STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555049	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodi Nursing & Rehabilitation	1334 S. Ham Lane Lodi, CA 95242

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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** 47046 Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for one of twenty-one sampled residents (Resident 10) when: 1. Certified Nursing Assistant (CNA) 1 stood over Resident 10 while assisting him with his meals; and, 2. CNA 1 called residents feeders who needed assistance with meals. This failure resulted in Resident 10 not being provided with a respectful and dignified dining experience, which could further impact Resident 10's quality of life. Findings: 1. During a review of Resident 10's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, and other pertinent information), indicated Resident 10 was admitted to the facility in August 2024 with diagnoses which included dysphagia (difficulty in swallowing) and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS- an assessment and care screening tool), the functional status section of the MDS dated [DATE], indicated Resident 10 required supervision and assistance by facility staff for eating. During an observation on 10/29/24 at 12:25 p.m. in Resident 10's room, Resident 10 was sitting at the edge of the bed and his lunch tray was on the bedside table. CNA 1 was standing on the side of Resident 10's bedside table while feeding him his lunch. During an interview on 10/29/24 at 12:30 p.m. with CNA 1, she stated Resident 10 required supervision and assistance with eating. CNA 1 confirmed she stood beside Resident 10 while feeding him lunch on 10/29/24. CNA 1 stated she should have been sitting while assisting Resident 10 during lunch because standing over a resident may make residents feel uncomfortable. Review of Resident 10's care plan with a focus, Impaired nutritional and hydration status related to . malnutrition, initiated on 8/7/24, indicated, .Provide pleasant atmosphere during meal time . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview on 10/29/24 at 12:25 p.m., CNA 1 was standing next to Resident 10 assisting him with his lunch. CNA 1 stated there were three feeders in her assignment including Resident 10. When asked what she meant by feeders, CNA 1 replied she called residents feeders who needed assistance with meals. CNA 1 stated she should not have called residents feeders, and further stated calling residents by words other than their names was a dignity issue. Review of Resident 10's care plan with a focus on feeding, initiated on 8/9/24, indicated, .Address resident with his/her name of choice . During an interview on 10/31/24 at 10:06 a.m. with the Director of Nursing (DON), the DON stated a CNA should be at eye level while assisting residents with meals. The DON explained CNAs should not call residents feeders who required assistance with meals. The DON stated calling residents feeders and standing while assisting residents with meals were dignity issues. During a review of the facility's policy and procedure (P&P) titled, Assistance with meals, revised 3/2022, the P&P indicated, .not standing over residents while assisting them with meals . During a review of the facility's P&P titled, Quality of life -Dignity, revised 8/2009, the P&P indicated, . Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality . Residents shall be treated with dignity and respect at all times .Staff shall speak respectfully to residents at all times, including addressing the resident by his, her name of choice and not labeling or referring to the resident by .care needs .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 50598 Based on observation, interview and record review, the facility failed to ensure needs were accommodated for 8 of 21 sampled residents (Resident 36, Residents 40, Resident 21, Resident 38, Resident 1, Resident 23, Resident 50, and Resident 39), when: 1. Residents 40, Resident 21, Resident 38, Resident 1, and Resident 39 call light did not work and were not provided alternative means to contact staff, and for Resident 23 and Resident 50 staff did not respond timely to calls made by Resident 23 and Resident 50 who were given and alternative means to contact staff; and 2. Resident 36's call light (device used to contact staff for assistance) was not within reach. This failure had the potential to result in Resident 36, Residents 40, Resident 21, Resident 38, Resident 1, Resident 23, Resident 50, and Resident 39 experiencing frustration and anxiety about calling for assistance, and not having needs met. Findings: 1. Review of Resident 40's admission record indicated Resident 40 was admitted with diagnoses including Ataxic Gait (uncoordinated movements when walking), Acute Respiratory Failure with Hypoxia (not enough oxygen for the tissues in the body), pain, and history of falling. Review of Resident 21's admission record indicated Resident 21 was admitted with diagnosis including repeated falls and apraxia (unable to perform learned tasks or movements). Review of Resident 38's admission record indicated Resident 38 was admitted with diagnoses including type two diabetes mellitus (the body's inability to produce insulin), pain, and transient ischemic attack (an episode of decreased blood flow to the brain). Review of Resident 1's admission record indicated Resident 1 was admitted with diagnoses including epilepsy (seizure disorder), acute embolism and thrombosis (blood clots) of the deep veins, malignant neoplasm of the cerebral meninges (a tumor that grows on the membrane that surrounds the brain). Review of Resident 39's admission record indicated Resident 39 was admitted with diagnosis including muscle weakness, dysphagia (inability to swallow), pain, neuralgia (sharp shocking nerve pain), and neuritis (inflammation of the nerves). Review of Resident 23's admission record indicated Resident 23 was admitted with diagnoses including Acute Respiratory Failure with Hypoxia, muscle weakness, shortness of breath, pain, and abnormalities of gait and mobility. Review of Resident 50's admission record indicated Resident 50 was admitted with diagnosis including difficulty walking, muscle weakness, and pain. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with Resident 50 on 10/29/24, at 10:42 AM, Resident 50 had a hand bell on her bedside table and indicated this was given to her due to the call light not working. Resident 50 indicated she experienced longer wait times when calling for staff assistance due to having the hand bell instead of a call light. Resident 50 indicated she was unsure if staff heard her bell when she rang it, and must continuously ring the bell for assistance especially when her pain level was high and she needed to use the restroom. Resident 50 stated her preference would be the call light with the button to alert staff. During an observation on 10/31/24, at 12:05 PM, in Resident 38, Resident 39, and Resident 23's rooms, all call lights were noted to be nonfunctional with no call bell in sight. During a concurrent observation and interview with Certified Nursing Assistant (CNA 3), on 10/31/24, at 12:16 PM, CNA 3 confirmed call lights for Residents 40, Resident 23, Resident 21, Resident 38, Resident 1, and Resident 39 were not in functional and working condition. CNA 3 indicated the one resident in each room with the hand bell was the one who would ring the hand bell for the other residents when they were in need of staff's attention. CNA 3 indicated the call system in these rooms had been down for about 6-12 months and having a call light system that is not functioning properly, placed the residents at risk for falling and prevented them from being able to contact staff when they needed assistance. During a concurrent interview and observation with CNA 3, on 10/31/24, at 12:26 PM, CNA 3 acknowledged one out three residents in the room had an alternative device in the form of a call bell and this resident (Resident 366) was responsible for notifying staff when her roommates needed assistance. Resident 366 had curtains from wall to wall wrapped around her bed. When asked how Resident 366 would notify staff if there was no visibility of her roommates, CNA 3 acknowledged the discrepancy. During an interview with the Administrator (ADM) on 11/1/24, at 10:31 AM, the ADM explained, when a call light issue arose, the maintenance director would take care of it. The ADM stated if the maintenance director was unable to fix the issue, then the issue would be priced and escalated to corporate. The ADM stated the non-functioning call light system was escalated to corporate and the repairs were denied due to the costs and because the entire system was not down. The ADM stated the status of the call lights did not meet his expectations and acknowledged each resident should have their own functioning call light kept within reach. Review of a facility policy titled Accommodation of Needs, revised March 2021, indicated, .Our Facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity well-being . maintaining hearing aids, glasses, and other adaptive devices for residents. Review of a facility policy titled Quality of Life- Homelike Environment, revised May 2017, indicated, .Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs belongings to the extent possible . 