STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555095	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Home of California - Yountville - Snf	100 California Drive Yountville, CA 94599

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 39795 Based on observation, interview, and record review, the facility failed to ensure one of 29 sampled residents (Resident 31) remained free from restraint when Resident 31's bed was placed against the wall with four bedrails in the upright position and the bedside table positioned over Resident 31's body. This failure had the potential to obstruct Resident 31's mobility and cause injury. Findings: During a review of Resident 31's Face Sheet [FS- a quick summary sheet that healthcare providers use to access key information, like name and medical history], the FS indicated Resident 31 had diagnoses of Alzheimer's Disease (a brain disorder that gradually destroys memory and thinking skills) and Vascular Dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain). During an observation on 3/3/25 at 9:04 a.m. in Resident 31's room, Resident 31 laid on his back awake in bed. The right side of the bed was pushed up against the wall with the bedside table placed between the bedrails, over Resident 31's body. All four bedrails were in the upright position. Resident 31 was pleasant but not interviewable. During an observation on 3/3/25 at 2:59 p.m. in Resident 31's room, Resident 31 laid on his back in bed with eyes closed. The bed was pushed up against the wall and three bedrails were in the upright position restricting Resident 31 from exiting the bed. The bedside table was positioned over Resident 31's body. During an interview on 3/4/25 at 10:30 a.m. with the designated person (DP) responsible for Resident 31's healthcare, the DP stated she observed all four bedrails in the upright position on several occasions but assumed they were facility measures implemented for Resident 31's safety. The DP stated she was not contacted by the facility about the bedrails. During concurrent observation and interview on 3/4/25 at 2:40 p.m. with Registered Nurse (RN) 3, in Resident 31's room, Resident 31 laid on his back awake in bed. The bed was pushed up against the wall, all four bedrails were in the upright position. The bedside table was positioned over Resident 31's body. RN 3 dropped the lower and upper bedrail and stated, This can't be like this. RN 3 stated bedrails were considered a restraint when left in the upright position to prevent the resident from exiting the bed. RN 3 stated she did not know Resident 31 was left like that. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 2:50 p.m. with the Nurse Supervisor (RNS) 1, RNS 1 stated the facility allowed two bedrails to remain in the upright position for certain residents to assist with bed mobility, however the use of four (upper and lower) bedrails were not permitted. RNS 1 stated bedrails or anything used to restrict the movement of a resident was considered a restraint and not allowed in the facility. RNS 1 stated Resident 31 was on 30-minute checks and the use for all four bedrails was not necessary. RNS 1 stated there was no restraint order in effect for Resident 31. During an interview on 3/4/25 at 3 p.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated he was assigned to the 30-minute checks for Resident 31. CNA 5 stated 30- minute checks were implemented on all residents to ensure their safety and prevent accidents. CNA 5 stated he did not notice Resident 31's bedrails were in the upright position during his safety rounds. CNA 5 stated he thought the bedrails were left in the upright position after Resident 31 was changed today, however CNA 5 could not explain why bedrails were used and in the upright position on 3/3/25 and why the bedside table was routinely positioned across Resident 31's body. During a review of Resident 31's Minimum Data Set (MDS- a tool for implementing standardized assessment and for facilitating care management in nursing homes), dated 12/18/24, indicated Resident 31's Brief Mental Interview for Mental Status (BIMs- a 15-point test indicating cognitive function) score was three (scores 13-15 suggest cognition is intact, 8-12 suggest mild impairment, and 0-7 suggest severe impairment). During a review of Resident 31's Safety Rounds [SR] monitoring log, dated 3/3/25 and 3/4/25, the SR log indicated safety rounds were performed every 30 minutes during the morning shifts and Resident 31 was in bed awake 7 a.m. and 2:30 p.m. The SR monitoring log included additional checks as follows: position, placement, function, & resident's comfort while in bed. There was no indication bedrails were in