartment with the tongue depressors was not clean and had white powdered medication residue. - The compartment drawer with the antifungal ointment medication was not clean and had white powdered medication residue. LVN 9 verified the above findings. 3. On 3/12/25 at 1047 hours, an interview and concurrent medical record review of Resident 98's Assure Platinum Blood Glucose Monitoring System was conducted with LVN 7. Resident 98's recorded serial number on the Assure Platinum Blood Glucose Monitoring System was documented as 1070-4372514. However, the label on Resident 98's Assure Platinum Blood Glucose Meter Machine's serial number was 1040-4273532. LVN 7 verified the numbers needed to be corrected immediately. LVN 7 further stated the machine was used solely for Resident 98 and labeled with Resident 98's name. On 3/12/25 at 1135 hours, an interview and concurrent medical record review of Resident 19's Assure Platinum Blood Glucose Monitoring System was conducted with LVN 8. Resident 19's recorded serial number on the Assure Platinum Meter Serial Number was documented as 1040-4324799. However, the label on Resident 19's Assure Platinum Blood Glucose Meter Machine's serial number was 1040-4324798. LVN 8 verified the numbers were recorded incorrectly. LVN 8 stated Resident 19's Assure Platinum Blood Glucose Meter Machine was used solely for Resident 19 since the machine and labeled with Resident 19's name. On 3/14/25 at 1045 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39856 Based on observation, interview, facility document review, and P&P review, the facility failed to ensure the DSS was competent in the day-to-day supervision of the kitchen as evidenced by: 1. Fried eggs were not pasteurized or cooked thoroughly for one of three non-sampled residents (Resident 33). 2. The DSS did not know the correct procedure to calibrate a thermometer. 3. The DSS did not know the manufacturer guidelines for the health shakes. 4. The DSS did not ensure food preparation equipment was replaced when worn. 5. The DSS did not ensure beard coverings were available for kitchen staff with facial hair. 6. The DSS competency was not evaluated by the Administrator. These failures posed the risk for 62 vulnerable residents who received food prepared in the kitchen to be exposed to potential food borne illnesses. Findings: Review of the facility's document titled Order Listing Report dated [DATE], showed 62 residents received food prepared in the kitchen. Review of the job description titled Dietary Manager signed and dated by the DSS on [DATE], showed the Dietary Manager supervises the operations of the Dietary Department .the quality of meals meets the facility standards and ensuring all facility dietary and food handling standards are met. Essential Duties and Responsibilities include the following supervises the operation of the food service department. Responsible for knowing, understanding, and conveying to other dietary staff personnel the Federal and State rules and regulations regarding nursing home dietary requirements and is responsible for their enforcements within the scope of the Dietary Department. Inspects and evaluates the department regularly to ensure compliance with all state and federal guidelines. Review of the employee file for the DSS did not show a competency evaluation. 1. According to the CDC, Salmonella are bacteria (germs) that can make people sick with an illness called salmonellosis. Anyone can get a Salmonella infection. Some groups of people have an increased chance of infection, and some people may become seriously ill. These groups include: Adults who are [AGE] years and older with underlying medical problems, such as heart disease, adults who are 65 and older, and people who have a weakened immune system. https://www.cdc.gov/salmonella/about/index.html#:~:text=People%20at%20risk&text=These%20groups%20include%3A,who%20are%2065%20and%20older (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the California Code, Health and Safety Code - HSC S 114091 showed in part, in a licensed health care facility the following shall apply . Pasteurized shell eggs or pasteurized liquid, frozen, or dry eggs or egg products shall be substituted for raw shell eggs in the preparation of foods. A reference review from the California Department of Food and Agriculture (CDFA) dated [DATE], showed California Shell Egg Food Safety Compliant or the abbreviated CA SEFS Compliant statement means that the eggs you're purchasing have gone through added measures to reduce the risk of Salmonella Enteritidis (SE) contamination, as specified in California Code of Regulation Title 3 Section1350 (3 CCR 1350). SE is the number one food borne illness associated to raw shell eggs. On [DATE] at 0756 hours, during the initial tour of the kitchen with the DSS, three cases of CA SEFS Compliant raw shelled eggs were observed in the walk-in refrigerator. The DSS confirmed she had not been able to order pasteurized eggs due to the current egg shortage. On [DATE] at 1121 hours, an interview was conducted with the RD. The RD stated the eggs stored in the walk-in refrigerator were safe for resident consumption because they were SEFS. On [DATE] at 11:35 AM an interview was conducted with the DSS. The DSS stated no residents were served under cooked eggs. On [DATE] at 0720 hours, during the breakfast meal service, the DSS was observed to be cooking fried eggs. An observation of Resident 33's breakfast meal was conducted with the RD. The fried egg on Resident 33's breakfast meal tray was not fully cooked, and the yolk was runny. The RD confirmed the findings and returned Resident 33's breakfast plate to the DSS to cook the fried egg until the yolk was fully cooked. The RD was asked how she would ensure all the fried eggs were completely cooked. The RD stated she would in-service the kitchen staff and nursing. Cross reference to F812, example #1. 2. A reference review from the Wisconsin Department of Agriculture titled Calibrating Thermometer dated , d+[DATE] showed thermometers should be calibrated regularly to ensure accurate temperatures. The ice-point method is the most widely used method to calibrate a dial or digital thermometer. Fill a large container with crushed ice, then add clean cold tap water until the container is full. Stir the mixture well. Place the thermometer stem or probe into the ice water. Make sure the thermometer is not touching the bottom or sides of the glass. Wait 30 seconds or until the reading stays steady. The attached picture of the reference shows the thermometer being held in the glass of ice and water, not touching the bottom or sides of the glass. Step three: Adjust the thermometer so it reads 32 degrees Fahrenheit (F). On [DATE] at 0700 hours, during the breakfast meal tray line, an observation and concurrent interview was conducted with [NAME] 1. One analog thermometer (a thermometer using a pointer or needle which moves across a dial to indicate temperature, rather than displaying a digital reading) was observed in a plastic cup with water and ice. The thermometer was resting on the side and bottom of the cup. [NAME] 1 stated this was the way he calibrated a thermometer. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 0705 hours, an interview was conducted with the DSS. The DSS was asked if it was correct for the thermometer to be resting on the side and bottom of the glass during the calibration process. The DSS stated it was ok for the thermometer to rest on the side and bottom of the cup and confirmed this was way the thermometers were calibrated every meal. On [DATE] at 1146 hours, during the lunch meal tray line, three analog thermometers were observed in a plastic cup with water and ice. All three analog thermometers were resting on the sides and bottom of the cup. The DSS stated, If this is not the correct way to calibrate a thermometer, can you tell us the correct way? [NAME] 1 used one of the analog thermometers that was in the ice/water mixture to take the lunch food temperatures. Using a digital thermometer, the surveyor also took the lunch food temperatures. The temperature for the puree vegetables was 180 degrees F per the facility's analog thermometer versus 208 degrees F per the surveyor's digital thermometer, a 28-degree difference. [NAME] 1 obtained a second thermometer from the ice/water mixture. The temperature for the puree chicken was 160 degrees F per the facility analog thermometer vs 210 degrees F per the surveyor's digital thermometer, a 50-degree difference. The RD confirmed the findings and asked if the facility was calibrating the thermometer incorrectly. 3. On [DATE] at 0756 hours, during the initial tour of the kitchen with the DSS, two cases of completely thawed health shakes (a nutritional supplement) were observed in the walk-in refrigerator. The DSS stated the health shakes were stored in the freezer then put in the refrigerator. One case of the health shakes was dated [DATE], when removed from the freezer, and the other case of health shakes was dated [DATE], when removed from the freezer. The DSS was asked how long the health shakes were allowed in the refrigerator once thawed. The DSS stated 30 days. The DSS was shown the manufacturer guidelines on the health shake carton which read the shakes are to be discarded after 14 days once thawed. The DSS confirmed the health shakes dated [DATE], were expired and would be discarded. Cross reference to F812, example #6.a. 4. According to the USDA Food Code Section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces and Utensils, (A) Equipment, food-contact surfaces and utensils shall be clean to the sight and touch. On [DATE] at 0756 hours, during the initial tour of the kitchen with the DSS, the can opener blade stainless steel was observed to be excessively worn. The DSS confirmed the finding and stated she had another blade she could have the maintenance put on the can opener. Cross reference to F812, example #9. a. On [DATE] at 0955 hours, during an observation of the puree food preparation with [NAME] 1 and the DSS present, the Robot Coupe, a device used to puree food was observed with a brown residue on the blade assembly. The DSS confirmed the finding and stated the residue did not come off with cleaning because the blade assembly was old. The DSS stated she would need to order a new blade assembly. Cross reference to F812 example #9.a. 5. According to the USDA Food Code 2022, Section ,d+[DATE].11 Hair Restraints, Effectiveness, Food employees shall wear hair restraints such as hats, hair covering or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, and utensils. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Sanitation and Infection Control (undated) showed beard and/or moustache should be closely trimmed or must be covered at all times. On [DATE] at 1355 hours, in the kitchen food preparation area, an observation and concurrent interview was conducted with DA 2 and [NAME] 2. Both employees had uncovered facial hair. When asked if their facial hair should be covered, [NAME] 2 stated the kitchen used to have beard restraints but not any longer. On [DATE] at 1359 hours, an interview was conducted with the DSS. The DSS was informed of DA 2 and [NAME] 2's uncovered facial hair. The DSS verified the findings and stated any facial hair must be covered with a hair restraint. The DSS stated she would order beard restraints. Cross reference to F812, example #8. 6. On [DATE] at 1044 hours, an interview was conducted with the Administrator. The Administrator was asked how she ensured her department directors were competent. For the kitchen, the Administrator stated she relied on the RD to assess the DSS competency. On [DATE] at 1107 hours, an additional interview was conducted with the Administrator. The Administrator stated the previous RD did not voice any concerns regarding the DSS or kitchen. On [DATE] at 1110 hours, an interview was conducted with the RD. The RD was asked about the competency evaluation of the DSS. The RD stated she did not do an actual competency checklist for the DSS; however, would communicate with the Administrator if there were any concerns with the kitchen or DSS. The RD stated however, she had only worked for the facility for two weeks and could not speak for the previous RD. On [DATE] at 0849 hours, a concurrent interview was conducted with the DSS and RD. The DSS was asked who assessed the DSS's competency. The DSS stated the Administrator was responsible to assess her competency. The DSS confirmed there was no competency evaluation in writing from the Administrator regarding her competency.

