

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Veterans Home of California - Yountville - Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 100 California Drive Yountville, CA 94599	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>50669</p> <p>Based on observation, interview and record review, the facility failed to provide reasonable accommodations for one of 35 sampled residents, Resident 120, and unsampled Residents 9, 185, and 64, by failing to ensure call lights were within reach in the restrooms. This failure had the potential to result in residents unable to request assistance when needed.</p> <p>Findings:</p> <p>During an observation on 4/8/24 at 11:07 a.m. in [NAME] 3, the restroom call-light pull-cord for Residents 120, 3, 185, and 64, were dangling from the wall, not within reach, and not properly latched to the toilet railing.</p> <p>During a concurrent observation and interview on 4/10/24 at 10:55 a.m. with Certified Nursing Assistant 1 (CNA 1) in [NAME] 3, CNA 1 was assisting Resident 9 with transferring to the restroom. The call-light pull-cord was observed to be not properly latched to the toilet railing and out of reach. CNA 1 demonstrated how to utilize the call-light and stated yes this cord needs to be latched on the railing.</p> <p>During an interview on 4/10/24 at 10:55 a.m. with Registered Nurse 2 (RN 2), RN 2 stated, The staff will help a resident to the restroom depending on their assistance level needed. The staff give the resident privacy and direct the residents to pull the call-light when they are done for the staff to come back and assist them.</p> <p>During a review of the facility's policy and procedure (P&P) titled, (Activities of Daily Living) ADL, Standards, dated 6/21/23, the P&P indicated, Each resident will be provided a call-light that is readily accessible to the resident and that is answered promptly. Ensure residents are reasonably accommodated for call-light usage based on their individualized need .</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>49266</p> <p>Based on observation, interview, and record review, the facility failed to ensure a clean environment when:</p> <ol style="list-style-type: none"> 1. A visibly soiled wheelchair was stored in a hallway. 2. Staff did not clean the lift equipment after use. <p>These failures had the potential to result in spreading disease causing organisms to residents using the unclean equipment.</p> <p>Findings:</p> <p>1. During an observation on 4/8/24 at 11:12 a.m. in the main hallway of Unit 1B, there were four wheelchairs stored in the hallway. One wheelchair had dried brown substance along the front of the seat cushion.</p> <p>During an interview on 4/8/24 at 11:22 a.m. with (Minimum Data Set) MDS Coordinator (MDSC 2), MDSC 2 stated that the wheelchairs were usually cleaned on a schedule during the night shift.</p> <p>During a concurrent observation and interview on 4/8/24 at 11:22 a.m. with Supervising Registered Nurse (SRN 6), SRN 6 was observed using her gloved finger to remove some of the dried brown substance from the seat cushion. SRN 6 stated, It's coming off, it looks like it's coming off.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Cleaning, Environmental, dated 1/1/24, the P&P indicated, Sanitary- Includes, but limited to, preventing the spread of disease causing organisms by keeping Resident care equipment clean and properly stored . The P&P further indicated, Resident Equipment- Nursing staff will clean non-disposable (reusable) items . according to Environmental Cleaning Schedule. The P&P in addition showed, Environmental Cleaning Schedule . Wheelchairs- Clean PRN-All Shifts, Clean thoroughly every month- PM & NOC shift .</p> <p>50669</p> <p>2. During an observation on 4/8/24 at 11:49 a.m. in [NAME] 3, Certified Nursing Assistant 1 (CNA 1) used resident lift equipment on Resident 45 to transfer resident from chair to toilet and back. CNA 1 returned resident lift equipment to room labeled lift/wheelchairs without cleaning after use. CNA 1 left the room labeled lift/wheelchairs and went to hand out lunch trays.</p> <p>During an observation on 4/9/24 at 12:02 p.m. in [NAME] 3, CNA 1 used resident lift equipment on Resident 92 to transfer resident from chair to toilet and returned resident lift equipment to room labeled lift/wheelchairs without cleaning afer use. CNA 1 left the room labeled lift/wheelchairs and went on to assist another resident.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/24 at 12:05 p.m. with CNA 1, CNA 1 stated, Policy is to use microbial wipes before and after using all devices.</p> <p>During an interview on 4/9/24 at 12:06 p.m. with Registered Nurse 1 (RN 1), RN 1 stated, Wipes are used for all devices before and after use before storing away.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Cleaning, Environmental, dated 1/6/24, the P&P indicated, .Nursing staff will clean non-disposable (reusable) items . according to Environmental Cleaning Schedule . lifts: clean after each use for all shifts .</p>

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>41816</p> <p>Based on interview and record review, the facility failed to determine one of 35 sampled residents, (Resident 159) required a Significant Change in Status Assessment (SCSA) within 14 days of a significant decline with the Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents) when Resident 159 had an:</p> <ol style="list-style-type: none"> 1. Emergence of a new unstageable (unable to determine where the injury begins and ends) pressure injury. 2. Emergence of unplanned weight loss problem. <p>This failure had the potential to further complicate Resident 159's medical status as the facility did not convene in a timely manner to address interdisciplinary measures from the care team.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 159's Physicians Orders, dated 2/15/24, the Physicians Orders indicated the need for a wound consult. <p>During a review of Resident 159's Care Plan, dated 2/27/24, the Care Plan indicated date of onset for pressure injury was 2/27/24.</p> <p>During a review of Resident 159's Progress Note Wound Care, dated 3/1/24, the wound care note written by the wound care physician described an unstageable pressure injury to the sacrum (a shield-shaped bony structure that is located at the base of the lumbar spine and that is connected to the pelvis).</p> <p>During a review of the facility's policy and procedure (P&P) titled, Wound Management and Skin Breakdown Prevention, dated 6/21/23, the P&P indicated, The Interdisciplinary Team (IDT) will: Address wound progress, treatment and preventable measures in the IDT meeting and update the care plan, as indicated.</p> <p>During an interview on 4/11/24 at 8:13 a.m. with MDS Coordinator 1 (MDSC 1), MDSC 1 stated, A change of condition status change report was not done for Resident 159 since his admission. MDSC 1 stated, Usually there is an IDT meeting, and it is discussed there, where it would be recommended by the IDT Team.</p> <p>During an interview on 4/11/24 at 8:27 a.m. with Supervising Registered Nurse 5 (SRN 5), SRN 5 stated, We notify the MD (Medical Doctor), Dietician, OT (Occupational Therapy), with pressure ulcers, we do not have an IDT meeting just for pressure ulcers . I do not notify the MDS Coordinator.