use. During a review of Resident 31's Behavior Monitoring Log, for March 2025, the log indicated Resident 31 did not exhibit agitation, aggressively hitting, or refusal of care behaviors. During a review of Resident 31's Care Plan, dated 12/20/24, the care plan indicated, . check side rail position, placement, function and residence comfort and resident in bed at least every shift . Staff to anticipate resident needs . continue 30 mins [minutes] safety rounds . offering toileting q [every] 2 hr. [hour] or while awake, snacks/ food . Environment, maintain hazard free . During a review of Resident 31's Physician's Orders, for March 2025, the orders indicated there was no physician order written for restraints. During a review of the facility's policy and procedure (P&P) Bedside Rails, Safety, dated 11/24/24, the P&P indicated, . To ensure safe use of bedside rails, especially for those residents considered high risk for entrapment . Nursing Staff will follow [Name of Facility] Bedside Rail, Restraint policy when considering the use of bedside rails . Residents at high risk for entrapment may include, but are not limited to, the following . Residents with altered mental status . Residents displaying general restlessness or agitation . Nursing staff will routinely evaluate and monitor the Resident for appropriateness of side rails . Check side rail position, placement, function, and residence comfort when in bed . (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P Physical Restraints, dated 4/8/24, the P&P indicated, . The facility will ensure that the resident is free from physical restraints imposed for purposes of discipline or convenience and that are not required to treat the Resident's medical symptoms . The following are physical restraint practices prohibited at the [Name of Facility], including, but not limited to . using bed rails that keep a Resident from voluntarily getting out of bed . Placing a chair or bed close enough to a wall that the Resident is prevented from rising out of the chair or voluntarily getting out of bed . Using devices in conjunction with a chair, such as trays, tables, cushions, bar or belts, that the Resident cannot remove and prevents the Resident from rising .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43258 Based on observation, interview and record review, the facility failed to ensure 1. Controlled substance medications (medication with a high potential for abuse and addiction) were accurately accounted for on the medication administration record (MAR) and the Controlled Drug Record (CDR) for four of five randomly selected residents (Residents 16, 75, 81, and 128); 2. To establish an accurate system to limit the diversion of narcotic medications designated for destruction by nursing staff; 3. To follow its policy and procedure (P&P) for the management of resident medications for out-on-pass (OOP) status and develop a system to include reconciliation of the last administered dose of medications upon the resident's return. These failures created the potential for medication diversion, mismanagement of controlled substances, lack of accurate medication administration, placing residents at risk for excessive sedation, increase risk of falls and overdose. Findings: 1. The CDRs for five randomly selected residents receiving as-needed controlled medications were requested for review during the survey. During a concurrent observation, interview and record review on 3/3/25 at 11:08 a.m. with Registered Nurse Supervisor [NAME] 3 (RNS 1), Resident 75's medical record, CDR and physical count for lorazepam were reviewed. Resident 75's medical record indicated a physician's order dated 7/17/24, for lorazepam (a medication to treat anxiety) 0.5 milligrams (mg- unit of measurement) give 1 tablet orally every 4 hours as needed for anxiety/agitation. RNS 1 confirmed the MAR indicated 1 tablet was administered on 3/2/25 at 9:25 p.m. but its removal from the medication cart was not documented by the nurse. She stated the nurse was expected to document on the MAR and the CDR right away after preparing and administering the medication. A review of Resident 81's medical record indicated physician's orders for oxycodone (a medication to treat pain) 5 mg IR (immediate release), ordered 12/24/24 and 1/27/25, take one tablet by mouth every 6 hours, as needed for severe pain not relieved by acetaminophen. The CDR indicated one tablet was removed from the medication cart on 1/15/25 at 9 a.m. and 1 tablet on 2/25 at 10 p.m. however their respective administrations to Resident 81 were not documented on the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/4/25 at 2:31 p.m. with the Director of