50977 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 10/30/24 at 10:26 AM in Resident 36's room, Resident 36 stated she used her call light to reach staff for assistance. When asked to reach for her call light she felt around her bed and stated that it was nowhere on the bed. Resident 36's call light was observed to be underneath her bed. During an observation on 10/30/24 at 4:10 PM Resident 36's call light was observed on the floor out of arms reach of Resident 36. During a concurrent observation and interview with Licensed Nurse (LN) 1, in Resident 36's room, LN 1 stated call lights should be within reach of residents. LN 1 further stated when call lights were not within reach, residents were not able to ask for help when they need it, and this increased residents risk for falls. LN 1 confirmed Resident 36's call light was on the floor under the bed. During an interview on 10/31/24 at 9:58 AM, with Certified Nursing Assistant (CNA)1, CNA 1 stated call lights should always be by the residents. CNA 1 further stated that she checks every time they are in the resident rooms for call light placement and if they are out of reach resident needs may not be met. During an interview on 11/1/24 at 8:30 AM, with the Director of Nursing (DON), the DON stated that he expected call lights to be operable and within reach of the resident. The DON further stated that if call lights were not within reach, there was a potential for staff to be unaware of resident needs. Review of Resident 36's fall care plan, initiated on 12/13/23, in the section Interventions, indicated, .Have things needed by the resident within reach including call light .initiated 12/13/23 . A review of facility policy and procedure titled, Call Light Answering, indicated, .It is the policy of this facility to provide the resident a means of communication with nursing staff .Leave the resident comfortable. Place the call device within resident's reach before leaving room .The nursing staff will check the placement of the call light during care .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50977 Based on observation, interview, and record review, the facility failed to protect the right for privacy of one of twenty-one sampled residents (Resident 45) when Resident 45 had no privacy curtains (cloth that separates residents and provides them with privacy). This failure had the potential to negatively impact Resident 45's psychosocial well-being. Findings: During a review of Resident 45's Admission Record, the record indicated Resident 45 was admitted to the facility on Fall of 2023. Resident 45's diagnoses included muscle weakness. During a concurrent observation and interview on 10/29/24 at 11:13 AM Resident 45 pointed to his curtains and stated, Curtain isn't able to close all the way. Since I've been here, I have no privacy. During an interview on 10/29/24 at 11:15 AM with Certified Nursing Assistant (CNA) 2, CNA 2 stated she had not been aware Resident 45's curtain was missing, and stated that without the curtain she would not be able to give Resident 45 privacy if she was providing care for Resident 45. During an interview on 10/29/24 at 11:17 AM with the Director of Maintenance (MTD), the MTD stated he was not aware that Resident 45's curtain was missing but would replace it promptly. When asked about the process for new curtains, the MTD stated, Residents are able to request to replace or clean curtains directly to him or laundry staff and they had plenty. During an interview on 11/1/24 at 8:30 AM with the Director of Nursing (DON), the DON stated it was his expectation curtains should have been complete and functioning. The DON further stated if a resident was missing curtains this could lead to residents feeling a lack of dignity and level of embarrassment. Review of Resident 45's, Ineffective Health Maintenance care plan, initiated on 10/28/24, in the section Interventions, indicated, Ensure privacy and comfort during brief changes. A review of the facility policy titled, Quality of Life - Dignity, indicated, .Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47046 Based on observation, interview, and record review, the facility failed to ensure one of twenty-one sampled residents (Resident 43) was assisted with nail care as a part of Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) when staff did not trim Resident 43's long, thick, and discolored toenails. This failure had the potential for Resident 43 to sustain injury and/or to acquire an infection. Findings: Review of Resident 43's Admission Record (AR - a summary of information regarding a patient which includes patient identification and past medical history), indicated Resident 43 was admitted to the facility in June 2024 with diagnoses which included neoplasm (abnormal mass of tissues) of bladder, encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of illness), anxiety, and heart failure. Review of Resident 43's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/12/24, indicated Resident 43 had the ability to understand and be understood by others with an intact memory. The functional section of the MDS indicated Resident 43 required supervision or touching assistance for personal hygiene. During a concurrent observation and interview on 10/29/24 at 11:10 a.m. with Resident 43 in his room, Resident 43's toenails were noted to be long, thick, curved, and discolored. Resident 43 stated his toenails had not been trimmed by staff for months. Resident 43 further stated his toenails were uncomfortable and painful because the curved nails were rubbing on the toes when he walked. Resident 43 explained staff were aware of his long toenails because he had asked multiple times to trim them, and staff told him his name was on the podiatry (services to treat the feet and their ailments) list. Review of Resident 43's Order Listing Report, indicated, .Podiatry services for treatment of . toenails and/ or other foot problem-diabetic [DM-a disorder characterized by difficulty in blood sugar control and poor wound healing] or vascular disease[any condition that affects system of blood vessels] Q [every] 60 days & PRN [as needed] .Order Status- active- .Revision date-6/6/2024- . Review of Resident 43's Social Services Notes, dated 10/29/24, indicated, .Reached out to Local podiatry offices .resident is not diabetic, therefore nursing will attempt to address his foot/toenail needs if able . During an interview on 10/31/24 at 11:43 a.m. with the Social Services Director (SSD), the SSD acknowledged Resident 43's toenails were not trimmed by staff. The SSD stated Resident 43's toenails required to be trimmed by podiatrist. The SSD explained she had been working with Resident 43's insurance to arrange for podiatrist. When asked if Resident 43 had diabetes or vascular disease, the SSD stated Resident 43 did not have diabetes or vascular disease. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24 at 11:56 a.m. with Licensed Nurse (LN)3, LN 3 confirmed Resident 43 had long, thick, curved, and discolored nails. LN 3 stated, Resident 43 was on podiatry list. LN 3 denied Resident 43 having diabetes or vascular disease. When asked if facility staff could trim Resident 43's nails, LN 3 stated facility had basic nail cutter/trimmer and filer and Resident 43's toenails were hard to trim with basic nail trimmer. During an interview on 10/31/24 at 2:06 p.m. with the Director of Nursing (DON), the DON acknowledged Resident 43's toenails were not trimmed by staff. The DON stated he was aware that Resident 43 was waiting for podiatrist for trimming of his long, thick toenails. The DON confirmed Resident 43 did not have diabetes or vascular disease. When asked if facility staff could trim Resident 43's nails, the DON stated trained staff such as LN would be able to trim resident 43's toenails with a trimmer. The DON explained Resident 43's toenails should have been trimmed. The DON stated long toenails were unhygienic and there was a risk for infection and skin issues. During a review of facility's policy titled, Foot Care, revised March 2018, indicated, . Residents will receive appropriate care and treatment in order to maintain mobility and foot health .Residents will be provided with foot/nail care and treatment in accordance with professional standards of practice .Trained staff may provide routine foot care within professional standards of practice for residents without complicating disease processes . During a review of facility's policy titled, Quality of Life- Dignity, revised August 2009, the policy indicated, . Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality .Residents shall be groomed as they wish to be groomed (.nails .) . During a review of facility's policy titled, Fingernails/Toenails, Care of, revised February 2018, the policy indicated, .Proper nail care can aid in the prevention of skin problems around the nail bed .Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47046 Based on observation, interview, and record review, the facility failed to provide restorative services to one of twenty-one sampled residents (Resident 35) when physical therapy was discontinued and further services by Restorative Nursing Assistant were not provided. This failure had the potential to cause a decline in Resident 35's optimal level of function. Findings: During a review of Resident 35's Admission Record (AR - a summary of information regarding a patient which includes patient identification and past medical history), indicated Resident 35 was admitted to the facility in August 2023 with diagnoses which included fracture of lower end of right femur (the bone of the thigh), abnormalities of gait and mobility, and muscle weakness. During a review of Resident 35's care plan initiated on 8/30/23, indicated, .Focus .Self Care Deficit as evidenced by - Requiring assistance or is dependent in: Bed mobility (extensive) .toileting (extensive) . personal hygiene (extensive) .interventions .Physical therapy as ordered .Observe and report to MD [physician] any change in the resident [Resident 35]'s functional mobility and ADL . During a review of Resident 35's Minimum Data Set (MDS- an assessment and care screening tool), the functional status section of MDS dated [DATE], indicated Resident 35 required maximal assistance by facility staff with walking 10 feet and was using a wheelchair. Further review of Resident 35's functional status indicated Resident 35 needed maximal assistance (where the helper does more than half the effort) with lower body dressing, toileting hygiene, and partial/moderate assistance (helper does less than half the effort) with personal hygiene by facility staff. Review of Resident 35's Multidisciplinary Care Conference, dated 12/13/23, indicated, .