</p> <ol style="list-style-type: none"> 2. During a review of Resident 159's Dietary Follow Up Report, dated 2/29/24, the report indicated, the reason for the assessment was for significant weight loss and pressure injury. <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 159's Weight Record, dated 3/2/24 for Resident 159 indicated, the physician was notified of a significant weight loss.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Weight Monitoring, dated 6/21/23, the P&P indicated, The licensed nurse is responsible for routinely monitoring weights and identifying significant changes .When a significant change of 5 lbs. or more within the last 30 days is identified, the nurse will: Initiate 'change of status' IDT/MDS .</p> <p>During an interview on 4/11/24 at 8:13 a.m. with MDS Coordinator 1 (MDSC 1), MDSC 1 stated she was unsure if a significant weight loss would trigger a significant change assessment.</p> <p>During an interview on 4/11/24 at 8:27 a.m. with Supervising Registered Nurse 5 (SRN 5), SRN 5 stated, I do not recall if we have an IDT for significant weight loss . We have a weight team who notifies doctors, supervisors and the dietician. The QA (Quality Assurance) team assigns an RN (Registered Nurse) to go to each ward and weighs the residents. This is the weight team.</p> <p>During an interview on 4/11/24 at 8:45 a.m. with MDSC 2, MDSC 2 stated, The IDT would let us know if there was a significant weight loss . If due for an assessment we compare from the previous assessment. Resident 159 is due for his April quarterly assessment . It will be a significant change assessment rather than a quarterly. It (the need for an MDS) should have been communicated in an IDT meeting. That is how we know about changes. It got missed.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview and record review, the facility failed to update the comprehensive care plan for Resident 120 that accurately stated assistive devices resident required. This failure resulted in the inability to track resident progress to provide continued comprehensive care for one of 35 sampled residents, Resident 120.</p> <p>Findings:</p> <p>During a review of Resident 120's medical record, the medical record indicated Resident 120 was admitted to the facility on [DATE], with diagnoses of Age-Related Cognitive Decline (gradual decline in memory, thinking, or other brain processes associated to age) and Generalized Muscle Weakness (lack of muscle strength), and Spondylosis of thoracic region (deterioration of the middle of the spine).</p> <p>During multiple observations on 4/8/24 at 10:46 a.m., on 4/9/24 at 1:49 p.m., on 4/10/24 at 12:24 p.m. and on 4/11/24 at 8:52 a.m., Resident 120 was observed sitting in a wheelchair. Resident 120 needed assistance from staff for ambulation with the wheelchair. Resident 120 was not seen using any other assistive devices.</p> <p>During multiple observations on 4/8/24 at 10:43 a.m., on 4/9/24 at 9:51 a.m. and on 4/11/24 at 9:51 a.m., of Resident 120's room, there was no four-wheel walker (4WW) found.</p> <p>During a phone interview on 4/10/24 at 10:24 a.m. with Resident 120's Family Member (FM), FM stated, he had been in a wheelchair for over a month. FM stated, she was concern for residents' weakness and wanting resident to be rehabilitated. FM stated he has told me I want to leave here; I want to move around.</p> <p>During a concurrent interview and record review on 4/11/24 at 9:07 a.m. with Supervising Registered Nurse 4 (SRN 4), Resident 120's Restorative Nursing Assistant Program Care Plan- Range of Motion (ROM) dated 1/7/24, indicated, .risk for decline in ROM . provide appropriate level of assistance to promote safety of resident . target date 4/6/24. SRN 4 stated, we need to update this.</p> <p>During a concurrent interview and record review on 4/11/24 at 9:05 a.m. with SRN 4, Resident 120's Care Plan, dated 4/5/24 was reviewed. The Care Plan indicated, .fall related injuries will not occur .intervention . uses 4WW for mobility .initiated 9/14/23. The Care Plan dated 4/5/24, did not address Resident 120's current and accurate use of assistive devices and level of assistance needed, being a wheelchair not a 4WW. SRN 4 confirmed Care Plan had not been updated to reflect Resident 120's current need for the wheelchair.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plan, dated 2/13/24, the P&P indicated, .each discipline will be responsible for the ongoing follow up for the care plan . services are to be furnished to attain or maintain the Resident's highest practicable physical well-being. The comprehensive care plan must describe . the Resident's goals and desired outcomes .</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>49266</p> <p>Based on interview and record review, the facility failed to revise a care plan for one of 35 sampled residents (Resident 99) when Resident 99's wound care orders were changed. This failure had the potential for miscommunication among staff and for Resident 99 to receive care that was no longer required, and to delay wound healing.</p> <p>Findings:</p> <p>During a review of Resident 99's Podiatry Clinic Note, dated 3/29/24, the Podiatry Clinic Note indicated, Resident 99 had bilateral heel wounds from ischemia (lack of blood supply to a part of the body) and peripheral arterial disease (narrowed arteries that reduce blood flow to the legs or arms).</p> <p>During a review of Resident 99's Physician Orders, dated 3/29/24, the Physician Orders indicated, Wound Care Orders . Frequency QOD [every other day] . apply a generous amount of betadine to all wound sites . The Physician Orders further indicated, D/C [discontinue] old orders.</p> <p>During a concurrent interview and record review on 4/10/24 at 10:12 a.m. with (Minimum Data Set) MDS Coordinator 2 (MDSC 2), Resident 99's Care Plan, dated 3/8/24 was reviewed. The care plan indicated, problem bilateral heel wounds, added on 2/21/24. The care plan further indicated, Intervention . Treatment as ordered: B/L [bilateral] heels, Betadine paint 4x (four times) a day . MDSC 2 stated, The care plan should have been updated to reflect new wound care orders.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans, dated 2/13/24, the P&P indicated, Each discipline will be responsible for the initiation and ongoing follow up for the care plan .</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>41816</p> <p>Based on interview and record review, the facility failed to provide facility sponsored community activities for one of 35 sampled residents (Resident 80). This failure had the potential to prevent Resident 80 from obtaining a meaningful connection with his community and improving his quality of life.</p> <p>Findings:</p> <p>During an interview on 4/8/24 at 3:41 p.m. with Resident 80, Resident 80 stated, There is much to be desired with the 'facility' activities program. When I first came here, there were a lot of activities to choose from, outdoor experiences . Now I just get in my chair and go. We would go out to dinner and visit culinary schools . There is a fire house just down the street, I'd like to go there . I haven't seen that kind of outing in the last 3 years . I have requested these many times.