Nursing (DON), Resident 81's MAR dated 1/2025 to 2/2025 and CDR for oxycodone were reviewed. DON stated nursing staff were expected to document the administration of controlled medications on both the MAR and the CDR. He stated he hoped that nursing staff would document on both and not just one. The DON acknowledged the oxycodone doses identified as removed but not documented as administered to Resident 81 on the MAR were not signed by the nurse. He stated it was preferred for the nurse to initial the MAR on the front (where it indicated, Charting for 1/1/25- 1/31/25 PRN Medications'). A review of the facility's policy and procedure (P&P) titled, Medication, Administration Standards, dated 11/21/24, the P&P indicated, E. Documentation 1. Medication name, administration time, route and dose of the drug or treatment administered to the Resident will be recorded in the MAR . by the licensed nurse who administers the drug . During a concurrent interview and record review on 3/4/25 at 2:46 p.m. with DON, Resident 128's medical record was review. Resident 128's medical record indicated physician's orders dated 2/3/25 and 2/24/25, for oxycodone 5 mg, take one half (0.5) tablets by mouth every 8 hours, as needed. The MAR indicated 1 tablet was administered to Resident 128 on 2/25/25 at 5:30 a.m. but its removal from the medication cart was not documented on the CDR. Review of the CDR indicated 1 tablet was removed on 2/28/25 at 5 a.m., 3/1/25 at 8:30 p.m., and 3/2/25 at 8 a.m. and 8:30 p.m. but their administrations were not documented on the MAR. DON acknowledged the finding and confirmed there were discrepancies between the MAR and CDR. A review of Resident 16's medical record indicated a physician's order dated 2/3/25, for oxycodone 5 mg IR, take one tablet by mouth every 6 hours as needed for severe breakthrough pain (>8/10). Resident 16's MAR indicated oxycodone was administered on the following dates and times but their removal from the medication cart was not documented: 1 tablet on 2/3/25 at 1:30 a.m.,1 tablet on 2/5/25 at 10 p.m., 1 tablet on 2/8/25 at 7 p.m., 1 tablet on 2/14/25 at 5:30 a.m., and 1 tablet on 2/21/25 at 7:06 a.m. Resident 16's CDR indicated oxycodone was removed from the medication cart on the following dates and times but their respective administrations were not documented: 1 tablet on 2/10 at 12 a.m., and 1 tablet on 2/13/25 at 2 a. m. and 4 a.m. During a concurrent interview and record review on 3/4/25 at 4:18 p.m. with Nursing Supervisor 2 (NS 2), Resident 16's MAR dated February 2025 and CDR for oxycodone 5 mg IR were reviewed. NS 2 confirmed the identified discrepancies and stated all doses of controlled medication administered to a resident needed to be documented on the front of the MAR. During a review of the facility's P&P titled, Controlled Substances, dated 12/3/24, the P&P indicated, VI. Storage, Security and Accountability of Controlled Substances for Licensed Care . B. Record Keeping and Accountability 1. Controlled Substances must be reconciled at least every shift by counting and verifying the number of each drug on corresponding CDR by a Licensed Nurse. 2. Pharmacy will verify accuracy of Narcotic count on nursing unit during monthly nursing unit inspection . C. Administration Records 1. Administration of controlled substance, will be documented on the Medication Administration Record (MAR) and on the Controlled Drug Record . 2. During an interview on 3/3/25 at 11:34 a.m. with Registered Nurse 4 (RN 4) in [NAME] 1, RN 4 stated controlled medications that needed to be destructed were stored in the separately locked compartment in the medication carts and picked up by the Quality Assurance (QA) Nurse once weekly on Wednesdays. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 3/4/25 at 10:43 a.m. with Pharmacy Services Manager (PSM), PSM stated nursing staff were expected to sequester controlled medication that required destruction in the medication cart for the once weekly pick up by the nurse and the pharmacist. She stated the nurse did the once weekly destruction with the pharmacist. During an interview on 3/4/25 at 10:57 a.m. with NS 2 in [NAME] 1, NS 2 stated controlled drugs that needed to be destructed were placed in a clear plastic pouch then put into the locked narcotic section of the medication cart. She stated these medications were still counted during the narcotic inventory counts completed between nursing shift changes until picked up on Wednesdays. During an interview on 3/4/25 at 10:59 a.m. with RN 8 in [NAME] 2, RN 8 stated controlled medications were destroyed by calling the nursing supervisor, crushing the pill, then dumping it into a plastic receptable designated