[Resident 35] recently picked up for skilled services after change to WB [weight bearing] status-currently skilled for therapy services. States she [Resident 35] still plans to DC home, her other son and his family has moved into the same home, so she has a lot of family at home now .Discharge Goal/ Plan .short term .cont'd PT/OT [Physical Therapy/Occupational Therapy] services 5xwk [5 times a week] to improve strength, bed mobility, transfers, ambulation, self care, and ADLs . Review of Resident 35's Physical Therapy Discharge Summary, Dates of Service: 11/14/23-12/21/23, indicated, .Discharge Recommendations: FMP/RNP [Function Motion Prevention- a type of physical therapy/Restorative Nursing Program] .To facilitate patient maintaining current level of performance and in order to prevent decline . During a review of Resident 35's Multidisciplinary Care Conference, dated 3/6/24, SOCIAL SERVICES section indicated, .Discharge Goal/Plan: Long term [long term section was checked] .to remain in the facility unless able to return home . Further review of Resident 35's care conference REHAB, section indicated, . Progress: N/A[Not Applicable] .Plan: N/A .Restorative nursing order and response: N/A . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 35's MDS dated [DATE], the functional status section indicated Resident 35 was dependent for toileting hygiene and required maximal assistance (helper does more than half the effort) by facility staff for personal hygiene. During a concurrent observation and interview on 10/29/24 at 10:55 a.m., Resident 35 was lying in her bed, dressed, and groomed. Resident 35 stated she previously received physical therapy, but her insurance ran out. During a concurrent interview and record review on 10/31/24 at 10:55 a.m. with the Occupational Therapist (OT), Resident 35's physical therapy discharge notes were reviewed. The OT stated Resident 35 was discharged from PT on 12/21/23. The OT also stated the plan was to send Resident 35 home to her family. The OT further stated Resident 35 would have benefitted from continued physical therapy and stated the therapy was discontinued most likely due to insurance. The OT explained Resident 35 still needed 50 percent moderate assistance when her PT services were discontinued. During an interview on 10/31/24 at 2:30 p.m., the PT stated Resident 35 received physical therapy from 8/29/23 to 12/21/23 and was discharged with RNA. The PT also stated the recommendations for Resident 35 were active and passive ROM and transfers with RNAs. When asked if continuation of physical therapy or providing RNA services could have helped Resident 35 to improve her mobility, the PT stated yes. The PT further stated, if there was decline in Resident 35's mobility or activity level, nurses could have referred Resident 35 back to PT and PT would reevaluate Resident 35 and would provide PT services if required. During an interview on 10/31/24 at 4:03 p.m. with Restorative Nursing Assistant (RNA), the RNA denied providing RNA services to Resident 35 after her PT services were discontinued on 12/21/23. During an interview on 10/31/24 at 3:37 p.m. with the Director of Nursing (DON), the DON acknowledged that Resident 35 did not receive RNA services as recommended by PT. During a review of facility's policy titled, Restorative Nursing Services, revised 7/2017, the policy indicated, . Residents will receive restorative nursing care as needed to help promote optimal safety and independence . Residents may be started on a restorative nursing program .when discharged from rehabilitative care . During a review of facility's policy titled, Rehabilitation Services, undated, the policy indicated, . Residents/patients will be reviewed at following times: New admission .Newly identified condition/change of condition .Restorative Nursing Assistant Program referral . After comprehensive consultation with nursing, review of IDT notes, and corresponding medical records, the following should be initiated to address the resident's need to improve condition, prevent further decline, and/or maintain levels of care related to the rehab findings . Resident/ patient currently on active therapy program at this time; therapy treatment . will be reviewed with physician and adjusted to include any additional necessary therapy treatment interventions indicated .Care giver training provided by therapy as indicated. Resident referred to RNA for revision to current program, and/or resident specific training, and/or initiation of new orders for RNA .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47046 Based on observation, interview, and record review, the facility failed to ensure one of four residents (Resident 27) with an indwelling catheter (foley catheter-a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage) received proper care and services consistent with professional standard of care, when Resident 27's urinary collection bag was not positioned lower than his bladder (body organ where urine is collected). This deficient practice had the potential to result in urinary tract infection (UTI- an infection in any part of the urinary system, the kidneys, bladder, and urethra) for Resident 27. Findings: Review of Resident 27's Admission Record (AR - a summary of information regarding a patient which includes patient identification and past medical history), indicated, Resident 27 was admitted to the facility in November 2024 with diagnoses which included encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of illness), and obstructive uropathy (blockage in the urinary tract). During a review of Resident 27's Minimum Data Set (MDS, an assessment and care screening tool) dated 8/22/24, the MDS indicated Resident 27 did not have the ability to understand and be understood by others, with a Brief Interview for Mental Status (BIMS) score of 3 (The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points suggests severe cognitive impairment. 8 to 12 points suggests moderate cognitive impairment. 13 to 15 points suggests that cognition is intact). The bladder and bowel section of the MDS dated [DATE], indicated Resident 27 had an indwelling catheter. Further review of MDS section Active Diagnosis, dated 8/22/24, indicated Resident 27 had diagnosis of Septicemia (a severe infection). During an observation on 10/29/24 at 11:27 a.m., Resident 27's urinary collection bag was observed on top of Resident 27's bed rail (helps to keep residents from rolling out of bed) and was above Resident 27's bladder level. During an observation and concurrent interview on 10/29/24 at 11:29 a.m. with the Certified Nursing Assistant (CNA)2, CNA 2 confirmed and stated that Resident 27's urinary collection bag was placed on the upper bed rail and was above the level of Resident 27's bladder. CNA 2 further stated the urinary catheter bag should never be above the bladder for risk of infection. During an interview on 10/30/24 at 3:01 pm, Licensed Nurse (LN) 2 stated, the urinary collection bag should not be placed on the Resident 27's bed rail. LN 2 also stated, the urinary collection bag should be below the bladder to make sure urine was flowing downward. LN 2 further stated when Resident 27's urinary collection bag was not kept lower than the bladder, the risk were retention of urine, UTI (urinary tract infection), and overflow of urine. During an observation on 10/30/24 at 3:14 p.m., Resident 27's urinary collection bag was on Resident 27's upper bed rail and was above the level of Resident 27's bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/30/24 at 3:14 p.m. with LN 1, LN 1 confirmed that Resident 27's urinary collection bag was placed on the upper bed rail and was above the level of Resident 27's bladder. LN further stated the urinary collection bag should be kept below the level of bladder to avoid risk of infection. During an observation on 10/31/24 at 10:43 a.m., Resident 27 sleeping in his bed and his urinary collection bag was placed on Resident 27's upper bed rail. During a concurrent observation and interview on 10/31/24 at 10:52 a.m. with LN 3, LN 3 confirmed Resident 27's urinary collection bag was placed on the upper bed rail and should always be kept below Resident 27's bladder level. Review of Resident 27's care plan dated 3/15/24, indicated, .Focus .High risk for developing complications including UTI due to use of foley catheter .Interventions .keep drainage bag below level of bladder . During an interview on 10/31/24 at 12:21 p.m. with the Infection Preventionist (IP), the IP stated there was risk of hydronephrosis (a condition that occurs when one or both kidneys swell due to a buildup of urine) and UTI if a urinary collection bag was kept above the bladder. During an interview on 10/31/2024 at 2:00 p.m. with the Director of Nursing (DON), the DON stated a urinary collection bag should never be on the upper bed rail, and should be placed properly on the bed frame. The DON also stated the risk was urine going back to bladder and not draining properly. During an interview on 11/01/24 at 12:39 p.m. with the Director of Staff Development (DSD), the DSD stated the urinary collection bag should be below the bladder level so that urine could flow by the gravity (the force that attracts a body toward the center of the earth). The DSD further stated the risk was urinary retention, pain in abdomen, and UTI if a urinary collection bag was positioned above the level of bladder. A review of the facility's Policy and Procedure titled, Catheter Care, Urinary, revised 8/2022, indicated, . Position the drainage bag lower than the bladder at all times to prevent urine form flowing back into the urinary bladder . During a review of the Centers of the Disease Control (CDC) online publication titled, Guidelines for Prevention of Catheter- Associated Urinary Tract Infections, dated 2009, the section, Proper Techniques for Urinary Catheter Maintenance, indicated, .Keep the collecting bag below the level of the bladder at all times . (https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html)