</p> <p>During an interview on 4/9/24 at 10:41 a.m. with Recreational Therapist 1 (RT 1), RT 1 acknowledged Resident 80's preferences for community outings and stated he does not participate in outings within the community (outside of the facility).</p> <p>During an interview on 4/10/24 at 10:56 a.m., RT 1 stated, Due to Covid and the flu, we have not been on so many outings . We have two types of transportation; the state shuttle, and a private company with hired transportation . The problem is with the hired transportation is that Resident 80's wheelchair is too big, it won't fit on the lift. The private company has informed the facility it cannot facilitate transporting Resident 80, due to the size of his chair. RT 1 stated, The state shuttle has issues as well. They are short staffed with drivers. They are only being used for medical appointments right now. This has been going on for at least a year . We would go to the movies when we had the state van available. We'll have to wait until we hire more drivers . Community outings are big for Resident 80, that and food.</p> <p>During a review of Resident 80's Care Plan, dated of 3/13/24, the care plan indicated in Problem #11 Activity independence, Resident 80 is encouraged to make own choices. It indicated Resident 80 enjoyed going to the movies independently and out to eat, doing things with groups of people, spending time outdoors.</p> <p>During a review of Resident 80's Activity Participation Log, for January, February and March 2024, the log indicated, Resident 80 had no outings within the community, as requested.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34448</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of 35 sampled residents (Resident 597 and Resident 71) received the following:</p> <p>1a. Resident 597 failed to receive timely cardiology (branch of medicine that deals with diseases and abnormalities of the heart) follow up after a fall as ordered by the Physician. This failure had the potential to adversely affect Resident 597's medical condition.</p> <p>1b. Resident 597's referral to neurosurgery (medical specialty that diagnosis and treats diseases/disorders of the spine) was completed, as recommended by the Physician. This failure had the potential to adversely affect Resident 597's medical condition.</p> <p>2. Resident 71's compression stockings were not changed regularly or when visibly soiled. This failure had the potential for Resident 71 to acquire skin irritation.</p> <p>Findings:</p> <p>1a. During a review of Resident 597's Admission Face Sheet Record (demographics), undated, the Face Sheet Record indicated, Resident 597 was admitted to Unit 1B on 1/25/24, with diagnoses that included a history of falling.</p> <p>During a review of Resident 597's POST-FALL REPORT, dated 1/23/24, the Post-Fall Report indicated, Resident 597 had experienced falls while living in Section C of the facility on 2/17/23, 3/29/23, 8/25/23, 1/11/24, and 1/23/24.</p> <p>During a review of Resident 597's History and Physical (H&P), dated 2/1/24, the H&P indicated, Eliquis (medication to prevent and treat blood clots) was discontinued due to gait instability / fall risk . Will order cardiology follow up to determine thromboembolic (obstruction of a blood vessel by a blood clot) risk .</p> <p>During a review of Resident 597's INTERDISCIPLINARY PROGRESS NOTES POST-FALL / NURSING NOTE, dated 3/8/24 and 3/22/24, indicated Resident 597 had experienced a fall on both of the dates after admission to Unit 1B.</p> <p>During a review of a Physician's order, dated 2/6/24, the Physician's order indicated cardiology follow-up for Resident 597 status post fall with a history of atrial fibrillation (irregular heartbeat). The Physician's order further indicated, Please re-assess anticoagulation need .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review, on 4/9/24 at 1:32 p.m. with the Chief of Medical Records (CMR), CMR stated the Physician's order for the cardiology consult was entered into the computer by the Certified Nursing Assistant on 2/6/24. CMR stated her department received the order and the Medical Assistant Scheduler booked the appointment for 4/24/24, as a six month follow up from the 8/30/23 appointment. CMR stated, if the appointment was a status post fall, the appointment should have been moved up. CMR was questioned how the scheduler would know whether to move an appointment up closer than the six month follow up. CMR stated it was common sense, and that training had been provided to the schedulers how to decide if an appointment should be moved up.</p> <p>During a review of the protocol for scheduling appointments, undated, provided by CMR, the protocol indicated, Booking appts (appointments) from a CONS (Consultation) - Meditech request Pull up the resident, verify if the resident already has a schedule appointment with that clinic/provider NO: Go ahead and find an appt date/time under the provider schedule and book according to the CONS request YES: Add the order number to the existing booked appt on the reason for visit Edit the appointment up or down per the CONS request .</p> <p>1b. During a review of Resident 597's Admission Face Sheet Record (demographics), undated, the Face Sheet Record indicated, Resident 597 was admitted to Unit 1B on 1/25/24, with diagnoses that included a history of falling.</p> <p>During a review of Resident 597's History and Physical (H&P), dated 2/1/24, the H&P indicated, Resident 597 had a fall and was admitted to [name of hospital] from 1/24/24 to 1/25/24. The H&P indicated, Resident 597 had thoracic/lumbar compression fractures and right rib fractures. The H&P further indicated Resident 597, Was given TLSO (Thoracic-Lumbar-Sacral Orthosis, brace to provide stability to the spine and support to compression fractures) brace, and advised to wear at all times during ambulation .</p> <p>During a review of a Physician's order, dated 2/13/24, the Physician's order indicated, .Spine Ortho (medical specialty that diagnosis and treats bone and joint disorders) referral . Request f/u (follow up) with ortho including recommendation as to how long resident should be using TLSO brace .</p> <p>During a concurrent interview and record review, on 4/9/24 at 1:32 p.m. with the Chief of Medical Records (CMR), CMR stated the referral had been sent to the spine ortho Physician on 2/16/24. The faxed response from the spine ortho Physician was reviewed, dated 2/16/24, that indicated the referral was declined. The response further indicated, Patient needs to follow up with neurosurgery at [name of hospital]. CMR provided an email indicating she had notified Resident 597's care team of the declined referral. CMR stated, The care team usually follows up on it. I don't have any information it was followed up on.</p> <p>The facility did not provide a policy and procedure for referrals.