for medication waste in the medication storage room. He stated the destruction was signed by both nurses on the CDR. During an interview on 3/4/25 at 11:05 am. with RN 1 in [NAME] 4, RN 1 stated controlled drugs for destruction were placed inside a clear plastic pouch then put into the locked narcotic section of the medication cart. She stated they did not count the medication during nursing shift changes but just eyeballed it. During an interview on 3/4/25 at 11:11 a.m. with DON, DON stated controlled medications that were dropped by the nurse or denied by the resident were placed into a disposal bin containing a solution. He stated two nurses were expected to sign for the destruction. The DON stated each ward had a bin in the medication storage rooms. During an interview on 3/4/25 at 11:25 a.m. with Registered Nurse Quality Assurance (RN 7), RN 7 explained the process she followed for narcotic medication destruction. She stated she called each ward once a week on Wednesdays to see if they had any medications that required destruction. She stated that was how she was made aware of medications that needed to be destructed, otherwise the medication stayed in the cart until reported by nursing staff. RN 7 stated nursing staff were expected to place pills that required destruction into a clear plastic pouch labeled with the name of the resident, the date and the time, along with a second nurse as a witness. She stated when the medication was picked up on Wednesdays, the pouch and the information written on it was compared to the CDR before destruction with the pharmacist. She stated nursing staff were expected to include the medication during the shift-to-shift narcotic counts until the destruction took place. RN 7 stated the pill was not to be crushed prior to placing it into the pouch. During a review of the facility's P&P titled, Disposal of Pharmaceutical Waste- SNF/ICF (All Homes), reviewed 7/9/24, the P&P indicated, Policy Details and Implementation I. Residents' Medications No Longer In Use A. Controlled Drugs 1. Destruction: Drugs listed in Schedules II, III, IV, or V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 will be destroyed on the unit . Drugs may be destroyed to render them irretrievable . II. Facility Storage of Unusable Drugs . B. Controlled Drug Inventory/Facility Storage . 2. Drug Count: Nurses will verify the inventory at each change of shift until proper disposition of the drug. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent interview and record review on 3/3/25 at 11:58 a.m. with NS 2 in [NAME] 1, Resident 81's record titled, Pass Medication Release, dated 2/28/25, was reviewed. NS 2 stated whenever a resident went OOP, before they left the nurse counted the medications they were taking with them with the family. She stated the medications and quantities were documented on the form and the count was completed with the family upon the resident's return. NS 2 confirmed nursing staff did not indicate the quantity of medication returned upon the return of the Resident 81 to the facility. She stated unfortunately nursing staff should have counted them when they came back. NS 2 confirmed one of the medications that was given to Resident 81 when he was OOP was oxycodone 5 mg, quantity of 4. NS 2 reviewed the CDR for Resident 81's oxycodone, scheduled to be given as needed every six hours, and confirmed the resident took one tablet while on pass. She stated she did not know when that tablet was taken by the resident and that information was not collected by nursing staff upon the resident's return to know when the next dose could be safely administered. During an interview on 3/3/25 at approximately 12 p.m. with RN 4 in [NAME] 3, RN 4 stated nursing staff relied on the narcotic count to determine what time the next dose could be given to a resident. A review of the front and back of Resident 81's MAR, dated 2/2025, indicated the nurse did not document whether Resident 81 took oxycodone while he was OOP on 2/2/8/25. During an interview on 3/3/25 at 4:16 p.m. with RN 6 in [NAME] 1, RN 6 stated when a resident went OOP, nursing staff documented OOP on the MAR for any doses of medication that were scheduled but not administered by nursing staff in the facility. During an interview on 3/4/25 at 2:50 p.m. with DON, DON stated nursing staff were expected to know when the last dose was taken by a resident when they were OOP. During a review of the facility's P&P titled, Medications, Pass/Leave (SNF, ICF, RCFE), reviewed 1/29/24, the P&P indicated, Policy Details and Implementation . D. Medication Administration Record (MAR) Documentation: 1. The out-on-pass/leave medications taken by resident are recorded on the reverse side of the resident's current medication administration record MAR or similar form. 2. Doses are not documented on the front of the MAR unless the nurse administers the medications . 