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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. 39856 Based on observation, interview, facility document review, and P&P review, the facility failed to ensure two of 10 kitchen employees (Cook 1 and DA 1) were competent in their daily job duties when: 1. [NAME] 1 failed to perform the following: - Follow proper hand hygiene, - Take food temperatures correctly during meal service, - Prepare resident meals according to the facility recipes, - Accurately test the sanitizing solution used to sanitize food preparation surfaces, and - Utilize the manual dishwashing process correctly. 2. DA 1 was unable to read the temperature dial of the dish machine. These failures posed the risk for unsafe food handling practices which could expose the 62 residents who received food prepared in the kitchen to food borne illnesses. Findings: Review of the facility's document titled Order Listing Report dated 3/11/25, showed 62 residents received food prepared in the kitchen. 1. Review of the facility's job description titled [NAME] signed by [NAME] 1 (undated) showed the [NAME] is responsible for the preparation of all dietary components in accordance with the menu of the day utilizing sanitary standards established for the department by the facility and the appropriate regulatory agencies. Review of the facility's document titled Competency Checklist signed and dated by [NAME] 1 and the DSS dated 1/6/25, showed [NAME] 1 was competent in hand hygiene, able to identify the appropriate ppm of quaternary solution, and food temperature log. a. Review of the facility's P&P titled Hand Washing undated, showed wash hands after handling cart, soiled dishes and utensils. Before and after handling foods. Wash hands when changing gloves. Change disposable gloves when: * Gloves get ripped or torn * Beginning a different task. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* After coughing or sneezing into hands, use of handkerchief or tissue, smoking, touching hair or face, and using the toilet. * After handling waste * During food preparation, as often as necessary when it get soiled and when changing task to prevent cross contamination. Review of the facility's document titled Record of In-service Training dated 4/18/24 and 8/7/24, showed the policy titled Sanitation and Infection Control was covered. [NAME] 1 was in attendance for both in-services. On 3/11/25 at 0756 hours, during the initial tour of the facility's kitchen with the DSS, [NAME] 1 was asked to discard two rubber spatulas and wash a dirty peeler. [NAME] 1 touched the trash can lid to throw away the rubber spatulas, then proceeded to wash the dirty peeler. [NAME] 1 did not change his gloves or wash his hands after touching the trash can. After washing the peeler, [NAME] 1 wiped his wet gloved hands on his apron and returned to food preparation. On 3/12/25 between 1002 hours and 1025 hours, an observation of the puree meal preparation was conducted with [NAME] 1. [NAME] 1 was observed preparing puree meat with gloved hands. [NAME] 1 removed his gloves to wash the RC in the automatic dish machine. [NAME] 1 touched the dish machine tray and dish machine handle then donned a new pair of gloves without washing his hands. [NAME] 1 proceeded with the puree meal preparation. During the puree meal preparation, [NAME] 1 rested his gloved hands on the counter. Without changing his gloves or washing his hands, [NAME] 1 continued to touch multiple objects in the kitchen; a cooking pan, a blender, and an oven handle while preparing the puree food for residents. [NAME] 1 washed the RC again in the automatic dish machine using the same gloved hands then he prepared the chicken broth which he added to the noodles and continued to puree the food for the facility residents. On 3/13/25 at 0837 hours, a concurrent interview was conducted with the DSS and RD. Both the RD and DSS agreed the Cooks should wash their hands and change gloves prior to starting a new task such as food preparation. Cross reference to F812, example #2. b. Review of a professional literature titled Food Safety Tips: Using a Food Thermometer dated 9/10/24, showed when using a thermometer to measure internal temperature, use these tips: - Insert the thermometer into the thickest part of the meat or the center of the casserole. - Make sure the thermometer is not touching the pan, bone or fat. Foodhero.org/healthy-food/food-safety-tips-using-food thermometer#:~:text=When%20using%20a%20thermometer%20to,the%20pan%2C%20bone%20or%20fat. Review of the facility's document titled In-service Daily Food Temperatures dated 5/10/24, showed [NAME] 1 was in attendance. The in-service reviewed the policy for thermometer calibration; however, did not include how to correctly take food temperatures. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 1146 hours, an observation of the lunch meal tray line and concurrent interview was conducted with [NAME] 1. [NAME] 1 was taking food temperatures using an analog thermometer. While taking the food temperatures, the thermometer was touching the hot pan. [NAME] 1 was asked if it was correct to touch the pan with the thermometer. [NAME] 1 did not answer. [NAME] 1 was asked to read the temperature on the food thermometer dial. [NAME] 1 stated he could not read the temperature on the thermometer because it was too small. On 3/13/25 at 0837 hours, a concurrent interview was conducted with the DSS and RD. When asked if a [NAME] should be proficient in taking food temperatures, the RD stated the [NAME] should be able to accurately take food temperatures and read the thermometer. The RD further stated she would order a digital thermometer that was easier to read. c. Review of the facility's P&P titled Menu (undated) showed the standard menu will ensure for the nutritional adequacy of all the diets, offer a variety of food in adequate amounts at each meal, and a standardized food production. On 3/12/25 between 1002 and 1021 hours, an observation of the puree preparation for the lunch meal and concurrent interview was conducted with [NAME] 1. The recipes for puree sweet and sour chicken, puree stir fry vegetables, and puree sesame noodles were not followed. On 3/13/25 at 0837 hours, a concurrent interview was conducted with the RD and DSS. The RD confirmed all recipes should be followed. Cross reference to F803, examples #1, #2, and #3. d. Review of the facility's P&P titled Sanitizing Equipment and Surfaces undated, showed sanitizer levels will be checked and recorded at least once per shift to ensure equipment and surfaces are sanitized appropriately. Procedure: 3. Test strip should read 200-400 ppm refer to manufacturer's recommendations. Review of the sanitizing test strip container showed: Dip paper in quat solution , for ten seconds, Don't shake. Review of the facility's document titled In-service titled Manual dishwashing; Quat bucket dated 3/4/25, showed [NAME] 1 was in attendance. On 3/12/25 at 0948 hours, an observation of the sanitizing solution and concurrent interview was conducted with [NAME] 1. [NAME] 1 was asked to test the ppm of the sanitizing solution. [NAME] 1 held the sanitizing test strip in the sanitizing solution for three seconds. The test strip read 100 ppm. [NAME] 1 obtained a second test strip and held it in the sanitizing solution for three seconds and stirred the test strip in the solution. [NAME] 1 was shown with the instructions on the sanitizing test strip container. [NAME] 1 was asked to test the strip a third time. Using the surveyor's phone stopwatch, the testing was monitored for ten seconds. [NAME] 1 held the sanitizing test strip in the sanitizing solution for ten seconds and the strip read 200 ppm. On 3/13/25 at 0837 hours, a concurrent interview was conducted with the RD and DSS. The DSS confirmed the kitchen employees should know how to test the sanitizing solution correctly. e. Review of the facility's P&P Manual Dish Washing - 2 or 3 compartment sink undated showed, two-compartment sink procedures: (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Fill sink 1 with warm water and soap to proper level to complete wash process. Scrub all surfaces to clean and remove food and other debris. 2. Drain sink 1 and rinse walls with fresh water. 3. Refill sink 1 to proper level to freely rinse all items with fresh water only. 4. Fill sink 2 with fresh water to proper level with water from cold line and add Quaternary sanitizer. 5. Test to ensure paper solution of no less than 200 ppm to no more than 400 ppm is available with proper test strips. 6. Place all items in solution for no less than 1 minute. 7. Place on a clean surface and allow to dry clean. Review of the facility's document titled In-service titled Manual dishwashing; Quat (sanitizing solution) bucket dated 3/4/25, showed [NAME] 1 was in attendance. On 3/11/25 at 0756 hours, during initial tour of the facility's kitchen, an observation of [NAME] 1 and concurrent interview was conducted with the DSS. [NAME] 1 was asked to wash a dirty peeler. [NAME] 1 used the cleaning solution located in a green bucket by dipping the peeler in the bucket. [NAME] 1 then rinsed the peeler off with the faucet and dried the peeler using a paper towel. [NAME] 1 returned the peeler to the storage drawer. The DSS verified the findings and stated [NAME] 1 should have followed the manual dish washing procedure. Cross reference to F812, example #5. 2. Review of the facility's Job Description titled Dietary Aide/Dishwasher undated and unsigned by Diet Aide 1 showed essential duties and responsibilities: properly cleans, sanitizes and stores all dishes, utensils and cooking/food prep equipment. Review of the facility's document titled Competency Evaluation signed by DA 1 and the DSS on 1/6/25, showed DA 1 was competent in dish machine temperature and ppm log maintained. Review of the facility's P&P titled Dish Washing Procedures- dish machine (undated) showed to inform the Dietary Services Supervisor or Maintenance personnel if the dish machine is not reaching the proper temperature and chlorine levels. Manual Dish washing or disposables will be used if the dish machine is not working properly. Low temperature dish machine: temperature between 120-135 degrees F, Chlorine - 50 to 100 ppm. The DSS was unable to provide evidence of in-services on the dish machine operations for the past year. Review of the facility's document titled Dish Machine Temperature Log dated March 1-March 11 breakfast through dinner showed the automatic dishwashing machine temperature was 120-123 degrees F on every entry. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/25 at 0833 hours, an observation of the automatic dishwashing machine and concurrent interview was conducted with DA 1 using the DSS as a translator. As DA 1 was washing dishes, she was asked where she checked the temperature for the automatic dish washing machine. DA 1 was unable to state where she obtained the dish machine temperature. The surveyor showed DA 1 the dish machine temperature dial which was under the machine near the floor. DA 1 was unable to stoop down to read the dish machine temperature dial. The surveyor informed DA 1 and the DSS the temperature of the wash water was 100 degrees F. DA 1 agreed 100 degrees F was too low. Although the dish machine had been running for several cycles before DA 1 was interviewed, the DSS stated the dish machine needed to be run few times to get the water temperature to the correct range. Cross reference F812, example #2.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50953 Based on observation, interview, and facility document review, the facility failed to ensure the menus were followed when the recipes for puree meat, vegetables, and starch were not adhered to. This failure had the potential for the nutritional needs to not be met for 15 residents who received a puree diet. Findings: Review of the Order Listing Report dated 3/11/25, showed 15 residents had the physicians' orders for the pureed diet. 1. Review of the facility's document titled Recipe: Puree (IDDSI Level 4) Meats dated 2024 showed 12 servings mix 12 to 24 oz (1 1/2 to 3 cups) warm fluid such as gravy, or low sodium both. If the meat is moist, you can start with only a few ounces of liquid. These amounts are only an average and may vary. If needed: Stabilizer: for 12 serving to mix 6 to 12 Tbsp (3/8 - 3/4 cup) instant potato, non -fat dry milk, breadcrumbs, toast, instant cream of rice or farina, or commercial instant food thickener. On 3/12/25 at 1002 hours, an observation of the puree meat preparation and concurrent interview was conducted with [NAME] 1. [NAME] 1 stated he was preparing 12 servings of puree sweet and sour chicken. [NAME] 1 added nine six-ounce servings of sweet and sour chicken to the Robot Coupe (RC, a device used to puree foods), then blended. The puree sweet and sour chicken had a runny consistency. [NAME] 1 stated he could use thickener to reach the appropriate consistency. [NAME] 1 pour an unmeasured quantity of thickener into a metal pitcher that held one quart (equivalent to four cups). The metal pitcher was approximately half full (two cups) with thickener. [NAME] 1 added the unmeasured thickener to the puree sweet and sour chicken and stirred it with a wire whisk. On 3/13/25 at 0837 hours, an interview was conducted with the RD and DSS. Both the RD and DSS agreed all recipes should be followed. 2. Review of the facility's document titled Recipe: Stir Fry Vegetables dated 2024 showed Ingredients: assorted vegetables, margarine, garlic powder, salt. Directions: 2. Pan fry vegetables with margarine or boil, steam vegetables until soft. Drain well. Add margarine, garlic and salt. Review of the facility's document titled Recipe: Pureed Vegetable (undated) showed 12 serving puree vegetables: mix vegetable with 2 to 6 oz (1/4 cup to 3/4 cup) of warm fluid such as milk, or low sodium broth. These are suggested amounts and may vary from vegetable to vegetable. Some vegetables may not require any fluids at all. If needed: Stabilizer: for 12 serving to mix 6 to 12 Tbsp (3/8 - 3/4 cup) instant potato, or commercial instant food thickener. Review of the chicken flavored bouillon nutritional information showed 3/4 teaspoon chicken flavored bouillon mixed with one cup of water contained 620 mg sodium. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 1016 hours, an observation of the puree vegetable preparation and concurrent interview was conducted with [NAME] 1. [NAME] 1 took a large pan out of the oven with vegetables cooked in liquid. [NAME] 1 stated he cooked the stir fry vegetables in chicken broth in the oven. [NAME] 1 placed 13 1/2 cup servings of the stir fry vegetable mixture into the RC. The product was blended and placed in the oven at 500 degrees. recipes should be followed. The stir fry vegetable recipe was reviewed with the RD. The RD confirmed the stir fry vegetable recipe did not specify what liquid to boil or steam the vegetables in. The RD stated she would prefer the vegetables to be boiled in water. The RD agreed using regular chicken broth with a high sodium content to cook the vegetables was not correct. 3. Review of the facility's document titled Recipe: Sesame Noodles dated 2024 showed Ingredients: Low sodium vegetable or chicken broth (200 mg or less per eight-ounce reconstituted broth). Review of the facility's document titled Recipe: Pureed Starch (Rice, Pasta, Potatoes) (undated) showed 12 servings mix 12 to 24 oz (1 1/2 to 3 cups) warm milk, starting with the smaller amount and adding in more as needed to achieve the desired consistency. If needed: Stabilizer: for 12 serving to mix 6 to 12 Tbsp (3/8 - 3/4 cup) instant potato, non -fat dry milk, breadcrumbs, toast, instant cream of rice or farina, or commercial instant food thickener. Review of the chicken flavored bouillon nutritional information showed 3/4 teaspoon chicken flavored bouillon mixed with one cup of water contained 620 mg sodium. On 3/12/25 at 1021 hours, an observation of the puree noodle preparation and concurrent interview was conducted with [NAME] 1. [NAME] 1 pour an unmeasured quantity of chicken flavored bouillon into a metal pitcher that held one quart (equivalent to four cups). [NAME] 1 added water to the metal pitcher to equal approximately two cups (the metal pitcher was half full). [NAME] 1 added 13 1/2 cup servings of sesame noodles and the chicken flavored bouillon mixture to the RC. The noodles were blended until smooth then placed in a pan and put in the oven at 500 degrees F. On 3/13/25 at 0837 hours, an interview was conducted with the RD and DSS. The RD confirmed all the recipes should be followed and the pureed starch should be pureed with milk per the recipe or low sodium broth.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39856 Based on observation, interview, and facility P&P review, the facility failed to ensure the nutrient content of pureed vegetables was preserved when pureed vegetables were prepared more than one hour prior to meal service and held in an oven at 500 degrees F. This failure posed the risk of 15 residents on a puree diet to not meet their nutritional needs. Findings: Review of the Order Listing Report dated 3/11/25, showed 15 residents had physician's orders for a pureed diet. During the review of the professional reference titled, https://www.healthline.com/nutrition/cooking-nutrient-content, dated 11/7/2019, the reference showed in part, . The following nutrients are often reduced during cooking: water-soluble vitamins: vitamin C and the B vitamins - thiamine (B1), riboflavin (B2), niacin (B3), pantothenic acid (B 5), pyridoxine (B6), folic acid (B9), and cobalamin (B12), fat-soluble vitamins: vitamins A, D, E, and K, and minerals: primarily potassium, magnesium, sodium, and calcium . On 3/12/25 at 1011 hours, an observation of the puree preparation and concurrent interview was conducted with [NAME] 1. [NAME] 1 stated he was preparing 13 portions of the puree stir fry vegetables. [NAME] 1 had placed 13 1/2 cup servings of the stir fry vegetables previously cooked in chicken broth, into the Robot Coupe (RC, a device used to puree food). The stir fry vegetables were blended until a pudding consistency was obtained then placed in a pan and stored in the oven at 500 degrees fahrenheit (F) until the lunch meal tray line began at 1146 hours. On 3/13/25 at 1041 hours, an interview was conducted with the RD. The RD agreed that storing the pureed vegetables in an oven at 500 degrees F for more than one hour prior to the meal service was not the ideal way to preserve the nutrients of the pureed vegetables.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, and facility document review, the facility failed to ensure two of 10 final residents reviewed for dining (Residents 11 and 85) received food prepared in a form to meet their individual dietary needs. * The facility failed to ensure Resident 11 was provided with the minced and moist diet as per physician's diet order. * The facility failed to ensure Resident 85 was provided with the mechanical soft snacks as per the resident's diet order. These failures placed Residents 11 and 85 at risk for aspiration (accidental breathing in of food or fluid into the lungs) or choking. Findings: 1. Medical record review for Resident 11 was initiated on 3/11/25. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's SLP Evaluation and Plan of Treatment dated 3/12/24, showed Resident 11 was currently edentulous (toothless) per dentist recommendation and was awaiting a procedure on her gums to improve the ability to wear dentures. Further review of the SLP Evaluation and Plan of Treatment showed Resident 11 had difficulty chewing tough/fibrous material but refused to be downgraded to a puree diet. The recommendation showed for minced and moist textures, thin liquid and puree vegetables only per the residents' request. Review of Resident 11's Order Summary Report for March 2025 showed a physician order dated 3/12/25, for no added salt diet, minced and moist texture (foods must be soft, moist, and easily formed into a ball, with no hard lumps and pieces no larger than 4 mm), thin consistency, low purine diet, no beans, no nuts, oatmeal with breakfast lunch and dinner. Puree vegetables only. Review of Resident 11's H&P examination dated 7/26/24, showed Resident 11 had the capacity to understand and make decisions. On 3/11/25 at 0959 hours, an interview was conducted with Resident 11. Resident 11 stated she was in a process of getting an oral surgery and could not use her dentures. Resident 11 further stated the facility had been providing her with minced diet; however, sometimes she would get food in big pieces which was hard for her to swallow. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 1224 hours, Resident 11 was observed eating her lunch in the dining room. Resident 11's food on the tray was mashed potatoes, cooked green leaves, chicken in pieces, milk, dessert, puree salad, and a bowl of oatmeal. Resident 11's plate had dry pieces of chicken approximately more than 1 cm long and was not finely minced and moist. Resident 11 was observed taking lumps of the chicken pieces out of her plate and putting it aside. Resident 11 stated the pieces of the chicken in her plate were big for her to swallow. On 3/11/25 at 1232 hours, an observation and concurrent interview was conducted with the DSD. The DSD verified the above observation and stated the chicken Resident 11 received was not moist and was not minced properly. The DSD was observed offering Resident 11 another tray of the meal. On 3/11/25 at 1240 hours, an observation and concurrent interview was conducted with the DSS. The DSS verified the observation and stated the chicken in Resident 11's plate was not minced and moist. The DSS stated she would replace the meal for Resident 11. On 3/11/25 at 1245 hours, Resident 11 was observed receiving another replacement tray for her lunch which included finely minced and moist chicken. Resident 11 stated she was finally able to easily swallow the food served. On 3/11/25 at 1251 hours, an interview was conducted with the SLP. The SLP was informed and verified the above findings and stated the food Resident 11 receive should be finely minced and moist that required very little or no chewing. On 3/14/25 at 0946 hours, the DON was informed and acknowledged the above findings. 47474 2. Medical record review for Resident 85 was initiated on 3/11/25. Resident 85 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 85's Order Summary Report for March 2025 showed a physician order dated 12/23/24, for an oral great diet. Puree texture, nectar/mildly thick consistency. Patient may have occasional soft and bite sized snacks/mechanical soft snacks upon request for per resident request only. Review of Resident 85's annual MDS dated [DATE], showed Resident 85 had a BIMS score of 14 which meant the resident was cognitively intact. On 3/11/25 at 0929 hours, during the initial tour observation, Resident 85 was in bed eating saltine crackers. There were three packets of saltine crackers on the resident's bedside table. On 3/11/25 at 1222 hours, a concurrent observation and interview was conducted with Resident 85 in her room. When asked if the resident eats the saltine crackers via her cellphone to communicate, Resident 85 replied it takes forever to eat the saltine crackers. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 1226 hours, a concurrent observation, interview, and medical record review was conducted with LVN 12. LVN 12 verified there were a total of eight saltine crackers at Resident 85's bedside table. LVN 12 stated Resident 85 was given saltine crackers; however, has a hard time eating them. LVN 12 further verified Resident 85's diet order showed she was allowed for a soft and bite sized snacks and/or mechanical soft snacks. LVN 12 acknowledged the saltine crackers were not appropriate snacks and Resident 85 was at risk for aspiration or choking. On 3/11/25 at 1233 hours, an interview with the DSS was conducted. The DSS verified the saltine crackers were not considered a mechanical soft snack. On 3/11/25 at 1235 hours, a concurrent interview and medical record review with the RD was conducted. The RD verified Resident 85's diet orders. When the RD was asked if the saltine crackers were offered for the residents on a mechanical soft snacks, the RD stated it was not. On 3/11/25 at 1244 hours, a concurrent interview with the SLP was conducted. The SLP stated Resident 85 can have soft and bite size snacks. The SLP stated Resident 85 can have saltine crackers if it was dipped in water first; however, verified instructions were not on the diet order and stated not all the nurses were aware of her instructions regarding the saltine crackers should be dipped in water first prior to the resident eating it. On 3/14/25 at 1320 hours, an interview was conducted with the Administrator and DON with the Regional Director of Operations present. The Administrator and DON was made aware and acknowledged the above findings.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on interview, medical record review, facility document review and facility P&P review, the facility failed to ensure the food preferences were honored for one of 24 final sampled residents (Resident 10). This failure had the potential for decreased meal intake, weight loss, and a negative impact on the resident's psychosocial wellbeing. Findings: Review of the facility's P&P titled Resident Food Preferences (undated) showed the DSS will meet with the resident or representative to go over food preferences, allergies, likes and dislikes upon admission and as needed. The DSS will visit the resident periodically to ensure food preferences are being honored. Medical record review for Resident 10 was initiated on 3/11/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility's Resident Council minutes dated 1/14/25, showed Resident 10 requested the collard greens with meals. Review of the the Resident Council Response Form dated 1/14/25, showed the DSS would order the collard greens and have them in the facility for Resident 10. Review of Resident 10's care plan dated 1/23/25, showed the resident had a risk for alteration in nutritional status and was at risk for weight loss and malnutrition. The care plan interventions included adhering to Resident 10's food preferences. Review of Resident 10's H&P examination dated 2/21/25, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Order Summary Report showed a physician's order dated 2/28/25, for CCHO, NAS diet, regular texture, thin liquids, no orange juice, no potatoes, and no banana. On 3/12/25 at 1106 hours, an interview was conducted with Resident 10. Resident 10 stated they requested collard greens at the Resident Council meeting in January 2025. Resident 10 stated the facility had not informed her of the status of her request or if the facility was able to order the collard greens. Resident 10 stated the collard greens had not been served with any meals. On 3/13/25 at 1101 hours, an interview and concurrent medical record review was conducted with the DSS for Resident 10. The DSS verified Resident 10's request for the collard greens was received by the facility. The DSS stated the facility had not purchased the collard greens. The DSS verified the facility has not accommodated Resident 10's request for collard greens. The DSS verified Resident 10's medical record failed to show documentation of a follow-up with Resident 10 regarding the request for the collard greens. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 1503 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of and acknowleged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50953 Based on observation, interview, facility document and facility P&P review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the egg served was fully cooked when there were no pasteurized eggs were available. * The facility failed to ensure the proper hand hygiene was followed during the food preparation. * The facility failed to ensure the fish thawing process was followed. * The facility failed to the ensure the automatic dish washing water temperature reached the acceptable range. * The facility failed to ensure the manual dishwashing process was followed. * The facility failed to ensure the refrigerated food items were stored properly. * The facility failed to ensure the ice storage was in sanitary condition. * The facility failed to ensure the hair restraints were available and worn by staff in the kitchen. * The facility failed to ensure the kitchen equipment were maintained in a sanitary condition. * The facility failed to ensure the food item in the walk-in freezer was dated, label and not left open. * The facility failed to ensure the dry food was properly stored. * The facility failed to ensure the food preparation equipment was air dried. * The facility failed to ensure Resident 7's personal refrigerator was maintained. These failures had the potential to cause foodborne illnesses for Resident 7 and in the 62 residents who consumed food prepared in the kitchen. Findings: Review of the facility's document titled Order Listing Report dated 3/11/25, showed 62 of 109 residents received food prepared in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. According to the Center for Disease Control (CDC) Salmonella are bacteria (germs) that can make people sick with an illness called salmonellosis. Anyone can get a Salmonella infection. But some groups of people have an increased chance of infection, and some people may become seriously ill. These groups include Adults who are [AGE] years and older with underlying medical problems, such as heart disease, Adults who are 65 and older and People who have a weakened immune system. https://www.cdc.gov/salmonella/about/index.html#:~:text=People%20at%20risk&text=These%20groups%20include%3A,who%20are%2065%20and%20older. A reference review from California Department of Food and Agriculture (CDFA) dated 7/1/13, showed California Shell Egg Food Safety Compliant or the abbreviated CA SEFS Compliant statement means that the eggs you're purchasing have gone through added measures to reduce the risk of Salmonella Enteritidis (SE) contamination, as specified in California Code of Regulation Title 3 Section 1350 (3 CCR 1350). SE is the number one food borne illness associated to raw shell eggs. Review of California Code, Health and Safety Code - HSC S 114091 showed in part, in a licensed health care facility the following shall apply . Pasteurized shell eggs or pasteurized liquid, frozen, or dry eggs or egg products shall be substituted for raw shell eggs in the preparation of foods. https://www.cdfa.ca.gov/ahfss/mpes/pdfs/CA_SEFS_Compliant.pdf On 3/11/25 at 0756 hours, during the initial tour of the facility's kitchen, observation and concurrent interview was conducted with the DSS. Three cases of CASEFS eggs were observed in the walk-in refrigerator. The DSS verified there were no pasteurized eggs and stated she was unable to purchase the pasteurized eggs from the provider. On 3/11/25 at 1121 hours, an interview was conducted with the RD. The RD stated the eggs were safe because they were CASEFS approved. On 3/12/25 at 0645 hours, a breakfast meal tray-line observation was conducted. The DSS was observed cooking the fried eggs for residents on the grill. On 3/12/25 at 0720 hours, an observation of Resident 33's breakfast meal tray and concurrent interview was conducted with the RD. Resident 33's breakfast meal tray ticket showed a daily standing order for two fried eggs. The two fried eggs were observed on the plate; however, one of the egg yolks was observed runny and not fully cooked. The RD verified the findings and stated she would have the DSS cook the eggs until the yolk was completely cooked. 2. Review of the facility's P&P titled Hand Washing (undated) showed to wash hands after handling the cart, soiled dishes and utensils, before and after handling foods, and wash hands when changing gloves. Change the disposable gloves when: - gloves get ripped or torn; - beginning a different task; - after coughing or sneezing into hands, use of handkerchief or tissue, smoking, touching hair or face, and using the toilet; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- after handling waste and - during food preparation, as often as necessary when it get soiled and when changing task to prevent cross contamination. On 3/11/25 at 0756 hours, during the initial tour of the facility's kitchen, an observation and concurrent interview was conducted with the DSS. [NAME] 1 was asked to discard the two rubber spatulas and wash a dirty peeler. [NAME] 1 touched the trash can lid to throw away the rubber spatulas, then proceeded to wash the dirty peeler. [NAME] 1 did not change his gloves or wash his hands after touching the trash can. After washing the peeler, [NAME] 1 was observed wiping his wet gloved hands on his apron and returned to the food preparation. On 3/12/25 at 0859 hours, a follow-up observation was conducted of [NAME] 1. [NAME] 1 was observed placing her gloved hands in the trash can to remove a sticker from her gloves. [NAME] 1 did not remove her gloves or wash her hands prior to returning to the food preparation. On 3/12/25 between 1002 and 1025 hours, an observation of the puree meal preparation was conducted with [NAME] 1. The following was observed: - [NAME] 1 was observed preparing the puree meat with gloved hands, - [NAME] 1 removed his gloves to wash the Robot Coupe (RC) in the automatic dish machine, - [NAME] 1 touched the dish machine tray and dish machine handle then donned a new pair of gloves without washing his hands, - [NAME] 1 proceeded with the puree meal preparation. During the puree meal preparation, [NAME] 1 rested his gloved hands on the counter. Without changing his gloves or washing his hands, [NAME] 1 continued to touch multiple objects in the kitchen; a cooking pan, a blender, and oven handle while preparing the puree food for the residents, and - [NAME] 1 washed the RC again in the automatic dish machine using the same gloved hands, then he prepared the chicken broth which he added to the noodles and continued to puree the food for the facility residents. On 3/13/25 at 0837, an interview was conducted with the DSS and RD. Both the RD and DSS acknowledged the cooks should wash their hands and change gloves prior to starting a new task such as the food preparation. 3. Review of the facility's P&P titled Refrigerator /Freezer Storage (undated) showed all the items should be properly covered, dated, and labeled. The food items should have the following appropriate dates: - delivery date upon receipt, - open date for opened containers of the PHF (potentially hazardous food), and - thaw date of any frozen items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the chart from the US Food & Drug Administration (USFDA) posted outside of the walk-in refrigerator titled Refrigerator and Freezer Storage Chart dated March 2018 showed the lean and fatty fish may be stored in the refrigerator safely for one to two days. On 3/11/25 at 0800 hours, an observation of the walk-in refrigerator and concurrent interview was conducted with the DSS. Two boxes of 10 pounds tilapia were observed in the walk-in refrigerator dated 3/5/25. The DSS was asked what the 3/5/25 date meant. The DSS verified the 3/5/25 was the delivery date and there was no date to indicate when the tilapia was removed from the freezer to thaw. 4. Review of the facility's P&P titled Dish Washing Procedures- Dish Machine (undated) showed to inform the DSS or Maintenance personnel if the dish machine is not reaching the proper temperature and chlorine levels. Manual dish washing or disposables will be used if the dish machine is not working properly. For the low temperature dish machine, the temperature should be between 120-135 degrees Fahrenheit (F), and Chlorine at 50 to 100 ppm. Review of the facility' s document titled Dish Machine Temperature Log for 3/1-3/11/25, the breakfast through dinner showed the automatic dishwashing machine temperature was 120-123 degrees F on every entry. On 3/11/25 at 0833 hours, an observation of the automatic dishwashing machine and concurrent interview was conducted with DA 1 using the DSS as a translator. As DA 1 was washing the dishes, she was asked where she checked the temperature for the automatic dish washing machine. DA 1 was unable to state where she obtained the dish washing machine temperature. DA 1 was shown where the dish machine temperature dial which was located at the bottom of the machine near the floor. DA 1 was unable to stoop down to read the dish machine temperature dial. DA 1 and the DSS was informed the temperature of the wash water was at 100 degrees F. DA 1 acknowledged the temperature of 100 degrees F was too low. Although the dish machine had been running for several cycles before DA 1 was interviewed, the DSS stated the dish machine needed to be run a few times to get the water temperature to the correct range. On 3/13/25 at 1134 hours, a follow-up observation of the automatic dish machine and concurrent interview was conducted with the RD. The RD stated the dish machine company had come out to check the machine and stated everything was fine. Upon the inspection of the dish machine temperature dial, the wash temperature was at 112 degrees F. The dish machine was then ran twice; however, the dish machine temperature remained at 112 degrees F. The RD stated she would notify the maintenance. 5. Review of the facility's P&P titled Manual Dish Washing - 2 or 3 Compartment Sink (undated) showed the two-compartment sink procedures as follows: - Fill sink 1 with warm water and soap to proper level to complete wash process. Scrub all surfaces to clean and remove food and other debris. - Drain sink 1 and rinse walls with fresh water. - Refill sink 1 to proper level to freely rinse all items with fresh water only. - Fill sink 2 with fresh water to proper level with water from cold line and add Quaternary sanitizer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Test to ensure paper solution of no less than 200 ppm to no more than 400 ppm is available with proper test strips. - Place all items in solution for no less than 1 minute. - Place on a clean surface and allow to dry clean. On 3/11/25 at 0756 hours, during the initial tour of the facility's kitchen, an observation of [NAME] 1 and concurrent interview was conducted with the DSS. [NAME] 1 was asked to wash a dirty peeler. [NAME] 1 was observed dipping the peeler in the solution in a green bucket. [NAME] 1 then rinsed the peeler off with the water from the faucet and dried the peeler using a paper towel. [NAME] 1 returned the peeler to the storage drawer. The DSS verified the findings and stated [NAME] 1 should have followed the manual dish washing procedure. 6. Review of the facility's document titled Refrigerator and Freezer Storage Chart dated 3/2018 showed these short but safe time limits will help keep the refrigerated food at 40-degree F from spoiling or becoming dangerous. The section for the Hot Dogs and Lunch Meats (in freezer wraps), the opened package of the lunch meat can be stored in refrigerator for 3-5 days and 1-2 months in the freezer. Review of the facility's document Health Shake Nourishment Storage and Handling instruction: Store frozen showed to thaw under refrigeration (at 40 degree F or below), after thawing keep refrigerated, and use within 14 days after thawing. On 3/11/25 at 0800 hours, an observation and concurrent interview was conducted with the DSS. An opened package of turkey lunch meat dated 3/3/25, and one box of the health shakes dated 2/12/25, were observed inside the walk-in refrigerator. The DSS verified the finding and stated the turkey lunch meat should be discarded after seven days. When asked regarding the process for thawing of the health shakes, the DSS stated the health shakes can be used for 30 days after thawing. Upon the inspection of the health shake guidelines located on the health shake carton, the DSS verified the health shakes can only be used for 14 days once thawed. 7. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, food-contact surface and utensils shall be clean to sight and touch. On 3/11/25 at 1102 hours, an observation and concurrent interview was conducted with the DSS. The DSS stated the ice cooler located near the kitchen door was used by the CNAs to get ice for the residents' water pitchers. The inside of the ice cooler was observed with a brown residue. The DSS was asked about the process on how to clean the ice cooler. The DSS stated the ice cooler was cleaned weekly with soap and water. The DSS verified the ice cooler was not clean and removed it to be cleaned. 8. According to the USDA Food Code 2022, Section 2-402.11 Hair Restraints, Effectiveness, Food employees shall wear hair restraints such as hats, hair covering or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, and utensils. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Sanitation and Infection control (undated) showed the beard and/or moustache should be closely trimmed or must be covered at all times. On 3/12/25 at 1355 hours, an observation in the kitchen and concurrent interview was conducted with DA 2 and [NAME] 2. DA 2 and [NAME] 2 was observed with uncovered facial hair. When asked if their facial hair should be covered, [NAME] 2 stated the kitchen used to have beard restraints but not any longer. On 3/12/25 at 1359 hours, an interview was conducted with the DSS. The DSS was informed of DA 2 and [NAME] 2's uncovered facial hair. The DSS verified the findings and stated any kitchen staff with facial hair or beard need to use the hair restraints and she would need to order some hair restraint. 9. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, food-contact surface and utensils shall be clean to sight and touch. a. On 3/11/25 at 0800 hours, during the initial tour of the facility's kitchen, an observation and concurrent interview was conducted with the DSS. The following was observed and verified by the DSS: - one peeler was not clean, - a plastic container used to store the silverware was not clean and observed with food debris, - two rubber spatula were chipped and no longer in a cleanable condition, - one can opener blade with excessive wear, and - one nonstick pan was unclean and the coating was coming off. b. On 3/12/25 at 0955 hours, a lunch meal puree preparation observation and concurrent interview was conducted with [NAME] 1 and the DSS. The Robot Coupe was observed with hard brown residue on the blade assembly. The DSS stated the Robot Coupe was old and the residue did not come off with cleaning. The DSS further stated she would order a new blade assembly. 10. Review of the facility's P&P titled Refrigerator /Freezer Storage (undated) showed all the items should be properly covered, dated and labeled. The food items should have the following appropriate dates: - delivery date upon receipt, - open date for opened containers of the PHF (potentially hazardous food), and - thaw date of any frozen items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/25 at 0800 hours, during the initial tour of the facility's kitchen, an observation and concurrent interview was conducted with the DSS. One 20 pounds bag of peas was observed open with no date label in the walk-in freezer. The DSS verified the finding and stated all the food items should be dated and sealed once opened. 11. Review of the facility's P&P titled Storage of Canned and Dry Goods (undated) showed the plastic or metal containers (with tight fitting lids and NSF approved), or re-sealable plastic bags will be used for staples and opened packages (like pasta, rice, cereal, flour, etc.). The food items will be dated and labeled when placed in the containers. The scoops should not be left in the container and will be cleaned after each use. On 3/12/25 at 0649 hours, during the breakfast tray line observation, a scoop was observed inside the thickener container. On 3/12/25 at 0804 hours, an observation and concurrent interview was conducted with the DSS. The DSS verified the finding, and stated the scoop should not be kept in the thickener container. 12. According to the USDA Food Code 2017, Section 4-901.11, Equipment and Utensils, Air-Drying Required, items must be allowed to drain and to air-dry before being stacked or stored. Stacking of the wet items prevents them from drying and may allow an environment where microorganism can begin to grow. On 3/11/25 at 0800 hours, during the initial tour of the facility's kitchen, an observation and concurrent interview was conducted with the DSS. A clean blender was observed stored with the top lid on and wet inside. The DSS verified the blender was not air-dried. On 3/14/25 at 0947 hours, an interview was conducted with the Administrator, RD, and DSS. The Administrator, RD, and DSS were informed and acknowledged the above findings 51352 13. Review of the facility's P&P titled Resident's Refrigerator/Freezer Storage (undated), showed the nursing staff or a designee to check and record temperatures of all refrigerators and freezers daily to ensure the equipment is within the appropriate temperature for food. The section for Procedure showed the following: 1. Nursing staff or designee will check the inside temperature of refrigerators and freezers. 2. Nursing staff or designee will record and initial the temperature log twice a day. 3. If the temperatures are not within appropriate range, nursing staff or designee will notify the Maintenance Supervisor and Administrator. - Refrigerator Temperature: 40 degrees F (Fahrenheit) or lower - Freezer Temperature: 0 degrees F or lower (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 7 was initiated on 3/11/24. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's H&P examination dated 8/9/24, showed Resident 7 had the capacity to understand and make decisions. On 3/11/25 at 0930 hours, an observation and concurrent interview was conducted with Resident 7. Resident 7's room was observed with a personal refrigerator and the log titled Refrigerator Log March 2025 was posted on the outside of the refrigerator. Resident 7 verified the refrigerator inside the room was his personal refrigerator. Review of the Refrigerator Log for March 2025 showed the columns for the date, nurse's initials, and refrigerator temperatures for 0600 and 1800 hours. The daily refrigerator temperature log for Resident 7's personal refrigerator showed the following temperature at 0600 hours: - 48 degrees F on 3/2, and 3/3/25; - 49 degrees F on 3/8/25; - 50 degrees F on 3/1, 3/4, 3/5, 3/6, 3/7, 3/9, 3/11, and 3/12/25, and - 52 degrees F on 3/13/25. Further review of the refrigerator log failed to show the documentation of Resident 7's personal refrigerator temperature for the 1800 hours or documentation of the freezer temperature. On 3/13/25 at 0847 hours, an observation, interview, and concurrent facility document review for Resident 7's personal refrigerator was conducted with RN 3. RN 3 verified the refrigerator log showed the temperature for the refrigerator must be between 36 and 46 degrees F and the RN Supervisor and/or Maintenance Supervisor should be notified immediately for the temperatures not within range. RN 3 verified the refrigerator log showed the temperature for Resident 7's personal fridge was outside of the acceptable temperature range every day for March 2025. RN 3 verified the log showed no documentation if the RN Supervisor and/or Maintenance Supervisor was contacted when Resident 7's personal refrigerator temperature was outside of the acceptable range. RN 3 stated the RN Supervisor and/or Maintenance Supervisor should have been notified. RN 3 also verified the refrigerator log showed no documentation the temperature of Resident 7's personal refrigerator was checked daily at 1800 hours. Furthermore, RN 3 acknowledged the facility's policy for maintaining the personal refrigerator temperatures of less than 40 degrees F should be followed. RN 3 verified the refrigerator log showed an unacceptable temperature range that was inconsistent with the facility's policy for personal refrigerators. On 3/13/25 at 0912 hours, a follow-up observation and concurrent interview was conducted with RN 3. RN 3 verified the refrigerator log for Resident 7's personal refrigerator showed no documentation of the freezer temperatures for March 2025. The temperature of the freezer in Resident 7's personal refrigerator was observed at 10 degrees F. RN 3 verified and acknowledged the temperature of Resident 7's freezer was at 10 degrees F, and was out of the recommended range of zero degrees or lower per the facility's policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 0948 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The facility's P&P titled Resident's Refrigerator/Freezer Storage (undated) and maintenance department's Refrigerator Log for Resident 7's personal fridge for March 2025 was reviewed with the Maintenance Director. The Maintenance Director verified the Refrigerator Log posted outside Resident 7's personal refrigerator showed the refrigerator temperatures were outside of the acceptable range of 40 degrees F or less every day for March 2025. The Maintenance Director stated he was unaware the temperature of Resident 7's personal refrigerator was outside of the acceptable range every day in March 2025. The Maintenance Director verified he should have been notified when Resident 7's refrigerator temperature was outside of the acceptable range so the refrigerator temperature could have been adjusted. Review of the maintenance department's Refrigerator Log for Resident 7's personal refrigerator for March 2025 showed the following temperatures: - 39 degrees F on 3/5, and 3/11/25; - 40 degrees F on 3/1, 3/2, and 3/6/25; - 41 degrees F on 3/3, 3/4, 3/7, 3/8, 3/9, and 3/10/25, and - no entry on 3/12/25. The Maintenance Director verified the maintenance department checks the temperatures of all the personal refrigerators daily. The Maintenance Director verified the maintenance department's Refrigerator Log for Resident 7's personal refrigerator was incomplete and showed no documentation if the refrigerator's temperature was checked on 3/12/25. The Maintenance Director verified the facility's policy for maintaining the personal refrigerator temperatures of less than 40 degrees F should be followed and the refrigerator logs showed an unacceptable temperature range that was inconsistent with the facility's policy for personal refrigerators. The Maintenance Director verified the maintenance department's refrigerator log for Resident 7's personal refrigerator showed the temperature was outside of the acceptable range on 3/3, 3/4, and 3/7 to 3/10/25, and the log showed no documentation the refrigerator temperature was adjusted to ensure the refrigerator's temperature remained within the acceptable range. On 3/14/25 at 1503 hours, an interview was conducted with the Administrator and DON. The Administrator and the DON were informed and acknowledged the above findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observation, interview, and facility P&P review, the facility failed to ensure food brought from the outside was stored for three nonsampled residents (Residents 57, 65, and 70). Additionally, the facility failed to ensure the visitors and staff were educated on safe food handling guidelines. These failures had the potential to expose residents who received food brought from the outside to food borne illnesses. Findings: Review of the facility's P&P titled Food from Outside Sources (undated) showed the food from outside sources is discouraged due to concerns with food safety and infection control and maintaining control of therapeutic diet orders. 1. While it is preferred that families and/or friends do not bring foods or beverages into the facility, it is within the resident's right to allow the resident to eat outside food, especially if an individual is eating poorly. If outside food is brought in, the facility is not liable for safety and infection control concerns. a. Review of Resident 70's medical record showed Resident 70 was admitted to the facility on [DATE], with diagnoses which included cardiomegaly (enlargement of the heart), old myocardial infarction (heart attack) and acute kidney failure. A No Added Salt diet was ordered by the physician on 1/3/25. On 3/11/25 at 1158 hours, an observation of the lunch meal in the dining room and concurrent interview was conducted with Resident 70's family member. Resident 70's family member brought a piece of cake for Resident 70. Resident 70's family member stated the facility did not like the family member to bring food from the outside because Resident 70 was on a special diet. When Resident 70's family member asked if she had received information from the facility regarding safe food handling guidelines, she stated she was not sure. b. Review of Resident 65's medical record showed Resident 65 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (a disease that results with too much sugar in the blood), alcoholic liver disease (liver damage caused by long term excessive alcohol consumption), and hepatic failure (liver failure). On 3/11/25 at 1201 hours, an observation of the lunch meal in the dining room and concurrent interview was conducted with Resident 65 using CNA 3 as a translator. Resident 65 was observed eating BBQ ribs and macaroni salad. Resident 65 stated his friend brought the food from the outside for him. When asked if his friend received information from the facility regarding safe food handling guidelines, Resident 65 stated he told his friends what foods they were allowed to bring to the facility. c. Review of Resident 57's medical record showed Resident 57 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular disease (medical emergency that encompasses a range of conditions affecting the brain's blood vessels and blood flow), and diabetes mellitus. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 1206 hours, an observation of the lunch meal in the dining room and concurrent interview was conducted with Resident 57's family member using the Activities Director as a translator. Resident 57's family member had brought in pureed chicken and rice in a plastic container. When asked if Resident 57's family member had received information from the facility regarding safe food handling guidelines, Resident 57's family member stated she had received information regarding Resident 57's diet. On 3/12/25 at 8:26 hours, an interview was conducted with RN 1. RN 1 was asked to explain the facility process for food brought to the facility from the outside. RN 1 stated they made sure the food was appropriate for the resident. When asked where the food from the outside was stored, RN 1 stated storage of the food was not allowed; the food must be eaten in one sitting. RN 1 confirmed there was no refrigeration available for storage of outside food. RN 1 was asked how the food from the outside was heated. RN 1 showed two microwave ovens located in the dining room. One microwave oven was observed with excess food debris inside. RN 1 stated the housekeeping was responsible to clean the microwave. On 3/12/25 at 0929 hours, an interview was conducted with the DSD. The DSD confirmed there was no staff training given regarding safe food handling guidelines.