</p> <p>22069</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a concurrent observation and interview, on 4/8/24 at 11:10 a.m. with Resident 71 in room [ROOM NUMBER]B, the resident's right lower extremity compression stocking was observed with a large brown stain measuring approximately 2 inches in diameter at the middle shin area. The stocking was observed to be visibly soiled. When asked if the stain was from bleeding, he stated, No. Resident 71 further stated, his compression stocking was dirty and had not been changed for a while. Resident 71 stated, I need a new stocking.</p> <p>During an interview on 4/8/24 at 11:15 a.m. with Supervising Registered Nurse 1 (SRN 1), SRN 1 stated the compression stockings should be changed when it was soiled. SRN 1 confirmed the stocking needed to be changed.</p> <p>During a review of the facility's policy and procedure titled, Antiembolism Stocking Application (undated), indicated, Using warm water and mild soap, wash stockings when they become soiled. Keep a second pair handy so that the patient can wear them while the other pair is being laundered.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50669</p> <p>Based on observation, interview and record review, the facility failed to ensure an audiology assessment was conducted and right hearing aid was replaced in a timely manner for one of 35 sampled residents (Resident 120). This failure resulted in Resident 120 not receiving an audiology (branch of science and medicine concerned with the sense of hearing) assessment and replacement of the hearing aid.</p> <p>Findings:</p> <p>During a review of Resident 120's medical record, the medical record indicated that Resident 120 was admitted to the facility on [DATE], with diagnoses of Age-Related Cognitive Decline (gradual decline in memory, thinking, or other brain processes associated to age) and Sensorineural Hearing Loss (a type of hearing loss that stems from damage to inner ear).</p> <p>During a concurrent observation and interview on 4/8/24 at 3:27 p.m. with Resident 120 in [NAME] 3, Resident 120 was observed without his hearing aids. Resident 120 stated, things go missing all the time. When asked what things were missing, he mentioned his hearing aids.</p> <p>During a concurrent observation and interview on 4/8/24 at 3:29 p.m. with Registered Nurse 2 (RN 2), RN 2 stated, Resident has had right hearing aid missing for a while. When RN 2 went to assist Resident 120 to put on left hearing aid, it was found with a dead battery.</p> <p>During an interview on 4/10/24 at 10:24 a.m. with Resident 120's Family Member (FM), FM stated, the hearing aid had been missing since November of last year. FM had asked multiple times about audiology. FM stated, Resident 120 was still waiting for an appointment.</p> <p>During a concurrent interview and record review on 4/8/24 at 3:41 p.m. with RN 2, Resident 120's Interdisciplinary Team Conference, dated 2/19/24 indicated, right hearing aid missing on 11/30/23 and audiology referral ordered RN 2 was unable to find a pending audiology appointment or referral request.</p> <p>During a review of Resident 120's Restorative Assessment, dated 1/7/24, the Restorative Assessment indicated, Resident 120 should be encouraged to wear bilateral hearing aids for optimal hearing for safety.</p> <p>During an interview on 4/8/24 at 3:48 p.m. with Supervising Registered Nurse 4 (SRN 4), SRN 4 stated, once audiology referral is entered in the system, then scheduling department will get it ordered in their system. SRN 4 reviewed Resident 120's medical record and computer system and stated she did not see a pending appointment for audiology.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Processing Incoming Orders, undated, the P&P indicated, after the packets are faxed/emailed to the office. The office will then notify us. book the appointment in system, complete the order in system The facility failed to follow up with audiology to ensure Resident 120 had an appointment after five months of audiology referral being inputted.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>50669</p> <p>Based on observation, interview and record review, the facility failed to provide Physical Therapy (PT) per physician's order in a timely manner for one of 35 sampled residents (Resident 120). This failure resulted in delay of care (greater than one month) for Resident 120, that contributed to prolonged use of wheelchair and decline in mobility.</p> <p>Findings:</p> <p>During multiple observations on 4/8/24 at 10:46 a.m., 4/9/24 at 1:49 p.m., 4/10/24 at 12:24 p.m. and 4/11/24 at 8:52 a.m., Resident 120 was observed sitting in a wheelchair. Resident 120 required assistance from staff for ambulation with the wheelchair. Resident 120 was not observed using any other assistive devices.</p> <p>During a review of Resident 120's Restorative Nurse Referral Note, dated 1/7/24, the Restorative Nurse Referral Note indicated, Resident 120's reason for referral: to maintain range of motion . strength, functional mobility, maintain endurance and prevent deconditioning . ambulate with 4WW (four-wheeled walker) assistive device and stand by assistance . Care plan initiated 1/7/24- plan of care: range of motion exercises . ambulate with 4WW and stand by assistance.</p> <p>During a review of Resident 120's Interdisciplinary Team Conference Note, dated 2/19/24, the Interdisciplinary Team Conference Note indicated, Resident 120 had problems with: Potential risk for injury related to accident .uses 4WW for ambulation. Resident 120's gait was weak, forgets limitations, high risk for falls .</p> <p>During a review of Resident 120's Interdisciplinary Progress Notes, dated 3/2/24, the Interdisciplinary Progress Notes indicated, Resident 120 returned to [NAME] 3 at 12:30 PM with staff escort in wheelchair. Resident 120 appeared weak with standing. The Supervising Registered Nurse 4 (SRN 4) was made aware, the doctor was made aware and gave order for PT evaluation for weakness and use of 4WW/transfer device.</p> <p>During an interview on 4/10/24 at 10:24 a.m. with Resident 120's Family member (FM), FM stated, Resident 120 had COVID a month ago, and since going back to usual room, he has been in a wheelchair. FM had asked Registered Nurse 1 (RN 1) why Resident 120 was still in a wheelchair and RN 1 had stated every resident that had COVID, has come back weaker and RN 1 was concerned about Resident 120's noticeably increasing weakness.</p> <p>During a concurrent interview and record review on 4/11/24 at 8:58 a.m. with SRN 4, Resident 120's Physician Orders, indicated, on 03/03/2024 a referral was entered for PT evaluation due to weakness and mobility. SRN 4 stated, Resident 120 should have received evaluation by now.</p> <p>During a review of the Physical Therapy Notes, dated 4/8/24, the physical therapy notes indicated Resident 120's first physical therapy assessment was on 4/8/24, however Resident 120 was participating with activities, will re-attempt at later date.