3. The licensed nurse will circle their initials on the MAR for each dose of regularly scheduled medications that would normally have been administered by the facility while a resident is out on pass/lease. The reason for the circled initial is explained in the nursing comments section on the back of the MAR for each medication dose due . G. Returning to Facility Upon: Upon return to the facility, the licensed staff will document the quantity returned and report any discrepancies to the nursing supervisor.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43258 Based on observation, interview, and record review, the facility failed to: 1. Ensure expired medications were not available for resident use; 2. Opened multi-dose biologicals were dated with an opened or discard date to ensure they were not used beyond the expiration date. The deficient practices had the potential for residents to receive medications with unsafe and reduced potency from being used past their expiration date. Findings: 1. During an inspection on 3/3/25 at 10:04 a.m. of the medication storage room in [NAME] 5 and [NAME] 6 with Nursing Supervisor 1 (NS 1), the following were identified: two tubes Desitin Max Strength (ointment used to treat rash) expired 6/2024, one bottle hydrogen peroxide (a topical antiseptic) 3% expired 12/2024, two tubes terbinafine (a medication to treat fungal infections) 1% cream expired 12/2024, one bottle aspirin 325 milligrams (mg, a unit of measurement) tablets expired 12/24, three bottles Move + Vision + Bones Pureflex (a supplement for joint, eye and bone health) capsules expired 10/2024, one bottle Move Pureflex (a supplement for mobility and joint health) capsules expired 7/2024, and three tubes Insta-Glucose (used to treat low blood sugar) gel expired 2/2025. NS 1 confirmed the medications were expired and should have been removed from the facility's stock. NS 1 stated nursing and pharmacy staff were responsible for regularly checking expiration dates on the medications in the storage room to ensure all items were in date. During an inspection on 3/3/25 at 10:50 a.m. of the medication cart in [NAME] 2 with RN 2, one bottle of magnesium 250 mg tablets was identified without an expiration date. RN 2 stated if a medication did not have an expiration date on it, nursing staff were expected to check with the pharmacy then put a sticker on it that stated what the expiration date was. During a review of the facility's policy and procedure (P&P) titled, Disposal of Pharmaceutical Waste-SNF/ICF (All Homes), reviewed 7/9/24, the P&P indicated, Unneeded, expired, or deteriorated medications will be disposed of . The Home will maintain a process whereby expired or deteriorated pharmaceuticals are removed from use . Definitions . Pharmaceutical Waste includes medications that are: Expired . Mislabeled (improper, illegible, missing, or worn). 2. During an inspection on 3/3/25 at 11:19 a.m. of the medication storage room refrigerator in [NAME] 3 with RN 3, one vial Tubersol (an injectable solution used to aid in the diagnosis of tuberculosis infection, a bacterial disease that affects the lungs) opened and unlabeled with an open date was identified. RN 3 confirmed the finding and stated the vial should have been labeled with the date it was opened. She stated the manufacturer's labeling on the product indicated to discard it 30 days once punctured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the manufacturer's labeling for Tubersol, revised 3/18/22, the labeling indicated, A vial of TUBERSOL which has been entered and in use for 30 days should be discarded. During an interview on 3/4/25 at 2:55 p.m. with the Director of Nursing (DON), DON confirmed the Tubersol should have been labeled with an open date once used since it was only stable for 30 days after. DON stated it was the expectation that expired medications were removed from the facility's medication storage rooms and not available for resident use. During a review of the facility's P&P titled, Medication, Storage & Labels, reviewed 11/21/24, the P&P indicated, Policy Details and Implementation . J. Date Opened Label: The nurse will label multi-dose vials with the date the vial was opened and the date it will expire. Multi-dose vials are discarded as recommended by manufacturer or Pharmacy Services .