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 50953 Based on observation, interview, and facility P&P review, the facility failed to ensure the facility's garbage and refuse was properly disposed as evidence by: * The facility failed to ensure the waste dumpsters were properly closed. * The facility failed to ensure the organic waste and recycling refuse were handled as per state mandate SB1383. * The facility failed to ensure trash was placed in the appropriate containers and not stored in the trash bags placed on the ground or stacked on hand carts. These failures had the potential to cause unsafe sanitary conditions and potential to harbor pests and rodents. Findings: 1. According to the USDA Food Code 2022, Section 5-501.113 Covering Receptacles: Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered. (B) With tight-fitting or doors if kept outside the food establishment, Review of the facility's P&P titled Waste Control and Disposal (undated) showed outside garbage bin should be keep closed at all times and surrounding area must be kept clean. On 3/11/25 at 0733 hours, during the initial tour of the facility, an observation of the facility's garbage dumpsters was conducted. One of the four dumpsters was observed with the lid open and garbage inside. Another dumpster was observed with the lid propped open by garbage, preventing the lid from fully closing. On 3/11/25 at 1122 hours, an interview was conducted with Maintenance Director. The Maintenance Director verified the findings (via a photograph taken of the findings). On 3/12/25 at 0638 hours, an observation of the facility's outside dumpster located in front of the facility was conducted. One of four dumpsters was observed with the lid open and garbage inside. On 3/12/25 at 0849 hours, an interview was conducted with Maintenance Director. The Maintenance Director verified the findings (via a photograph taken of the findings). 2. Review of the Senate [NAME] (SB) 1383 regulation dated 1/1/22, showed every jurisdiction was to provide organic waste collection services to all residents and businesses. Jurisdiction includes city, county, a city and county, or a special district that provides solid waste collection services. Organic waste includes food, green material, landscape and pruning waste, organic textiles and carpets, lumber, wood, paper products, printing and writing paper, manure, biosolids, digestate, and sludges. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 1122 hours, an observation and concurrent interview was conducted with Maintenance Director. One organic waste barrel was observed in the dumpster storage area with the regular trash inside. The Maintenance Director verified the findings. On 3/11/25 at 1146 hours, an interview was conducted with the Administrator. The Administrator verified the facility was not collecting the organic trash. On 3/12/25 at 0804 hours, an interview was conducted with the DSS. The DSS verified the kitchen was not collecting the organic trash. 3. Review of California State [NAME] AB 341, also called the Mandatory Commercial Recycling Regulation, requires businesses and multi-family residential dwellings of five units or more, that generate four or more cubic yards of commercial solid waste per week to implement recycling programs, on or after 7/1/12. https://calrecycle.ca.gov/recycle/commercial/ According to the USDA Food Code 2022, Section 5-501.11 Storing Refuse, Recyclables, and Returnables showed refuse, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. On 3/11/25 at 1146 hours, an interview was conducted with the Administrator. The Administrator verified the facility was not collecting the recycle trash. On 3/14/25 at 0947 hours, an interview was conducted with the Administrator, RD, and DSS. The Administrator, RD, and DSS were informed and acknowledged the above findings. 39683 4. According to the USDA Food Code 2022, Section 5-501.113 Covering Receptacles: Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered. (B) With tight-fitting or doors if kept outside the food establishment. On 3/13/25 at 0924 hours, an observation and interview were conducted with the Maintenance Director outside by the side of the building. The following was observed: - More than 10 large plastic trash bags piled on the ground along the block wall; and two empty cardboard boxes (one flattened) laying on top of the bags in the rain. - A gray wheeled trash bin with clear plastic bunched up in the bin, with a portion hanging over the top of the bin, there was no lid. - A black plastic trash bag filled with trash next to the building, with an empty cardboard box on top of it, and a broom propped against it. - Two hand carts with stacked cardboard boxes. Most of the boxes were flattened. The Maintenance Director verified the above findings were all trash/refuse, and stated the dumpsters were already full. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 1054 hours, during a follow-up observation with the Maintenance Director, a pile of more than 20 large trash bags full and closed with a knot, was observed along the block wall next to a storage unit in the back corner of the facility. The Maintenance Director stated that was also trash.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview, medical record review, document review, and facility P&P review, the facility failed to ensure the medical records were accurately maintained for eight of 24 final sampled residents (Residents 9, 40, 45, 47, 51, 52, 72, 89, and 99). * The facility failed to ensure the respiratory care documentation for Resident 72 were accurate. * The facility failed to ensure the side rails assessment for the risk for entrapment for Residents 9, 40, 45, 47, 51, 52, 89, and 99 were accurate. These failures posed the risk for residents not to receive the necessary care and services as their medical records were not accurate. Findings: 1. Review of the facility's P&P titled Charting and Documentation revised on 7/2017 showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Medical record review for Resident 72 was initiated on 3/11/25. Resident 72 as admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 72's annual MDS dated [DATE], showed Resident 72's cognitive skills for daily decision making was severely impaired. Review of Resident 72's Order Summary Report for March 2025 showed the following physician orders: - dated 11/17/24, for Trach tube type: Portex 8 uncuffed - dated 11/17/24, to change trach tube: Portex 8 uncuffed as needed Further review of Resident 72's Order Summary Report showed no documented evidence the resident was on a ventilator. Review of the Progress Notes showed the license nurses documented Resident 72 was on a ventilator on the following dates: - 3/7/25 at 1929 hours, - 3/6/25 at 1714 hours, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/5/25 at 1725 hours, - 3/4/25 at 1733 hours, - 3/3/25 at 1704 hours, and - 2/28/25 at 1711 hours. On 3/14/25 at 1000 hours, a concurrent observation and interview was conducted with LVN 8 in Resident 72's room. LVN 8 verified Resident 72 was not on a ventilator and stated the resident had not been on a ventilator since he started working at the facility. On 3/14/25 at 1036 hours, a concurrent interview and medical record review was conducted with RT 2. RT 2 reviewed Resident 72's discontinued orders and verified the resident's ventilator orders were discontinued on 10/16/24. RT 2 acknowledged Resident 72's progress notes showed the resident was still on a ventilator and verified the above findings. RT 2 stated Resident 72 was not on a ventilator; however, the progress notes showed the resident was on a ventilator and could be confusing. RT 2 further stated it was important to assess and document accurately. On 3/14/25 at 1300 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 72 was not on a ventilator; however, the nurses' progress notes documentation showed the resident was still on a ventilator. The DON stated she expected the licensed nurses to have proper documentation and to assess their residents rather than assuming the subacute residents were on a ventilator. On 3/14/25 at 1320 hours, an interview with the Administrator and DON was conducted with the Regional Director of Operations present. The Administrator and DON acknowledged and verified the above findings. 50967 2. The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails (1995). Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc., that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Safety and Bed Rails dated March 2023 showed regardless of the mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident ' s head or body. Any gaps in the bed system are within the safety dimensions established by the FDA, and the Maintenance Staff routinely inspects all beds and related equipment to identify the risk and problems including potential entrapment risks. a. On 3/12/25 at 0952 hours, an observation was conducted for Resident 51. Resident 51 was observed lying in bed, awake, and alert with the bilateral half upper side rails elevated. Medical record review for Resident 51 was initiated on 3/14/25. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's Order Summary Report dated 3/12/25, showed the physician's order dated 10/4/23, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. On 3/14/25 at 1025 hours, a concurrent observation and interview was conducted with LVN 1. LVN 1 observed and verified the bilateral half upper side rails were elevated. Review of Resident 51's NC - Side Rail/Entrapment/Care Plan dated 1/6/25, showed Zones 1-7 were assessed and marked as they were within the measurement guidelines of less than four and 3/4 (three quarters) of an inch. On 3/14/25 at 1029 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 verified the entrapment assessment was inaccurate, and Zone 5 should have not been assessed since it was not applicable when there were no split bed rails. b. On 3/11/25 at 0943 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with CNA 2. Resident 52 was observed lying in bed asleep with the bilateral upper half side rails elevated. CNA 2 stated Resident 52's bilateral arms and hands were contracted and unable to grab or use the side rails. Medical record review for Resident 52 was initiated on 3/11/25. Resident 52 was readmitted to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 52's Order Summary Report showed a physician's order dated 5/13/24, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. On 3/12/25 at 1029 hours, a concurrent observation and interview was conducted with LVN 1. LVN 1 verified Resident 52's bilateral upper half side rails were elevated. Review of Resident 52's NC - Side Rail/Entrapment/Care Plan dated 8/6/24, showed Zones 1-7 were assessed and marked as they were within the measurement guideline of less than four and 3/4 (three quarters) of an inch. On 3/14/25 at 1044 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 reviewed and verified Resident 52's Entrapment assessment was inaccurate and stated Zone 5 should have not been assessed since it was not applicable when there were no split bed rails. On 3/14/25 at 1400 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 51539 e. Medical record review for Resident 47 was initiated on 3/11/25. Resident 47 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 47's Order Summary Report 3/14/25, showed a physician's order dated 1/12/25, for the bilateral upper half side rails up and locked when in bed as enabler for positioning and ease of mobility. Review of Resident 47's NC-Side Rail/ Entrapment Assessment/Care Plan dated 4/13/24 and 1/11/25, showed the side rails for Zones 1-7 were assessed for the entrapment and marked as they were within the guidelines of less than four and 3/4 (three quarters) of an inch. On 3/14/25 at 1308 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was asked if all the seven zones should have the check marks on the side rail entrapment assessment. RN 2 verified all the seven zones should not have the check marks for Resident 47 who had an order for only the bilateral upper half side rails and not the split bed rails. On 3/14/25 at 1335 hours, an interview and concurrent medical record review was conducted with the MDS RN. The MDS RN was asked about Resident 47's NC-Side Rail/ Entrapment Assessment/Care Plan dated 4/13/24, and 1/11/25. When asked if all the zones should have been assessed for entrapment for Resident 47, the MDS RN stated no and only the zones that were applicable to the physician's order should have the check marks. f. Medical record review for Resident 9 was initiated on 3/11/25. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's Order Summary Report dated 3/13/25, showed a physician's order dated 1/30/25, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9's NC-Side Rail/ Entrapment Assessment/ Care Plan dated 1/29/25, showed the side rails for Zones 1-7 were assessed for entrapment and marked as they were within the guidelines of less than four and 3/4 (three quarters) of an inch. On 3/14/25 at 1314 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was asked if all the seven zones should have the check marks on the NC-Side Rail/Entrapment Assessment/Care Plan dated 1/29/25. RN 2 verified all seven zones should not have the check marks for Resident 9 who had an order only for the bilateral upper half side rails and not the split bed rails. On 3/14/25 at 1407 hours, an interview and concurrent medical record review was conducted with the MDS RN. The MDS RN was asked if all the seven zones for Resident 9 should have been assessed for entrapment on the NC-Side Rail/Entrapment Assessment/Care Plan dated 1/29/25. The MDS RN verified all the seven zones should not have the check marks for Resident 9. g. Medical record review for Resident 99 was initiated on 3/11/25. Resident 89 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 99's Order Summary Report 3/13/25, showed a physician's order dated 02/24/25, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. Review of Resident 99's NC-Side Rail/ Entrapment Assessment/Care Plan dated 2/24/25, showed the side rails ' Zones 1-7 were assessed for entrapment and marked as they were within the guidelines of less than four and 3/4 (three quarters) of an inch. On 3/14/25 at 1316 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was asked if all the seven zones for Resident 99 should have the check marks on the NC-Side Rail/Entrapment Assessment/Care Plan dated 2/4/25. RN 2 verified all seven zones should not have the check marks for Resident 99 who had an order only for the bilateral upper half side rails and not the split bed rails. On 3/14/25 at 1350 hours, an interview and concurrent medial review was conducted with the MDS RN. The MDS RN was asked if all the seven zones for Resident 99 should have the check marks on the NC-Side Rail/Entrapment Assessment/Care Plan dated 2/24/25. The MDS RN verified all seven zones should not have the check marked for Resident 99. h. Medical record review for Resident 89 was initiated on 3/11/25. Resident 89 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 89's Order Summary Report dated 3/13/25, showed a physician's order dated 8/27/24, for the bilateral upper half side rails up and locked when in bed as an enabler for positioning and ease of mobility. Review of Resident 89's NC-Side Rail/Entrapment Assessment/Care Plan dated 8/27/24, showed the side rails for Zones 1-7 were assessed for entrapment and marked as they were within the guidelines of less than four and 3/4 (three quarters) of an inch. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 1321 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was asked if all the seven zones for Resident 89 should have the check marks on the NC-Side Rail/Entrapment Assessment/Care Plan dated 8/27/24. RN 2 verified all the seven zones should not have the check marks for Resident 89 who had an order only for the bilateral upper half side rails and for the split bed rails. On 3/14/25 at 1405 hours, an interview and concurrent medial review was conducted with the MDS RN. The MDS RN was asked if all the seven zones for Resident 89 should have the check marks on the NC-Side Rail/ Entrapment Assessment/Care Plan dated 8/27/24. The MDS RN verified all the seven zones should have not the check marks for Resident 89 who had an order only for the bilateral upper half side rails and not the split bed rails. 51352 c. On 3/11/25 at 0844 hours, an observation was conducted for Resident 45. Resident 45 was observed lying in bed on his back with the bilateral upper half side rails elevated. Medical record review for Resident 45 was initiated on 3/11/25. Resident 45 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 45's Order Summary Report dated 3/14/25, showed a physician's order dated 3/1/25, for the bilateral upper half side rails up when in bed for positioning and ease of mobility. Review of Resident 45's NC - Side Rail/Entrapment Assessment/Care Plan dated 10/31/24, showed the recommendation for the bilateral upper half side rails was due to Resident 45's generalized muscle weakness. Additionally, the Side Rail/Entrapment Assessment showed Resident 45's bed was assessed for entrapment on Zones 1-7 and all the zones were within the measurement guidelines of less than four and 3/4 (three quarters) of an inch. On 3/12/25 at 1411 hours, a concurrent observation and interview was conducted with LVN 1. LVN 1 verified Resident 45's bed had the bilateral upper half side rails elevated. On 3/14/25 at 1308 hours, an interview and concurrent medical record review for Resident 45 was conducted with RN 2. RN 2 verified Resident 45's NC - Side Rail/Entrapment Assessment/Care Plan dated 10/31/24, showed the entrapment assessment was conducted for Zones 1-7. RN 2 verified the assessment was inaccurate and stated the entrapment assessment for Zone 5 should have not been assessed as it was not applicable when there were no split bed rails. d. Medical record review for Resident 40 was initiated on 3/11/25. Resident 40 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 40's Order Summary Report dated 3/14/25, showed a physician's order dated 2/10/25, for the bilateral upper side rails for positioning due to gravity related to involuntary movements. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 1308 hours, an interview and concurrent medical record review for Resident 40 was conducted with RN 2. RN 2 verified Resident 40's NC - Side Rail/Entrapment Assessment/Care Plan dated 2/10/25, showed the entrapment assessment was conducted for Zones 1-7. RN 2 verified the entrapment assessment was inaccurate, and stated the entrapment assessment for Zone 5 should have not been assessed as it was not applicable when there were no split bed rails. On 3/14/25 at 1503 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39683 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control program and practices to help prevent the development and transmission of diseases and infections. * Two used mugs and a utensil were sitting on the laundry room's clean sink, and the clean linen shelf had staffs' personal belongings, hand sanitizers and lotion bottles next to the clean linen. * The facility was not cleaning and maintaining their decorative water feature, as well as maintaining logs per the facility's water management program. * Residents 28, 77, 88, and 98's (nonsampled residents) infections were incorrectly listed as meeting McGeer's Criteria on the facility's monthly infection control report. * The LVN failed to maintain infection control practices when initiating Resident 100's GT feeding. * Hand hygiene was not performed prior to the medication administration for Resident 6. * Basins were found in Rooms A, B and C's shared restrooms and were not labeled. These failures resulted in inaccurate infection surveillance and/or prevention which had the potential for spread of infection in the facility. Findings: 1. Review of the facility's P&P titled Work Practices revised 8/2008 showed the staff's belongings should not be stored in clean areas. a. On 3/13/25 at 0924 hours, a laundry room inspection and concurrent interview was conducted with the Maintenance Director and the Laundry Staff. Two stacked mugs and one metal utensil were observed on the sink located in the laundry room. The Laundry Staff stated the dishes were used and from the staff's break. The Maintenance Director stated the sink was considered a clean sink, and used dishes should not be placed in or on the sink. b. During the inspection, the following was observed on the clean linen shelves located in the clean linen area: - An umbrella was on top of the linen shelf, touching a clean blanket. - A tote bag, water bottle and drink tumbler were on top of the clean linen shelf. - Two hand-pump bottles of hand sanitizer and two bottles of skin moisturizer were on a shelf with clean linen. Two of the bottles were touching the clean linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Laundry Staff stated the umbrella, tote bag, water bottle, and drink tumbler were staff's personal belongings. The Maintenance Director stated the personal belongings and hand sanitizer, and skin moisturizers should not be stored with the clean linen. 2. Review of the facility's Water Management Program dated 2025 showed the program is designed to reduce the risk for Legionnaires' disease and other opportunistic pathogens associated with the facility's water systems and devices. The program showed the following control point areas to be monitored and tested : - HVAC vents will be checked monthly to ensure there is no water leaking from the vents, which could be aerosolized and inhaled by the residents. - The decorative water fountain will be monitored and cleaned monthly. - Water heaters and the HVAC will be checked quarterly to ensure there are no leaks, stagnant water, or biofilm collecting of fitting, in drip trays, and any other area where water can collect and stagnate. Review of the Water Management Program showed each time a control point was checked, the date and time should be entered on a log sheet, which must be kept in a central location. On 3/13/25 at 1054 hours, an observation, interview, and concurrent facility document review was conducted with the Maintenance Director. A water fountain feature was observed outside by the facility's front entrance. The feature was a raised rectangular pond lined with smooth rocks at the bottom, a decorative pot with rocks spilling out, and two additional decorative pots. [NAME] residue was observed on two of the pots, and on some of the rocks spilling out of a pot. The Maintenance Director stated he did not test the water fountain, but adds a disinfectant tablet to the water monthly. The Maintenance Director stated he did not perform any other cleaning of the water fountain. When reviewing the disinfectant container used, the Maintenance Director verified the container showed to use an automatic feeder, a float, or a skimmer designed for the product. The directions showed to add the disinfectant to reach a free available chlorine level between 1-4 ppm. The Maintenance Director stated he did not test the chlorine level. When asked to review the control logs for the cleaning, inspection and maintenance of the HVAC unit, vents, and the water fountain, the Maintenance Director was unable to locate any. 3. Review of the facility's P&P titled Surveillance for Infection revised 4/2023 showed the purpose of infection surveillance is to identify cases and trends of infection, to guide appropriate interventions, and prevent future infections. The IP will gather data to determine if the resident has a healthcare-associated infection, analyze the data trends and present the findings to the infection control committee. On 3/13/25 at 1536 hours, a concurrent interview, medical record review, and facility document review was conducted with the IP. The IP stated the facility used McGeer's criteria to identify true infections and the data was presented to the infection control committee. Review of the facility's Monthly Infection Surveillance Report for February 2025 showed there were 34 resident infections, with four of them not meeting criteria. The report showed Residents 28, 77, 88, and 98 had infections that not met criteria. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Resident 28's NI - Surveillance Data Collection Form (Respiratory Tract Infections) effective 2/3/25, inaccurately showed the resident's condition met McGeer's criteria for a true infection. b. Resident 77's NI - Surveillance Data Collection Form (Respiratory Tract Infections) effective 2/25/25, inaccurately showed the resident's condition met McGeer's criteria for a true infection. c. Resident 88's NI - Surveillance Data Collection Form (Respiratory Tract Infections) effective 2/4/25, inaccurately showed the resident's condition met McGeer's criteria for a true infection. d. Resident 98's NI - Surveillance Data Collection Form (Respiratory Tract Infections) effective 2/6/25, inaccurately showed the resident's condition met McGeer's criteria for a true infection. The IP verified the above residents' (Residents 28, 77, 88, and 98) dates were inaccurately reported to the infection control committee as meeting criteria when their infections did not meet criteria. 4. On 3/11/25 at 1252 hours, an observation of Resident 100's enteral tubing (connected to the enteral formula and water flush hanging on the enteral pump pole) and concurrent interview was conducted with LVN 5. Resident 100's enteral tubing was observed lying on the floor until LVN 5 entered and came to the resident's bedside at 1302 hours. LVN 5 was observed retrieving the tubing from the floor, and proceeded to connect it to the resident's GT. LVN 5 verified the tubing tip was on the floor and they should have discarded the enteral set-up, and retrieved a new set-up before connecting it to the resident's GT. 47474 5. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 5/2023 showed the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The P&P further showed to use an alcohol-based hand rub containing at least 62% alcohol or soap and water for the following situation including before preparing or handling medications. On 3/12/25 at 0939 hours, a concurrent medication administration observation and interview was conducted with LVN 1 in Resident 6's room. During the medication administration, LVN 1 did not perform hand hygiene prior to administering the oral medications to Resident 6. LVN 1 verified she did not perform hand hygiene prior to administering the medications to Resident 6. LVN 1 stated she should have performed hand hygiene. LVN 1 further stated hand hygiene would prevent contamination and ensures the cleanliness. On 3/14/25 at 1320 hours, an interview with the Administrator and DON was conducted with the Regional Director of Operations present. The Administrator and DON acknowledged and verified the above findings. 