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Physical & Occupational Therapy Services, dated 7/31/23, the P&P indicated, The Physical/Occupational Therapist (OT) will respond timely to primary care physician's (PCP) orders for PT/OT evaluation . PT/OT Evaluation referrals . will be evaluated within 5 business days</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>22069</p> <p>Based on interview and record review, the facility failed to ensure a discontinued Novolin R Insulin Sliding Scale (dose of insulin based on blood glucose level) was not carried over to the current physician's order for one of 35 sampled residents (Resident 79). This failure had the potential for medication administration error.</p> <p>Findings:</p> <p>During a review of Resident 79's current physician's recapitulation order, dated 2/1/24, indicated two different Novolin R Insulin Sliding Scales which included the following;</p> <p>1. 12/21/23 Novolin R insulin per sliding scale .</p> <p>150 - 200 = 3 units</p> <p>201 - 250 = 6 units</p> <p>251 - 300 = 9 units</p> <p>301 - 350 = 12 units</p> <p>> (greater than) 351 = 15 units.</p> <p>2. (undated) *** Sliding Scale *** Novolin R :</p> <p>150 - 200 = 3 units</p> <p>201 - 250 = 6 units</p> <p>251 - 300 = 9 units</p> <p>301 to 350 = 12 units</p> <p>351 - 400 = 15 units</p> <p>401 - 450 = 18 units</p> <p>>451 = 21 units.</p> <p>During an interview on 4/10/24 at 1:30 p.m. with the Nurse Practitioner 1 (NP 1), NP 1 stated the undated sliding scale was discontinued on 8/5/22. NP 1 stated the discontinued sliding scale should not have been carried over to the current recapitulation order.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49266</p> <p>Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals used in the facility were properly stored when Resident 43's Voltaren (a topical medication for pain) was found stored without a cap in a container with other residents medications. This failure had the potential to result in medication contamination and compromised effectiveness.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/10/24 at 8:20 a.m. with MDS (Minimum Data Set) Coordinator 2 (MDSC 2), of Unit 1B's treatment cart, Resident 43's Voltaren was found stored in a cassette mixed with other resident medications. The cap was missing from the Voltaren tube. The MDSC 2 stated that the medication should have a cap on it to keep it moist and clean.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication, Storage & Labels, dated 3/14/23, the P&P indicated, Drug Containers . Containers which are cracked, soiled, or without secure closures will not be used.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41337</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety when:</p> <ol style="list-style-type: none"> 1. Live roaches were found in a sticky trap on the floor under the stainless-steel counter in the nourishment area, behind the ice machine, in the room with the 3-compartment sink, and in the dish washing room of the staging kitchen of the [NAME] Building. Pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. 2. Floor under the counter tops had food crumbs and trash in the nourishment area, behind the ice machines, under the tray line assembly (where staff serve the food on plates for the residents), and in the house keeping closet in the staging kitchen in the [NAME] Building. In the main kitchen there was food crumbs and build up on the floors in the food production area, behind the tumble chill machine (large batches of food can be rapidly chilled), behind the steamer and under the grill in the MDR (Main Dining Room) kitchen area and under the reach in refrigerator that was reserved for vegan (no animal products or dairy) and vegetarian (no animal products) foods. Build-up of food crumbs on the floor under equipment can allow pathogenic microorganisms to grow and attract pests. 3. Multiple floor drains had a build-up of black grime, food particles and trash in the staging kitchen of the [NAME] Building and in the main kitchen. Build-up in the floor drains can allow pathogenic microorganisms to grow and attract pests. 4. The ice machine in the nourishment area of the [NAME] staging kitchen, had a build-up of black substance in the ice bin. 5. Cook Specialist II (CSII) did not follow the process for cool down when he did not log the time and temperature of rice, spaghetti, and mashed potato when he put it in the blast chiller. In addition, the cooling temperature log was incorrectly filled out by multiple employees when they did not fill in the final temperature and/or they used the exact same time and temperature for multiple food items. Proper cool down is critical to prevent microbial growth. Excessive time for cooling of time/temperature control for safety foods (TCS) (food that requires time and temperature controls to limit the growth of illness causing bacteria) has been consistently identified as one of the leading contributing factors to foodborne illness. Documenting time and temperature on a log ensures that TCS foods are monitored and cooled safely. 6. Two nursing staff ([Certified Nursing Assistant] CNA 1 and CNA 2) were observed touching RTE (ready to eat) food with their bare hands when assisting residents with their lunch on Monday, 4/8/24. Depending on the microbial contamination level on the hands, handwashing with plain soap and water, as specified in the Food Code, may not be an adequate intervention to prevent the transmission of pathogenic microbes to ready-to-eat foods via hand contact with ready-to-eat foods. <p>This had the potential to contaminate food and cause food-borne illness for 197 medically compromised residents who received food from the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Findings:</p> <p>1. During an observation and concurrent interview with the Food Service Supervisor (FSS) in the [NAME] staging kitchen on 4/8/24 at 10:12 a.m., there were live roaches in a sticky trap on the floor under the stainless-steel counter in the nourishment area. The FSS stated that they had been having this issue for a while since the construction had been going on across the street. Roaches were also observed in the sticky trap behind the ice machine.</p> <p>During an observation in the [NAME] staging kitchen on 4/8/24 at 10:28 a.m. in the area with the 3-compartment sink (three separate sink compartments, one for each step of the ware-wash procedure: wash, rinse, and sanitize), there was a sticky trap behind the handwashing sink on the floor that had a dead roach.</p> <p>During an interview on 4/9/24 at 3:14 p.m. with Plant Operations Manager (POM) and the Pest Technician (PT) from [Company name] pest control services, PT stated that the roach problem in the [NAME] staging kitchen was not as bad as it used to be. He stated the roaches that he was finding were German Cockroaches. PT stated he usually found them around the dishwasher. He stated that there is a door in the staging kitchen that lead to the dumpsters, and he always saw it propped open, and he believed that is how the cockroaches were entering the kitchen.</p> <p>During an observation in the [NAME] staging kitchen on 4/10/24 at 8:27 a.m., there was a sticky trap with a dead cockroach in the dish washing room.</p> <p>During an interview on 4/11/24 at 9:17 a.m. with Food Service Supervisor (FSS), he stated there should not be any pests in the kitchen at all.</p> <p>During a review of the facility policy titled Food and Nutrition Services- Sanitation, dated 11/5/2, the policy indicated, 1. Kitchen and serving area(s): B. will be protected from rodents, roaches, flies, and other insects.