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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. 47046 Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices for a census of 61 residents when: 1. Staff's personal belongings were stored in one of two medication storage rooms; and, 2. Loose pills were found on the floor and at the bottom of the base cabinet in the medication storage room. These failures had the potential to contribute to unsafe medication storage and diversion. Findings: 1. During a concurrent observation and interview on 10/30/24, at 2:44 p.m. with the Director of Nursing (DON) and Licensed Nurse (LN) 1, the Station 2 medication storage room was inspected with the DON. One personal bag and an insulated water bottle were observed to be stored on the top of the base cabinet. LN 1 confirmed the personal bag and insulated bottle belonged to her. LN 1 stated the personal items should not be stored in the medication room. During an interview on 10/30/24, at 2:46 p.m. with the Director of Nursing (DON), the DON acknowledged staff's personal belongings were stored in Station 2 medication room. The DON stated it was not acceptable to store personal items in the medication storage room. The DON also stated the risk of storing personal items in medication storage room was cross contamination and drug diversion. 2. During a concurrent observation and interview conducted on 10/29/24 at 9:28 a.m. with LN 4, the Station 1 medication room was inspected. Three loose round pills on the base of the cabinet and two round pills and one capsule on the floor were found. LN 4 confirmed there were five loose pills and one capsule on the medication storage room floor, and they needed to be disposed of. During an interview on 10/31/24 at 2:18 p.m. with the DON, the DON stated the loose pills should not be thrown on the floor or in the cabinet. The DON also stated the pills should have been destroyed properly. The DON further stated the risk was accidentally taking the pills and could cause infection. Review of facility policy titled, Storage of Medications, revised April 2007, indicated, .The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner .

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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. 50018 Based on observation, interview, and record review, the facility failed to ensure the kitchen staff competently carried out the functions of the food and nutrition services department according to facility policy and standards of practice when: 1. Two Cooks and two Dietary Aides did not use proper food safety and sanitation practices to prevent cross-contamination; and 2. Weekly thermometer temperature calibrations were not completed by kitchen staff per facility policy. These failures had the potential to expose residents to bacterial contamination, that could result in food borne illnesses for all residents who consume food from the kitchen. The census was 61. Findings: 1. During a tray line observation on 10/29/24 at 12:49 PM, two cooks and two dietary aides were observed not wearing gloves and using their bare hands while plating the lunch meal food to be served. [NAME] (CK) 1 was observed placing her bare thumb on the inside of a foam container while placing a portion of meatloaf into the space of the container touched by her thumb. CK 2 was observed preparing small dessert plates of sherbet squares without gloves or having washed her hands prior to preparing the dessert plates. Dietary Aide (DA) 1 and DA 2 were observed placing food trays onto food carts without gloves on. During an interview on 10/31/24 at 2:08 PM with the Dietary Services Manager (DSM), the DSM stated the kitchen staff should wear gloves during food preparation services. The DSM also stated that it would be a cross-contamination risk if staff did not wear gloves when preparing food. During an interview on 10/31/24 at 3:45 PM with Registered Dietitian (RD) 1, RD 1 stated the kitchen staff needed to wear gloves during food preparation services because it would pose a cross-contamination risk if staff were not using gloves. According to the Food and Drug Administration (FDA) Food Code 2022, Section 3-301.11 Preventing Contamination from Hands, .food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 2022 Federal Food Code, section 2-301.14, titled When to Wash, indicated, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands. During a review of a facility provided in-service titled, Personal Hygiene, dated 4/4/24, in the section, Food Handling, indicated, .Never touch the food contact area of plates, bowls, glasses or cups . During a review of a facility provided in-service titled, Food Safety, dated 6/10/24, in the section, Safe Use of Disposables, indicated, .Handle containers as little possible. In waited surface, servers should keep fingers away from any food-contact surfaces of cups, plates, or other containers . During a review of the facility's policy and procedure titled, Food Preparation and Service, revised 12/2022, in the section, Food Distribution and Service, indicated, .Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks . 2. During the initial kitchen tour on 10/29/24, a review of the facility WEEKLY THERMOMETER CALIBRATION CHART, dated 2024, indicated the last two thermometer calibrations occurred on 9/30/24 and on 10/21/24. The WEEKLY THERMOMETER CALIBRATION CHART also indicated, .All thermometers should be calibrated at least once a week . During a concurrent observation and interview on 10/29/24 at 10:25 AM with CK 2, CK 2 stated the cooks calibrate the thermometers on different days, it depended on the cooks' schedule. CK 2 further stated sometimes it may be a few weeks before they calibrated the thermometers. During an interview on 10/31/24 at 2:08 PM with the DSM, the DSM acknowledged the thermometer calibration log was not completed weekly, according to the chart instructions. The DSM stated the kitchen staff should have calibrated the thermometers every week. The DSM also stated food items may not be at correct temperatures if the thermometers were not calibrated weekly. During an interview on 10/31/24 at 3:45 PM with RD 1, RD 1 stated that she would have preferred the kitchen staff to calibrate the thermometers weekly. RD 1 also stated that the food items may not have the correct temperatures if the thermometers were not calibrated. According to the 2022 Federal Food Code, section 4-204.112 titled Temperature Measuring Devices, indicated, .The importance of maintaining time/temperature control for safety foods at the specified temperatures requires that temperature measuring devices be easily readable. The inability to accurately read a thermometer could result in food being held at unsafe temperatures. Temperature measuring devices must be appropriately scaled per Code requirements to ensure accurate readings . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of a facility provided in-service titled, Thermometer Calibration dated 11/21/23, in the section, Calibrating a Thermometer indicated, .Thermometers should be calibrated regularly to ensure accurate temperatures .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50018 Based on observation, interview and record review, the facility failed to ensure that food was served at an acceptable texture and palatability (taste) for six of six residents (Resident 12, Resident 55, Resident 22, Resident 26, Reisdent 16, and Resident 25) on a pureed (to blend, chop, mash, or strain a food until it reaches this soft consistency) diet when; 1. The cook did not follow a pureed recipe as written for the preparation of dilled zucchini and carrots; and 2. Pureed food items were not of correct texture and consistency. These failures had the potential to affect meal and food intake which could impair the nutrition status for the six residents on a pureed diet. Findings: 1. During a concurrent kitchen observation and interview on 10/29/24 at 12:49 PM with [NAME] (CK) 2, a small metal pan with puree dilled carrots and zucchini vegetables were placed on a steam table. The puree carrot and zucchini mixture was noted to have a dark brownish color. [NAME] (CK) 2 stated that she put the puree vegetable mixture in the oven to keep it warm before 10:00 AM. CK 2 then used a blender to prepare another batch of puree carrots and zucchini vegetables, and the color of the mixture was green. During an interview on 10/31/24 at 2:08 PM with the Dietary Services Manager (DSM), the DSM stated that she wanted the cooks to cook the puree food items evenly to avoid discoloration. The DSM stated that the oven may have been too hot which led to a brownish color for the puree dilled carrots and zucchini. During an interview on 10/31/24 at 3:45 PM with Registered Dietitian (RD) 1, RD 1 stated that she expected the cooks to use and follow standard recipes and to not change from the recipes. RD 1 stated placing food items in the oven for too long would result in overcooking of food. RD 1 further stated that food items would lose nutritional value. During a review of facility provided recipe titled, RECIPE: DILLED CARROTS AND ZUCCHINI, dated 2024, in the section, DIRECTIONS, indicated, .Simmer carrots in boiling water or steam until almost tender .Add zucchini and continue to cook until both are tender. Drain. Add margarine and dill . 2. During a test tray concurrent observation and interview on 10/30/24 at 12:29 PM with the DSM and the Corporate Registered Dietitian (RD 2), a puree of a beef entree was taste tested . The DSM and RD 2 confirmed that the puree beef entree was thin and not a mashed potato consistency. The DSM confirmed there was extra gravy poured on the beef pureed entree and that it may be too much. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/31/24 at 2:08 PM with the DSM, the DSM stated that she wanted the puree food items to be mashed potato-like in consistency. The DSM stated that there could be a choking hazard and aspiration (when something you swallow goes down the wrong way and enters your airway [trachea or windpipe] or lungs) risks if the pureed food items were too watery in consistency. During an interview on 10/31/24 at 3:45 PM with RD 1, RD 1 stated that pureed food items should hold its shape and not be runny. A review of a facility policy and procedure titled Food Preparation, dated 2023, in the section PROCEDURE, indicated, .The facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared .Prepare foods as close as possible to serving time in order to preserve nutrition, freshness, and to prevent overcooking .