49324 6. Review of the facility's P&P titled Personal Property dated 8/2022 showed the residents' belongings are treated with respect by facility staff, regardless of perceived value. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 0822 hours, an observation of Rooms A and B's shared restroom and concurrent interview was conducted with CNA 3. Residents 49 and 53 shared the restroom in Room A, while Residents 50 and 87 shared the restroom in Room B. In Room B's restroom, there was an unlabeled basin found on the shower floor. In Room A's restroom, there was an unlabeled basin on top of the sink. CNA 3 was asked what the basins were used for. CNA 3 stated the basins were used to clean up the residents. CNA 3 verified the basins should have been stored properly and labeled for infection prevention and control. On 3/11/25 at 0934 hours, an observation of Room C's shared restroom and concurrent interview was conducted with CNA 4. Residents 35, 75, and 101 shared the restroom in Room C. There were three unlabeled basins piled on top of each other on a bedside commode in Room C's shared restroom. CNA 4 verified all of the basins should be stored properly and labeled for infection prevention and control. On 3/14/25 at 1045 hours, an interview was conducted with the DON. The DON verified the basins should be labeled and stored properly.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 39683 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the antibiotic stewardship program to reduce the risk of unnecessary or inappropriate antibiotic use when one closed record sampled resident (Resident 1) and four nonsampled residents (Residents 28, 77, 88, and 98) were being treated for conditions which did not meet the McGeer's criteria. These failures had the potential of not accurately identifying true infections and exposing the residents to unnecessary antibiotic use. Findings: Review of the facility's P&P titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes revised 4/2023 showed the IP, or designee will review all antibiotic utilization and identify specific situations that are not consistent with the appropriate use of antibiotics, and the physician will be notified of the review findings. Review of the facility's P&P titled Infections - Clinical Protocol revised 3/2018 showed based on clinical review, the physician and staff will identify whether antibiotics are warranted or whether antibiotics that have already been started should continue or change. On 3/13/25 at 1536 hours, a review of the facility's documents on antibiotic stewardship, medical record review, and concurrent interview was conducted with the IP. The IP stated the facility used the McGeer's criteria to identify for the true infections. The IP stated the process was to notify the physician to evaluate the antibiotic usage for suspected infections that did not meet the McGeer's criteria and were treated with the antibiotics. a. Review of Resident 1's NI - Surveillance Data Collection Form (UTI) with Indwelling Catheter - V1.1 effective 1/26/25, had UTI-DNMC handwritten on the printed form. The form showed the resident was started on Levaquin (an antibiotic) medication for a UTI. The additional notes section showed the results were relayed to the physician with no antibiotics for UTI. The IP stated DNMC meant it did not meet criteria for an infection. Review of Resident 1's medical record showed the urine culture results received on 1/29/25 at 1236 hours, showed organisms were present, with no clinical significance. Review of Resident 1's MAR for January 2025, showed the resident completed the ordered five days of Levaquin 250 mg by mouth four times a day for UTI. The IP verified Resident 1's medical record failed to show the physician was notified when the resident's condition did not meet the McGeer's criteria and to reevaluate the need for the use of the antibiotic medication. b. Review of Resident 28's NI - Surveillance Data Collection Form (Respiratory Tract Infections) effective 2/3/25, showed the resident's condition met McGeer's criteria for a true infection. The form failed to show the constitutional criteria needed to meet the McGeer's criteria. The form showed Resident 28 was treated with the cefepime (an antibiotic) medication. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When the IP was asked to find where they had at least one of the constitutional criteria in Resident 28's medical records, the IP verified the resident's condition did not show at least one of the constitutional criteria, therefore, did not meet McGeer's criteria. The IP verified they incorrectly identified it as meeting the criteria. The IP stated the physician was not notified of Resident 28's condition not meeting the McGeer's criteria and would need to reevaluate the need for the use of the antibiotic medication. c. Review of Resident 77's NI - Surveillance Data Collection Form (Respiratory Tract Infections) effective 2/25/25, showed the resident's condition met McGeer's criteria for a true infection. The form showed the constitutional criteria needed to meet the McGeer's criteria. The form showed Resident 77 was treated with the Zosyn (an antibiotic) medication. When the IP was asked to find where they had at least one of the constitutional criteria in Resident 77's medical records, the IP verified the resident's condition did not show at least one of the constitutional criteria, therefore, did not meet the McGeer's criteria. The IP verified they incorrectly identified it as meeting the criteria. The IP stated the physician was not notified of Resident 77's condition not meeting the McGeer's criteria and would need to reevaluate the need for the use of the antibiotic medication. d. Review of Resident 88's NI - Surveillance Data Collection Form (Respiratory Tract Infections) effective 2/4/25, showed the resident's condition met the McGeer's criteria for a true infection. The form failed to show the constitutional criteria needed to meet the McGeer's criteria. The form showed Resident 88 was treated with the Zosyn (an antibiotic) medication. When the IP was asked to find where they had at least one of the constitutional criteria in Resident 88's medical records, the IP verified the resident's condition did not show at least one of the constitutional criteria, therefore, did not meet the McGeer's criteria. The IP verified they incorrectly identified it as meeting criteria. The IP stated the physician was not notified of Resident 88's condition not meeting the McGeer's criteria and would need to reevaluate the need for the use of the antibiotic medication. e. Review of Resident 98's NI - Surveillance Data Collection Form (Respiratory Tract Infections) effective 2/6/25, showed the resident's condition met the McGeer's criteria for a true infection. The form failed to show the constitutional criteria needed to meet the McGeer's criteria. The form showed Resident 98 was treated with the ciprofloxacin (an antibiotic) medication. When the IP was asked to find where they had at least one of the constitutional criteria in Resident 98's medical records, the IP verified the resident's condition did not show at least one of the constitutional criteria, therefore, did not meet the McGeer's criteria. The IP verified they incorrectly identified it as meeting the criteria. The IP stated the physician was not notified of Resident 98's condition not meeting the McGeer's criteria and would need to reevaluate the need for the use of the antibiotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555035	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Anaheim Healthcare Center	3435 W Ball Road Anaheim, CA 92804

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 50953 Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the essential equipment in a clean and safe operating condition when: * The ice machine located in the kitchen was not clean and the manufacturer's guidelines for cleaning and sanitizing were not followed. * The walk-in refrigerator floor was not maintained in a clean/sanitary condition. * The microwave used to heat the resident's food was not maintained in a clean condition. These failures had the potential for the essential equipment to not function in the way it was intended and expose residents to unsafe practices, which could lead to food borne illnesses for the residents. Findings: 1. Review of the facility's P&P titled Ice Machine cleaning (undated) showed the ice machine bin will be cleaned and sanitized once a month. The maintenance staff will clean and sanitize the motor (evaporator) every three to six months, depending on manufacturer's recommendation. Review of the ice machine manufacturer guidelines titled [Hoshizaki] Model KML -325/500 Instruction Manual revised date 5/13/21, showed the following instructions for Cleaning: - Move the mode switch to the CLEAN position, then move the control switch to the ON position (one short beeps occurs, then three seconds later one long beep occur). - When the control board starts beeping (two beeps sequence), remove the front panel. Move the control switch to the OFF position. - Remove the front insulation panel, then pour [Hoshizaki] Scale away into the water tank. [Model KML -325/500 - 9 fluid ounces(266 ml) Scale away] - Move the control switch to the ON position (one short beep occurs, then three seconds later one long beep occurs). Replace the front panel. To avoid excessive foaming in the water tank, there is a one minute delay before circulation begins. After approximately 30 minutes of circulation, the ice maker performs three rinse cycle. - When the control board start beeping (five beep sequence), remove the front panel. Move the control switch to the OFF position. Sanitizing: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Confirm the mode switch is in the CLEAN position, then move the control switch to the ON position (one short beeps occurs, then three seconds later one long beep occur). Replace the front panel. The water tank drains and then fills. - When the control board starts beeping (two beeps sequence), remove the front panel. Move the control switch to the OFF position. - Remove the front insulation panel then pour 7.5% Sodium Hypochlorite solution (chlorine bleach) into the water tank. - Move the control switch to the ON position (one short beep occurs, then three seconds later one long beep occurs). Replace the front panel. To avoid excessive foaming in the water tank, there is a one minute delay before circulation begins. After approximately 30 minutes of circulation, the ice maker performs three rinse cycle. - When the control board start beeping (five beeps sequence), remove the front panel. Move the control switch to the OFF position - Clean the dispenser unit/ice storage bin liner using a neutral cleaner. Rinse thoroughly after cleaning. On 3/11/25 at 1043 hours, an observation of the ice machine and concurrent interview was conducted with the Maintenance Director, RD, and DSS. When the Maintenance Director was asked about the cleaning of the ice machine, the Maintenance Director stated he cleaned the ice machine once a month. The Maintenance Director stated he used [Nucalgon] cleaner to clean the ice machine. The Maintenance Director stated he put the [Nucalgon] cleaner into the machine and ran the clean cycle. The internal hose was removed and cleaned using a brush and hot water. The ice machine chute (the channel through which ice was dispensed) was cleaned and sanitized on 2/28/25, with Pure Bright Germicidal Ultra Bleach 6% Sodium Hypochlorite. Upon inspection of the ice machine internal components, the chute had a black residue (with picture taken). The Maintenance Director verified the findings. The DSS stated the ice machine storage bin was cleaned with the bleach and rinsed with water. 2. According to the USDA Food Code 2022 Annex 3 Section 4-201.11 Equipment and Utensils showed Equipment and utensils must be designed and constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms, insects, and rodents. On 3/11/25 at 0800 hours, during the initial tour of the kitchen with DSS, the walk-in refrigerator floor was observed with gray paint that was excessively worn exposing the cement floor surface. On 3/12/25 at 0847 hours, an interview was conducted with the Maintenance Director. The Maintenance Director confirmed there was no communication log between the Dietary and Maintenance department for any Dietary concerns. Furthermore, the Maintenance Director confirmed there was no communication regarding the walk-in refrigerator floor condition. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 0859 hours, an observation of the kitchen walk-in refrigerator and concurrent interview was conducted with the Maintenance Director. The Maintenance Director confirmed the walk-in refrigerator floor was in need of repair, and he was not aware of the condition of the floor. The Maintenance Director agreed the walk-in refrigerator floor was not a cleanable surface. 3. On 3/12/25 at 0826 hours, an observation of one of two microwaves located in the dining room, used to heat the residents' food brought from the outside and concurrent interview was conducted with RN 1. The microwave was dirty with excess food debris. RN 1 verified the findings and stated she was not sure who was responsible to clean the microwave.