</p> <p>During a review of the FDA Federal Food Code, dated 2022, 6-501.11 indicated, The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises. In addition, Insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments.</p> <p>2. During an observation and concurrent interview with the Food Service Supervisor (FSS) in the [NAME] staging kitchen, on 4/8/24 at 10:12 a.m., the floor under the counters had a build-up of crumbs and spilled liquid. The FSS stated housekeeping pressure washed the floor under the counters and equipment once a month, but probably needed to be done more often to eliminate the build-up.</p> <p>During an observation in the [NAME] staging kitchen on 4/8/24 at 10:28 a.m., there was a build-up of food crumbs on the floor under and behind the retherm units (piece of commercial cooking equipment that uses hot water to reheat cold foods).</p> <p>During an observation in the [NAME] staging kitchen on 4/8/24 at 10:30 a.m., there was trash and dirty rags on the floor under a storage shelf in the housekeeping closet.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation and concurrent interview with the Food Service Supervisor (FSS), in the [NAME] staging kitchen on 4/8/24 at 10:43 a.m., there was a build-up of food crumbs and trash under the tray line assembly area. The FSS stated the floor under the tray line assembly area should be kept clean.</p> <p>During an observation and concurrent interview with the Housekeeping Services 1 (HS 1) in the main kitchen on 4/9/24 at 11:42 a.m., there was a dustpan in the housekeeping closet filled with trash and there was trash on the floor. The HS 1 stated that the dust pan should be empty and there should be no trash on the floor.</p> <p>During an observation in the main kitchen on 4/9/24 at 11:49 a.m., there were crumbs and food on the floor in the back corner under the stainless-steel counter.</p> <p>During an observation and concurrent interview with the Food Manager (FM), in the main kitchen pm 4/9/24 at 11:52 a.m., there was food crumbs build-up on the floor behind the tumble chill machine.</p> <p>During an observation in the main kitchen cooking line for the main dining room and concurrent interview with the Food Manager (FM) on 4/10/24 at 9:05 a.m., there was build-up of food crumbs on the floor under the cooking equipment. FM stated the equipment can't be moved so it's difficult to clean underneath.</p> <p>During an observation in the main kitchen on 4/10/24 at 9:15 a.m., there were a build-up of food particles and water on the floor behind the steamer and there was also a build-up of food on the floor behind the grill. The floor under the reach-in refrigerator for vegan and vegetarian foods had a build-up of trash and food crumbs.</p> <p>During an interview on 4/11/24 at 9:17 a.m., with the Food Service Supervisor (FSS) and the Supervising Cook 1 (SC1), FSS stated that his expectation was that there is no build-up of food, crumbs, or trash. The SC1 stated the floors under the equipment should be kept clean and free of any food crumbs.</p> <p>During a review of the facility document titled, Food and Nutrition Services - Sanitation, dated 11/5/23 indicated, 1. Kitchen and serving area(s): A. will be kept clean; free from litter and rubbish. 2. Ceilings, walls, windows, floors, and doors will be kept clean and maintained in good repair (i.e., free from breaks, corrosion, holes, cracks, chips, dirt, and/or grime).</p> <p>During a review of the FDA Federal Food Code, dated 2022, 4-601.11 indicated, (C) nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. In addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted.</p> <p>3. During an observation in the [NAME] staging kitchen and concurrent interview the Food Service Supervisor (FSS) on 4/8/24 at 10:12 a.m., the floor drained under the stainless-steel counter in the nourishment area had a build-up of black grime and food. The FSS stated the drains needed to be cleaned more often.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation in the [NAME] staging kitchen and concurrent interview with the Food Service Supervisor (FSS) on 4/8/24 at 10:38 a.m., two floor drains near the walk-in fridge had a build-up of black grime and food. The FSS stated the drains should be kept clean.</p> <p>During an observation in the main kitchen on 4/10/24 at 9:05 a.m., there was a drain in the kitchen area where food was prepped/cooked for the main dining room, the floor drains under a food preparation sink had black grime and trash. Another drain at the cooking line had a build-up of food grime.</p> <p>During an interview with the Food Service Supervisor (FSS) and Supervising Cook 1 (SC1) on 4/11/24 at 9:17 a.m., the FSS stated the floor drains should be kept clean and free of any build-up. The SC1 also stated that the drains should be kept clean.</p> <p>During the review of the facility policy titled, Food and Nutrition Services - Sanitation, dated 11/5/23 indicated, 1. Kitchen and serving area(s): A. will be kept clean, free from litter and rubbish.</p> <p>During a review of the FDA Federal Food Code, dated 2022, 4-601.11 indicated, (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. In addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted.</p> <p>4. During an observation in the nourishment area of the [NAME] staging kitchen and concurrent interview with the Plant Operations Engineer 1 (POE1) on 4/9/24 at 10:33 a.m., the ice machine had a black color build-up in the ice bin. The POE1 stated that his process was to clean the ice machine every six months and he did quarterly service.</p> <p>During an interview with the Food Service Supervisor (FSS) on 4/11/24 at 9:17 a.m., he stated the ice machine should not have any build-up in the ice bin.</p> <p>During a review of the facility document titled, Ice Machine Tasks- SA/Quarterly, dated 1/27/24, the document indicated, clean equipment per manufacture recommendations and sanitizing.</p> <p>During a review of the facility policy titled, Ice Machine Cleaning Procedures, dated 8/9/21, the policy indicated, Ice used in connection with food or drink will be from a sanitary source and will be handled and dispensed in a sanitary manner.</p> <p>During a review of the FDA Federal Food Code, dated 2022, 4-602.11 indicated, (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT:</p> <p>(a) At a frequency specified by the manufacturer, or</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>(b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. In addition, Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, 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.</p> <p>5. During an observation and concurrent interview with the Cook Specialist II (CSII) and document review of the blast chiller (piece of equipment that quickly lowers the temperature of food) Cooling Temperature Log on 4/9/24 at 11:27 a.m., there were two pans of spaghetti, mashed potato, and rice in the blast chiller with no label or date when it was put into the fridge. The food items were also not on the blast chiller Cooling Temperature Log. CSII indicated that he memorized the time and temperature of each food item he prepared and planned on writing it down later. He stated that he gets busy and does not have time to fill in the cooling temperature log. He stated that he made a mistake and should have written down the time and temperature on the cooling log when he did it.