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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** 38924 Based on observation, interview, and record review the facility failed to provide a diet in the correct texture to meet the needs of an unsampled resident, (Resident 19), according to facility policy. This failure had the potential to negatively impact Resident 19's food intake which could further impair nutrition status and lead to weight loss. The facility census was 61. Cross reference F806, CA Title 22-72337 Findings: Review of Resident 19's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses which included, essential hypertension (high blood pressure), gastro-intestinal esophageal reflux disease (GERD) (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus), and constipation (difficulty having bowel movements). Review of the Minimum Data Set document indicated Resident 19 had a BIMS (Brief Interview of Mental Status) of 13, where 13-15 points indicated a person's cognition (thinking ability) is intact. Review of Resident 19's Nutrition Care Plan dated 7/22/24, indicated Focus-Impaired nutrition and hydration status related to history of osteoporosis (a chronic disease that weakens bones and increases the risk of fractures) .dysphagia (difficulty swallowing) .Goal- .Will maintain safe swallow all day through next review date . Intervention- .Allow sufficient time for resident to chew every bite . Review of Resident 19's active Physician Diet Order dated 5/20/24 indicated, .Diet Order: NAS (No Added Salt) diet, Regular consistency, Thin liquids . Review of Resident 19's Weight progress note dated 5/7/24 completed by Registered Dietitian (RD) 1, indicated .Diet rx (prescription): NAS, Dysphagia (difficulty swallowing) Mechanical texture, Thin Liquids consistency .Continue plan of care. RD will continue to monitor resident. Review of Resident 19's Nutritional Evaluation dated 5/9/24 completed by the facility's RD indicated, . Function: .edentulous (having no teeth) .poses high nutritional risk for continued weight loss as she has already lost 3.8# over the past 6 days . At risk of involuntary weight loss RT (related to) poor intake and lack of self-feeding ability . Review of the Cook's Spreadsheet Fall Menus, Week 1, Wednesday dated 10/30/24, showed residents on the Dysphagia-Mechanical diet was to receive 3/8 cup Ground Beef cubes with mushrooms, 1/2 cup Soft chopped Egg noodles, 1/2 cup Chopped 1/2 inch mashable Seasoned Spinach, 1/3 cup Pureed Tossed [NAME] salad, 2x2 square slice of Spiced Applesauce cake chopped in 1/2 inch pieces soaked in milk, and 4 ounces of milk. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 9:23 AM with Resident 19, the resident was observed lying in bed watching TV and she had no teeth in her mouth. The resident stated she rarely wears dentures, and she is supposed to get soft foods and a mechanical soft meal. The resident stated she tries to eat foods like cooked meats with her gums. The resident further stated her daughter brings her chili beans and polenta with marinara sauce every week for her to eat. During a concurrent dining observation and interview with Resident 19 on 10/30/24 at 12:25 P.M., Resident 19 received a Regular texture lunch meal including beef cubes with mushrooms, egg noodles, seasoned spinach, spiced applesauce cake and 4 ounces of milk on her tray. The resident stated the noodles and vegetables served at the facility were hard to eat. Resident 19 stated she did not like the noodles because they were too hard to chew. The resident requested an alternate side item like mashed potatoes. During an interview with LN 3 on 10/30/24 at 3:14 PM, Licensed Nurse (LN) 8 stated Resident 19 received a Regular diet but mostly prefers soft and semi-soft foods. LN 8 further stated Resident 19 did not have teeth or dentures. LN 8 further stated the resident was on a regular texture diet a year ago but did not know why the diet was not switched to soft texture. During a concurrent interview and record review on 10/30/24 at 3:53 P.M. with RD 1 and the Dietary Services Manager (DSM), RD 1 stated she did not know resident 19 was not receiving a mechanical soft texture diet. The DSM stated she spoke with the resident about her food preferences but was unaware the resident was not on a soft texture diet. RD 1 reviewed Resident 19's physician's diet order and the facility's Diet Type Report dated 10/29/24 and noticed both documents indicated Resident 19's diet was Regular texture. RD 1 acknowledged she recommended a dysphagia mechanical soft texture diet many months ago in April, but the diet texture was not implemented. RD 1 further stated it was important for Resident 19 to receive food in the correct form to meet her nutrition needs and prevent potential issues like weight loss. Review of the facility's policy titled Diet Orders dated 2023, the policy indicated, .Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department .Nursing will send a Diet Order Communication slip to the Food & Nutrition Services Department. The FNS Director .in charge will make or adjust the diet profile and tray card as prescribed. The diet count is also to be adjusted as needed .Any discrepancy in the diet order slip will be clarified by the FNS Director or [NAME] in charge with Nursing. Review of the facility's policy titled Diet Texture Change dated 2023, indicated .When the resident's condition warrants, the texture of a diet may be downgraded for 72 hours by the Charge Nurse or the Facility Registered Dietitian without a written order from the Physician. Texture change may only decrease in consistency, such as a Mechanical Soft diet going to a Pureed .without a Physician's order . According to the Academy of Nutrition & Dietetics, Nutrition Care Manual, dated 2022, .Unintended weight loss is linked to increased mortality (death) among older adults . residents in long-term-care facilities who continue losing weight have a higher mortality rate compared with those who stop losing weight. Weight loss of 5% or more within 30 days is associated with a tenfold increase in the likelihood of death . (https://www.nutritioncaremanual.org/)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 38924 Based on observation, interview, and record review, the facility failed to ensure residents received snack foods that met their preferences, including two unsampled residents (Resident 19 and Resident 63), based on facility policy. This failure had the potential to lead to decreased food intake which could impair the resident's nutrition and health status. The facility census was 61. Cross reference F805 Findings: During a review of the facility's resident council meeting minutes from April 2024-October 2024, the meeting minutes indicated several concerns about not receiving regular snacks and nourishments. 1. During the resident council meeting on 10/30/24 at 10:27 AM with ten anonymous facility residents, the residents were asked Do you receive snacks at bedtime or when you request them? and the residents stated no, they run out of snacks, peanut butter and jelly, crackers, chocolate cookies, white bread, and dietary preferences for medical preferences are not met. The resident council attendees also stated the food here could be a lot better .we complained about meals and food but that's the only thing that never changes . 2. Review of Resident 19's Admission Record indicated Resident 19 was admitted to the facility with diagnoses which included, essential hypertension (high blood pressure), gastro-intestinal esophageal reflux disease (GERD) (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus), and constipation (difficulty having bowel movements). Review of Resident 19's Minimum Data Set (MDS, an assessment tool) indicated Resident 19 had a BIMS (Brief Interview of Mental Status) of 13, where 13-15 points means a person's cognition (thinking ability) was intact. During an interview on 10/30/24 at 9:23 AM, with Resident 19, the resident stated she did not receive alternative meals and foods that she likes, including cottage cheese, oatmeal, and yogurt. Resident 19 stated she had not spoken with the Registered Dietitian (RD) about her food preferences. 3. Review of the facility's Admission Record Sheet indicated Resident 63 was admitted to the facility with diagnoses including cellulitis (an infection beneath the skin tissues) of left lower limb, hyperlipidemia (large amounts of fat in the blood), hypertension (high blood pressure), and constipation (difficulty having bowel movements). Review of Resident 63's MDS indicated Resident 63's BIMS was 15, where 13-15 points means a person's cognition was intact. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with Resident 63 on 10/30/24 at 5:04 PM, Resident 63 was lying in bed watching the television. Resident 63 stated he liked the peanut butter and jelly sandwiches, but the facility always serves them as snacks. Resident 63 stated he preferred cheese and meat sandwiches, and sometimes crisp rice cereal treats, but they keep telling him they ran out all of them. During an interview with LN 6 on 10/30/24 at 3:03 PM, LN 6 stated the snacks come to the units around 7:00 PM and they include PBJ (peanut butter and jelly) sandwiches, gelatin, and honey crackers, about 12 snack items mixed up in the batch. During an interview with LN 7 on 10/30/24 at 3:09 PM, LN 7 stated the residents receive evening snacks like Turkey/ham sandwiches, PBJ sandwiches, pudding, crisp rice cereal treats, gelatin, cereal mix, and graham crackers. LN 7 stated the kitchen had soda or juice available in the evening if needed for residents with diabetes. During an interview with LN 8 on 10/30/24 at 3:14 PM, LN 8 stated the kitchen is open every day after 7:00 PM to give residents snacks like granola bars, PBJ sandwiches, and crackers. During an interview on 10/31/24 at 9:26 AM with the Administrator (ADM) and the Director of Nursing (DON) about resident snacks, the DON stated the Dietary Services Manager (DSM) and the Registered Dietician (RD) will check to make sure the standard snacks are offered like graham crackers and sandwiches to residents. The ADM and DON each stated they should make sure they ask the residents about their alternative food and snack preferences. The ADM and the DON both stated the facility should offer a variety of foods like tuna sandwiches and other foods. During an interview on 10/30/24 at 3:58 PM with the RD and the DSM about the resident snacks at the facility, the DSM stated she did an initial screening with resident about their food preferences. The DSM stated she did not attend the resident council meetings and did not know the snacks were not being offered to residents consistently at night. The RD also stated she was unaware the residents were not receiving their snacks but stated it was important for them to receive snacks to help meet their nutrition needs. Review of the facility's policy tilted Food Preferences, dated 2023, indicated, .Resident's food preferences will be adhered to .Substitutes for all foods disliked will be given from the appropriate food group .Food preferences can be obtained from the resident, family, or staff members. Updating of food preferences will be done as the resident's needs change and/or during the quarterly review . Review of the facility's policy and procedure titled Accommodation of Needs, dated 2001, indicated, .Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being .Policy Interpretation and Implementation .The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled NOURISHMENT POLICY, dated 2023, indicated, .Nourishments or between meal snacks shall be provided when required by the diet prescription. Bedtime snacks of a nourishing quality will be offered routinely to all residents unless contraindicated .Note that suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care and diet order .

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 50977 Based on observation, interview, and record review, the facility failed to ensure the needs of two of twenty-one sampled residents (Resident 3 and Resident 36) accommodated when water pitchers were not available or empty at the bedside. These failures had the potential to result in potential health problems related to dehydration (A condition that occurs when the body loses too much water and other fluids that it needs to work normally.) for Resident 3 and Resident 36. Findings: During an observation on 10/30/24 at 11:34 AM in Resident 36's room, the water pitcher on the bedside table was empty. During a concurrent observation and interview on 10/30/24 at 4:06 PM, in Resident 3's room, Resident 3 was observed sitting in her wheelchair with no water pitcher on her bedside table in front of her. Resident 3 stated that she was thirsty and wanted something to drink. During a concurrent observation and interview on 10/31/24 at 2:09 PM just outside of Resident 3 and Resident 36's room, with Certified Nursing Assistant (CNA) 3, CNA 3 confirmed Resident 3 did not have a water pitcher and Resident 36's water pitcher was empty. CNA 3 stated residents should have a water pitcher for hydration and that not having water available to Resident 3 and Resident 36 could put them at risk for dehydration. During an interview on 10/31/24 at 3:47 PM with the Registered Dietitian (RD) 1, RD 1 stated it was her expectation that water would be readily available to residents in a container if the resident had no fluid restriction. During an interview on 11/1/24 at 8:30 AM, with the Director of Nursing (DON), the DON stated it was his expectation for residents to have water available to them for hydration. The DON further stated if a resident did not have water available, it could put the resident at risk of dehydration and urinary tract infections as well. A Review of the facility's policy titled, Resident Hydration and Prevention of Dehydration, revised October 2017, indicated, .This facility will strive to provide adequate hydration .Nurses' aides will provide and encourage intake of fluids, on a daily and routine basis as part of daily care .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50018 The facility failed to store, prepare, distribute and serve food in accordance with professional standards and facility policy for food service when: 1. An Ice machine was not cleaned per manufacturer's guidelines and facility policy. 2. Lunch meal foods were not handled and served safely under sanitary conditions during a trayline observation. 3. Coffee machine water filter was expired for more than 1.5 years. 4. Serving ladles and scoop handles were damaged and not maintained in food safe manner. 5. A Griddle top collection tray cup had black sticky grime, brown stains and food residue inside of it. 6. Curry powder seasoning was out of date and code. 7. Parsley was found to be discolored with a tannish brown color on the leaves and stems. These failures had the potential to cause widespread foodborne illness in the 61 residents eating facility prepared meals. Cross reference F802 Findings: 1. During an interview [DATE] at 10:50 AM with the Maintenance Director (MTD), the MTD stated the ice machine was cleaned every three months. During an interview on [DATE] at 2:08 PM with Dietary Services Manager (DSM), the DSM stated the kitchen staff only cleaned the visible areas of the ice machine. The DSM also stated the kitchen staff did not clean the internal portions of the ice machine. During a kitchen observation and interview on [DATE] at 2:19 PM, the inside of an ice machine was observed to be dirty where the water tray loads and the ice making grid. Black and brown substances and debris material was on the ice machine chute, internal walls, water tray, and the ice bin. The external filter on the back of the ice machine was filthy with gray lint and debris. The MTD and DSM acknowledged the internal areas with black and brown debris inside the ice machine and the dirty filter. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 3:45 PM with Registered Dietitian (RD) 1, RD 1 stated ice machines should be clean and not have black mold inside of it. RD 1 stated the kitchen staff should clean the ice machine. RD 1 also stated a dirty ice machine could lead to dirt or mold getting into the ice. RD 1 further stated that ice was considered food and did not want residents to swallow dirty ice as it could lead to food-borne illnesses. During a review of the facility's policy and procedure titled, ICE MACHINE CLEANING PROCEDURES dated XX/23 indicated, .The ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly or per manufacturer's recommendations, and the date recorded when cleaned. According to the 2022 Federal FDA Food Code section ,d+[DATE].11 indicated Equipment Food-Contact Surfaces and Utensils. Ice bins and components of ice makers need to be cleaned: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold .Ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms . 2. During a trayline observation on [DATE] at 12:49 PM, two cooks and two dietary aides were observed preparing food to be served. [NAME] (CK) 1 was observed placing her bare thumb on the inside of a disposable foam dish where meatloaf was being plated. CK 2 was observed preparing plates of food without gloves on. Dietary Aides (DA) 1 and 2 were observed placing food trays onto food carts without gloves on. During an interview on [DATE] at 2:08 PM with the Dietary Services Manager (DSM), the DSM stated that she wanted the kitchen staff to wear gloves during food preparation services. The DSM also stated that it would be cross-contamination risk if staff are not wearing gloves preparing food. During an interview on [DATE] at 3:45 PM with Registered Dietician (RD) 1, RD 1 stated that she wanted the kitchen staff to wear gloves during food preparation services. RD 1 also stated it would pose a cross-contamination risk if staff were not using gloves. According to the Food and Drug Administration (FDA) Food Code 2022, Section ,d+[DATE].11 Preventing Contamination from Hands, .food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment . During a review of a facility provided in-service titled, Personal Hygiene dated [DATE], in the section, Food Handling indicated, .Never touch the food contact area of plates, bowls, glasses or cups. 3. During an initial kitchen tour on [DATE] at 10:05 AM, a water filter system on the coffee machine was observed to be dated [DATE] and expired according to manufacturer's information. During an interview on [DATE] at 11:10 AM with [company name] Vendor Technician (VTC) 2, VTC 2 stated he recommends the coffee water filter system be changed within a one-year timeframe. VTC 3 changed out the coffee water filter system because it was 18 months old. During an interview on [DATE] at 2:08 PM with the Dietary Services Manager (DSM), the DSM stated that the coffee water filter system should be changed out yearly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 3:45 PM with Registered Dietician (RD) 1, RD 1 stated that the coffee water filter system should be changed regularly. RD 1 also stated that the coffee may not be as fresh and that the flavor profile may change. During a review of the facility's policy and procedure titled, Maintenance Service revised ,d+[DATE], in the section, Policy Interpretation and Implementation indicated, .Maintenance personnel shall follow the manufacturer's recommended maintenance schedule . 4. During an initial kitchen tour on [DATE] at 8:45 AM, eight scoops and ladles were noted to have rubber handles that were melted down with black grime and debris deeply engrained in the hard rubber. During an interview on [DATE] at 9:19 AM PM with the DSM, the DSM stated the cooks were constantly burning the handles of the scoops and ladles while they cooked. During an interview on [DATE] at 2:08 PM with the DSM, the DSM stated that serving ladles and scoops should be in good working condition. The DSM also stated that particles could get into the food items. The DSM further stated that staff safety could be at risk because of the damaged utensils. During an interview on [DATE] at 3:45 PM with RD 1, RD 1 stated that burned ladles and scoops could impact staff safety. During a review of the facility's policy and procedure titled, KITCHEN SAFETY dated XX/23 indicated, . Maintain cutlery in good condition. During a review of the facility's policy and procedure titled, SANITATION dated XX/23 indicated, .All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas . 5. During the initial kitchen tour on [DATE] at 8:45 AM, a collecting tray cup located underneath the griddle with an opening at top of the griddle equipment, had black sticky grime, brown stains, and food residue inside of it. During an interview on [DATE] at 2:08 PM with the DSM, the DSM stated that the grill should be cleaned every time it is used. The DSM also stated she would not want to see a buildup of food residue. During an interview on [DATE] at 3:45 PM with RD 1, RD 1 stated that the griddle should be cleaned after every use. RD 1 also stated the griddle should be deep cleaned at least once a week. RD 1 further stated that she did not want food particles in the collecting duct of the griddle. According to Food and Drug Administration (FDA) Food Code 2022, ,d+[DATE].12 Cleaning, Frequency and Restrictions . (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . (B)Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing . According to FDA Food Code 2022, Section ,d+[DATE].11. Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils . (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure titled, Food Preparation and Service revised ,d+[DATE] indicated, .Cross-contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned . During a review of the facility's policy and procedure titled, RANGES AND OVENS dated XX/23 indicated, . Range drip pans must be emptied and washed on a routinely scheduled basis . Grills must be cleaned after each use . Always empty and wash the grease catch pan after each use . 6. During an initial kitchen tour on [DATE] at 8:45 AM, a container of curry powder was noted to have an open date of [DATE]. During an interview on [DATE] at 2:08 PM with the DSM, the DSM stated that expired curry powder could lead to spices losing its flavor. During an interview on [DATE] at 3:45 PM with RD 1, RD 1 stated that she did not want expired food items in the kitchen. RD 1 also stated that spices that are expired could lose flavor. During a review of an undated facility provided letter from [company name], the letter indicated, .Spices are generally considered Best Used By in ,d+[DATE] months . During a review of a facility provided in-service titled, DRY STORAGE OF FOOD AND SUPPLIES dated [DATE], in the section, Procedures for Dry Storage, the section indicated, .Dry food items which has been opened such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles, etc., will be tightly closed, labeled, and dated. These items are to be used per times specified in the Dry Food Storage Guidelines . During a review of the facility's undated policy and procedure titled, DRY GOOD STORAGE GUIDELINES dated XX/23 indicated spices such as curry powder have a shelf life of one year once opened. 7. During an initial kitchen tour on [DATE] at 10:05 AM, parsley was found discolored and wilting in a reach-in refrigerator. During an interview on [DATE] at 2:08 PM with the DSM, the DSM stated that she would prefer vegetables to fresh and not wilted. The DSM also stated she would not want to serve parsley that was discolored. During an interview on [DATE] at 3:45 PM with RD 1, RD 1 stated vegetables should be tossed out if they are wilting or discolored. During a review of the facility's policy and procedure titled, STORING PRODUCE dated XX/23 indicated, . Keeping fresh vegetables tightly wrapped with as little air in the bag/container as possible will keep them fresh longer . Remove the wilted or spoiled portions of lettuce, celery, and other fresh vegetables in the refrigerator often so they don't cause the rest of the vegetable to spoil.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50018 47046 Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 61, when: 1. A used urinal (a container used to collect urine) in Resident 51's shared bathroom was not labeled with a resident identifier; and, 2. The shared glucometer (a device used to measure blood sugar) and blood pressure device (BP device, measures the pressure of blood pushing against the walls of arteries) were not cleaned and sanitized in-between resident care based on manufacturer's recommendation and standards of practice. These failures had the potential to spread infections to residents residing in the facility, negatively impacting their health and well-being. Findings: 1. During an observation on 10/29/24 at 10:49 a.m. in Resident 51's shared bathroom (shared with Resident 27 and Resident 43), one urinal with no resident name and/or room number was observed on a metal grab bar. During a concurrent observation and interview on 10/29/24 at 10:51 a.m., with Certified Nursing Assistant (CNA) 2, CNA 2 confirmed the urinal in Resident 51's shared bathroom was used, soiled, and did not have a name or other resident identifier placed on the urinal. CNA 2 stated the soiled urinal should have been cleaned after use and should have a resident identifier placed on the urinal. CNA 2 stated three residents had access to that bathroom. CNA 2 further stated she did not know to whom that urinal belonged. CNA 2 stated the urinal could have been used for a resident it did not belong to, which could lead to spread of infection. During an interview on 10/31/24, at 12:26 p.m., with the Infection Preventionist (IP), the IP stated the urinals should be labeled with room number and the resident's name. The IP also stated when there was no resident identifier on a used urinal, other residents who shared that bathroom could use the same urinal and could cause cross contamination. During an interview on 10/31/24 at 2:03 p.m. with the Director of Nursing (DON), the DON stated the urinal in the shared bathroom should have been labeled with a resident identifier such as room number or resident's name. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. During an observation with Licensed Nurse (LN) 5, in station 2 hallway, on 10/30/24, at 10:57 a.m., LN 5 gathered the blood sugar supplies including a glucometer with a lancet device (spike needle) and entered Resident 33's room. LN 5 spiked Resident 33's right second finger to get blood and then soaked the test strip (a disposable testing strip used for blood sugar measurement) attached to the glucometer with blood and obtained a blood sugar reading. After exiting the room, LN 5 placed the glucometer on top of the mobile medication cart. LN 5, with bare hands used one wipe (purple top Super Sani-Cloth disposable wipe) to quickly clean the outer surface of the glucometer and left it on top of the cart. LN 5 then proceeded to administer Insulin (blood sugar medicine injection). 