</p> <p>During an interview with the Supervising Cook 1 (SC1) and concurrent record review of the Cooling Temperature log, for the date of 4/9/24 at 9:17 a.m., on 4/11/24, the cooling temperature log had the same exact time and temperature for scrambled egg, scrambled egg puree (blended until smooth), spinach, dill sauce, vegetable chicken nuggets and soy glaze. Final temperatures were missing for roast potatoes, roast veggies, sloppy joe, scrambled egg, scrambled egg puree and spinach. Also, the column titled Verified by/date was not filled out for any of the food items on the log. The SCI stated logs should be filled out correctly and should always be verified by a supervisor and initialed on the log under the column titled Verified by/date.</p> <p>During a review of the facility policy titled, Food Preparation Guidelines, dated 11/5/23, the policy indicated, 2. Cool down temperature logs will be: a. used to record hourly temperatures of potentially hazardous food items being cooled. B. initialed by the supervisor on duty and kept on file for a period of 1 year.</p> <p>During a review of the FDA Federal Food Code, dated 2022, 3-501.14 indicated, (A) Cooked time/temperature control for safety food (food that requires time and temperature controls to limit the growth of illness causing bacteria) shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. In addition, Safe cooling requires removing heat from food quickly enough to prevent microbial growth. Excessive time for cooling of time/temperature control for safety foods has been consistently identified as one of the leading contributing factors to foodborne illness. During slow cooling, time/temperature control for safety foods are subject to the growth of a variety of pathogenic microorganisms. A longer time near ideal bacterial incubation temperatures, 21oC - 52oC (70oF - 125oF), is to be avoided. If the food is not cooled in accordance with this Code requirement, pathogens may grow to sufficient numbers to cause foodborne illness.</p> <p>6. During an observation on 4/8/24 at 11:57 a.m., Certified Nursing Assistant 1 (CNA 1) grabbed a regular cup and a coffee mug by the rim of the cups and took them over to Resident 42 and set them on his bed side table next to his meal tray. He poured his milk into the cup and some coffee into the mug for the resident. CNA 1 grabbed a pieced of sliced cheese that was in a plastic bag and removed it with her bare hands and folded the piece of cheese and put it into Resident 42's soup. CNA 1 grabbed half of a sandwich and handed it to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 4/8/24 at 12:08 p.m., CNA was assisting Resident 193 and was peeling an orange with her bare hands, then she separated the sections of the orange for the resident.</p> <p>During an interview with the Director of Dietetics (DD) on 4/11/24 at 9:17 a.m., the DD stated nursing staff should wear gloves when handling ready to eat food (food that will not be cooked or reheated before serving) at all times.</p> <p>During an interview with the Director of Nursing (DON) on 4/11/24 at 11:30 a.m., the DON stated they do not currently have a policy that indicated nursing staff should not touch ready to eat foods with their bare hands, however he stated that they needed to develop one.</p> <p>During a review of the FDA Federal Food Code, dated 2022, 3-301.11 indicated, 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. In addition, In November 1999, the National Advisory Committee on Microbiological Criteria for Foods (NACMCF) concluded that bare hand contact with ready-to-eat foods can contribute to the transmission of foodborne illness and agreed that the transmission could be interrupted. The NACMCF recommended exclusion/restriction of ill food workers as the first preventative strategy and recognized that this intervention has limitations, such as trying to identify and manage asymptomatic food workers. The three interdependent critical factors in reducing foodborne illness transmitted through the fecal-oral route, identified by the NACMCF, include exclusion/restriction of ill food workers; proper handwashing; and no bare hand contact with ready-to-eat foods. Each of these factors is inadequate when utilized independently and may not be effective. However, when all three factors are combined and utilized properly, the transmission of fecal-oral pathogens can be controlled. Depending on the microbial contamination level on the hands, handwashing with plain soap and water, as specified in the Food Code, may not be an adequate intervention to prevent the transmission of pathogenic microbes to ready-to-eat foods via hand contact with ready-to-eat foods.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50674</p> <p>Based on observation, interview, and record review, the facility failed to maintain Transmission Based Precautions (infection control precautions) for one of 35 sampled residents (Resident 156) and one unsampled resident (Resident 130) when:</p> <ol style="list-style-type: none"> 1. An Xray Technician (XT) did not wear the required Personal Protective Equipment (PPE, equipment worn to minimize exposure to hazards) while providing care for Resident 156, who was on droplet isolation precautions (measures used to protect residents, staff, and visitors from exposure with infectious agents). 2. Resident 130 was exposed to contaminated Personal Protective Equipment (PPE, equipment worn to minimize exposure to hazards), when placement of a PPE disposal bin obstructed the path to his bed. <p>These failures had the potential to result in cross-contamination and the spread of infectious diseases to residents, staff and visitors.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation on 4/9/24 at 11:25 a.m., in [NAME] 3 of Resident 156's room, XT was observed performing a procedure while wearing only a surgical mask and no other articles of PPE. XT was then observed completing the procedure and came in direct contact with Resident 156 before exiting the room. A sign was posted in Resident 156's room door that indicated, Enhanced Droplet Precautions (EDP, used to help keep individuals from disease that spread through the air); To prevent the spread of infections, anyone entering this room must wear: N95 Mask, Face Shield, Gown, Gloves. All PPE must be worn regardless of expected activity in the resident's room. <p>During an interview on 4/9/24 at 11:31 a.m. with XT, XT stated, I didn't know I had to wear any PPE. XT further stated that no one let her know about Resident 156's isolation precautions.</p> <p>During an interview on 4/10/24 at 10:44 a.m. with the Infection Control Preventionist (ICP), ICP stated, Xray Tech was a contractor but, they should have been wearing the PPE.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Enhanced Droplet Precautions (EDP) dated 5/12/23, the P&P indicated, Staff follow Don/Doff (put on and take off) procedures established by the CDC (Centers for Disease Control) PPE Sequence Guidance 29.6, 32.2</p> <p>During a review of the CDC- PPE Sequence Guidance 29.6, 32.2, [undated], the CDC guidance indicated, Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an observation on 4/8/24 at 12:38 p.m., in [NAME] 3 of Resident 130's room, Resident 130 entered his room and attempted to go to the left side of his bed. Resident 130 was observed to be in a wheelchair and did not have enough room to get to his bedside. Resident 130 attempted to pass, but the placement of a disposal bin, used to throw away contaminated PPE obstructed his path causing Resident 130 to repeatedly bump into the bin with his wheelchair. The PPE disposal bin was located by the door against the wall of Resident 130's room, next to Resident 130's bed. Resident 130 asked Certified Nurse Assistant 1 (CNA 1) to remove the bin, but CNA 1 stated to Resident 130, they could not because it was for the disposal of used PPE. Resident 130 was seen opening and reaching into the disposal bin and touching the used PPE contained inside without washing his hands or using the hand sanitizer after touching the contaminated PPE.</p> <p>During an interview on 4/10/24 at 10:44 a.m. with Infection Control Preventionist (ICP), ICP stated, The disposal bin of PPE is kept by the doorway. ICP further stated, resident rooms are shared so the curtain provides a physical barrier between the residents, when one is on isolation and the other resident is not.</p> <p>During an interview on 4/11/24 at 8:45 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, We always keep the trash bin by the door. If it's in the way, we can move the bin next to the other wall, so it is not in the way for the resident.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Enhanced Droplet Precautions (EDP) dated 5/12/23, the P&P indicated, PPE is disposed upon exiting room and hand hygiene performed .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36067</p> <p>Based on observation, interview and record review, the facility failed to provide residents with a safe, functional, sanitary, and comfortable environment when:</p> <ol style="list-style-type: none"> Unit [NAME] 1D had visibly soiled windows in the entry hallway. In room [ROOM NUMBER], a urinal was unlabeled and undated for Resident 188. <p>These failures resulted in an unsafe and unsanitary environment for the residents.</p> <p>Findings:</p> <p>1. During an observation on 4/8/24 at 8:50 a.m., Unit [NAME] 1D had three (3) windows near the main entrance visibly soiled from the outside, and had spider webs on the inside.</p> <p>During an observation and concurrent interview on 4/9/24 at 8:55 a.m. with Supervising Registered Nurse 1 (SRN 1), SRN 1 confirmed and stated three (3) North facing windows near the entry to the unit looked dirty from the outside and had spider webs on the inside. SRN 1 stated she did not know how long the windows had been like that. SRN 1 stated it didn't look homelike. SRN 1 stated housekeeping was responsible for the cleaning of the windows.</p> <p>During an interview on 4/9/24 at 10:30 a.m. with Housekeeping 1, Housekeeping 1 stated the windows were not looking good. Housekeeping 1 stated the dirt from the outside of the windows had been there for about 3 months. Housekeeping 1 stated, she did not know how long the spider webs had been on the inside of the windows.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Cleaning, Environmental, dated 1/1/24, the P&P indicated, The [facility] will maintain the Skilled Nursing Facility (SNF) units in a safe, clean, comfortable, orderly, and homelike environment as free of hazards as is possible .</p> <p>22069</p> <p>2. During an observation conducted on 4/8/24 at 10:45 a.m. in room [ROOM NUMBER], a plastic urinal was observed on top of Resident 188's side table. The plastic urinal was not labeled and not dated.</p> <p>During an interview on 4/8/24 at 10:50 a.m. with Supervising Registered Nurse 3 (SRN 3), SRN 3 stated the urinal should have been dated and labeled with the resident's name.</p> <p>During a review of the facility's policy and procedure titled, Environmental Cleaning Schedule, dated, January 2024, the policy indicated the following; Urinals . Clean after each use . Replace Weekly / Friday . Label with resident name & projected change date .</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41337</p> <p>Based on observation, interview, and record review the facility failed to maintain an effective pest control program when a roach infestation in the [NAME] staging kitchen persisted since 6/8/23, unsanitary conditions were observed that provide harborage conditions for pests (cross-reference F 812) and pests were being allowed entry into the kitchen. This had the potential for pests to transmit disease to residents by contaminating food and food-contact surfaces for 197 medically compromised residents who received food from the kitchen.</p> <p>Findings:</p> <p>During observations on 4/8/24 between 10:12 a.m. and 10:28 a.m., there were multiple sticky traps in the [NAME] staging kitchen that contained roaches. One of the sticky traps had three (3) live roaches.</p> <p>During multiple observations on 4/8/24 between 10:12 a.m. and 10:43 a.m., in the [NAME] staging kitchen, the floor under equipment had a build-up of food crumbs, trash and spilled liquid.</p> <p>During multiple observations on 4/8/24 between 10:12 a.m. and 10:38 a.m., in the [NAME] staging kitchen, there were multiple drains that had a build-up of black grime and food.</p> <p>During an interview on 4/9/24 at 3:14 pm, with the Pest Technician (PT) from [company name] pest control services, PT stated the roaches that he was finding were German Cockroaches. PT stated he usually found them around the dishwasher. He stated there was a door in the staging kitchen that leads to the dumpsters, and he always saw it propped open, and he believed that is how the cockroaches were entering the kitchen.</p> <p>During an observation on 4/10/24 at 8:27 a.m. in the [NAME] staging kitchen, the back door in the dish room that lead to the loading dock and dumpsters was propped open.</p> <p>During a review of the facility document titled, [company name] Work order, dated 6/8/24, the document indicated, we are starting to see cockroaches again in our dish room area, hallway outside of the dish room area and inside the machine too. Within the last few days, the amount has raised, that are being seen in the morning time when I arrive.</p> <p>During a review of the facility policy titled Food and Nutrition Services- Sanitation, dated 11/5/23, indicated 1. Kitchen and serving area(s): B. will be protected from rodents, roaches, flies, and other insects.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the FDA Federal Food Code, dated 2022, 6-501.111 indicated, The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (B) Routinely inspecting the PREMISES for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12, 7-206.12, and 7-206.13; and (D) Eliminating harborage conditions. In addition, Insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments.</p>