2b. During an observation with LN 5, in the station 2 hallway, on 10/30/24, at 11:11 a.m., LN 5 gathered the blood sugar supplies including a glucometer previously used, with a lancet device and entered an unsampled Resident's room. LN 5 poked the Resident's finger to get blood and then soaked the test strip attached to the glucometer with blood . After exiting the room, LN 5 with bare hands, used one wipe (purple top Super Sani-Cloth disposable wipe) to quickly clean the outer surface of the glucometer and placed it in the drawer of the cart. LN 5 then proceeded to administer Insulin with a pen shaped injection device. 2c. During an observation on 10/30/24 at 11:34 a.m. with LN 2, in the Station 2 hallway, LN 2 gathered the blood sugar supplies including a glucometer, with a lancet device and entered Resident 38's room. With a gloved hand, LN 1 poked Resident 38's finger to get blood and then soaked the test strip attached to the glucometer with blood. After exiting the room, LN 2 with bare hands, used one wipe (purple top Super Sani-Cloth disposable wipe) to quickly clean the outer surface of the glucometer and put it in the drawer of the cart. LN 2 then proceeded to administer Insulin (blood sugar medicine). 2d. During a medication administration observation, with LN 1, in the station 2 hallway, on 10/30/24, at 3:29 p. m., LN 1 asked another facility staff to bring a blood pressure device to measure Resident 9's blood pressure from another cart. Staff handed a blood pressure device to LN 1. LN 1 did not clean device. LN 1 used the blood pressure device to measure Resident 9's blood pressure. After leaving the room, LN 1did not clean the BP device. During an interview on 10/30/24, at 3:41 p.m. with LN 1, at station 2 nursing station, LN 1 confirmed and stated she realized that she should have cleaned the blood pressure device before and after use. During an interview on 11/1/24 at 12:20 p.m. with the Director of Staff Development (DSD), the DSD stated she expected the nursing staff should clean blood pressure devices prior and after use, in -between resident care. The DSD also stated the glucometer should be cleaned with the recommended blue top wipe (bleach disposable wipes) not purple top disposable wipe. The DSD described the process to clean the glucometer in-between resident care, and stated the nurse with a gloved hand should have used the facility provided sanitizer wipe and allow it to be wet for 2 minutes. The DSD acknowledged they needed to re-educate the staff on proper two step cleaning and sanitizing of the shared patient care devices including the glucometer. During a review of facility's policy, titled, CLEANING AND DISINFECTION OF GLUCOMETER, revised 1/2019, indicated, .Clean glucometer surface after EACH use by wiping with a cloth dampened with soap and water to remove any organic material from the machine. Disinfect (after each use) after cleaning the exterior surfaces following the manufacturers' directions using a cloth/wipe . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, titled Cleaning and Disinfecting of Resident-Care Items and Equipment, dated 10/2018, the policy indicated Resident care equipment including reusable items .will be cleaned and disinfected according to current CDC (or Center for Disease Control, a federal agency) recommendations for disinfection . The policy further indicated Reusable items are cleaned and disinfected .between residents . Review of the facility's reference manual, titled ASSURE PLATINUM Quality Assurance/Quality Control (QA/QC) Reference Manual, (a brand name for glucometer), indicated, .Wear disposable .gloves .Clean the outside of the blood glucose(sugar) meter with a lint-free cloth dampened with soapy water of isopropyl alcohol (70-80%) .Disinfect the meter[glucometer] by .bleach .Use a lint-free cloth dampened with the solution to thoroughly wipe down the meter . Review of the facility's approved disinfectant wipe, labeled as Super Sani-Cloth Germicidal Disposable Wipe, with a purple color top, the label indicated .When using this product, wear disposable protective gloves . Avoid contact with skin .cleaning procedure: .must be thoroughly cleaned from surfaces before disinfection by application with this product [germicidal wipe] .Precleaning is to include . wiping all visible soil is removed . Use second germicidal wipe to thoroughly wet surface. Allow to remain wet two (2) minutes. During a review of the facility's document titled, INFECTION PREVENTION and CONTROL PROGRAM, revised 6/2021, the Policy and Procedure indicated, .established and maintained to provide a safe, sanitary and comfortable environment . During a review of the Centers of the Disease Control (CDC) online publication titled, Considerations for Blood Glucose Monitoring and Insulin Administration, undated, in the section, Recommend practices in healthcare settings, indicated, .meters[glucometers] should be cleaned and disinfected per the manufacturer's instructions .If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents . This article in the section, Rationale, further indicated, .Unsafe practices include using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses . (https://www.cdc.gov/injection-safety/hcp/infection-control/index.html)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555049	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodi Nursing & Rehabilitation	1334 S. Ham Lane Lodi, CA 95242

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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 - Some	Keep all essential equipment working safely. 50018 Based on observation, interview, and record review, the facility failed to ensure kitchen equipment was maintained in a safe, operating, and fully functioning manner, when a low-temperature dishwashing machine was not maintaining the correct wash temperature, per manufacturer specifications and facility policy. This failure had the potential to impact the ability of dietary staff to prepare and serve food in a safe and sanitary manner. The facility census was 61. Findings: During the initial kitchen tour observation on 10/29/24 at 9:05 AM, the low temperature dish machine was observed during a wash cycle of dishes and the wash temperature ranged between 90-100 degrees Fahrenheit (F) on the thermometer. During an interview on 10/29/24 at 9:10 AM with Dietary Aide (DA) 1, DA 1 stated the minimum temperature for the dish machine wash cycle should be 120 degrees F. DA 1 also stated that the booster equipment attached to the dish machine that heats the water temperature up to the proper level, was not working, causing the dish machine not to reach 120 degrees F. DA 1 further stated that the booster had not been working for a week. During an interview on 10/29/24 at 9:19 AM with the Dietary Services Manager (DSM), the DSM stated the Dish Machine Vendor Technician (VTC) 1 told her the wash temperature did not need to reach a minimum of 120 degrees F. During an interview on 10/29/24 at 10:50 AM with the Maintenance Director (MTD), the MTD stated that the low-temperature dish machine wash temperature should be at least 120 degrees F. During an interview on 10/29/24 at 11:13 AM with VTC 1, the VTC 1 stated that the low-temperature dish machine wash temperature should be at least 120 degrees F. During an interview on 10/31/24 at 2:08 PM with the DSM, the DSM stated that she was mistaken about the dish machine wash temperature because it should have been at least 120 degrees. The DSM also stated that residents could get sick if proper temperatures were not maintained for the dish machines. During an interview on 10/31/24 at 3:45 PM with Registered Dietitian (RD) 1, RD 1 stated the bare minimum temperature should be at 120 degrees F. RD 1 stated that the dishwashing machine wash temperature should not have been between 90-100 degrees F. The RD 1 also stated that bacteria would not be killed if the minimum water wash temperature was not reached. RD 1 further stated residents could get sick if those dishes were being used. According to the Food and Drug Administration (FDA) Food Code 2017, Section 4-204.113 Warewashing Machine, Data Plate Operating Specifications, indicated, .A warewashing machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine's design and operation specifications including the: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(A) Temperatures required for washing, rinsing, and SANITIZING . According to the FDA Food Code 2022, Section 6-501.11 Repairing, indicated, . Physical Facilities shall be maintained in good repair. During a review of the facility's policy and procedure titled, Maintenance Service revised 12/2009, in the section, Policy Interpretation and Implementation indicated, .The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . During a review of the facility's policy and procedure titled, Sanitization revised 12/2022, in the section, Policy Interpretation and Implementation indicated, .Low-Temperature Dishwasher (Chemical Sanitization): (1) Wash Temperature (120*F) .