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34975 Based on observation, interview, and facility document review, the facility failed to ensure food was palatable in regard to temperature, flavor, and texture. This failure had the potential to result in decreased food intake resulting in food related medical complications for 144 residents, who received food from the kitchen. Findings: During the initial screening of residents on 3/3/25, multiple residents complained about the facility food when they were interviewed including: 1. at 9:35 a.m., Unsampled Resident 100 stated the food served at the facility was flavorless and cold., 2. at 11:43 a.m., Unsampled Resident 4 stated food was frequently served cold, and 3. at 11:50 a.m., Resident 39 stated the food served at the facility was not too good and was sometimes cold. Observation, interview, and document reviews conducted from 3/3/25 to 3/5/25 showed the rethermalization (retherm) carts (mobile units designed to reheat precooked, chilled foods to a desired reheating temperature, as well as maintain cold food at a desired temperature) were not consistently reheating hot food to the desired temperature and not holding cold foods at desired temperatures (Cross-reference F812). Review of the facility document titled, Diet Spreadsheet, dated 3/5/25, showed lunch served on 3/5/25 included Orange Chicken and Asian Vegetable Blend for regular textured diets (no texture modifications), ground Asian Vegetable Blend for Mechanical Soft textured diets (a modified textured diet consisting of soft, easily chewed foods), and Pureed Orange Chicken and Whipped Potatoes for pureed textured diets (modified textured diet consisting of smooth, pudding like consistency foods). An observation on 3/5/25 at 12:05 p.m., showed retherm cart labeled 1D was unplugged by staff from the docking station and was ready to be transported to the resident ward for lunch food service. On 3/5/25 at 12:07 p.m., a test-tray observation was conducted. The temperature of food was measured with a calibrated thermometer for three test trays. Test tray 1 included pureed foods and the temperatures showed pureed chicken was 116.6 degrees Fahrenheit (F), and mashed potatoes were 109.4 degrees F. The pureed chicken and mashed potatoes were just barely warm when tasted. In addition, the regular textured vegetables and the mechanical textured vegetables tasted bland. Food Service Supervisor (FSS) 1 tasted the vegetables and stated they had no flavor. Also, the regular and mechanical vegetables had a fibrous, unappealing texture. FSS 1 stated the vegetables were a little crunchy for a regular person. When the regular textured Orange Chicken was tasted, it felt dry and a bit tough. FSS 1 stated the chicken was a little dry. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	It is the position of the American Dietetic Association (ADA; currently known as the Academy of Nutrition and Dietetics) that the quality of life and nutritional status of older residents in long-term care facilities may be enhanced by a liberalized diet. A diet that is not palatable or acceptable to the individual can lead to poor food and fluid intake, which results in weight loss and undernutrition, followed by a spiral of negative health effects. [NAME], B., [NAME] K. C., & [NAME] P.K. (2002). Position of the American Dietetic Association: Liberalized Diets for Older Adults in Long-Term Care. Journal of the American Dietetic Association 102(9), 1316-1323. https://doi.org/10.1016/S0002-8223(02)90289-0

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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. 34975 Based on observation, interview, and facility document review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety when: 1. The facility did not have a system in place to ensure all hot food was reheated to a minimum of 165 degrees Fahrenheit (F) and all cold food was held at or below 41 degrees F; 2. Three air vents located in the dish room and food production area in the Main Kitchen (where food was prepared for the licensed care kitchen), were not clean; 3. Supervisory staff did not cover facial hair in the kitchen where food was stored and handled; 4. Trays used for food service were in poor condition; and 5. An industrial can opener was not clean and stored available for use. These failures had the potential to contaminate food and/or utensils for resident use and/or consumption, leading to food borne illness and/or illness from cross-contamination for 144 residents who received food from the kitchen. Findings: 1. During an observation and interview on 3/3/25 at 9:16 a.m., staff placed chilled food on trays and placed the trays in food carts. Food Service Supervisor (FSS) 1 explained the facility used a cook chill rethermalization (retherm) process for resident meals. Food was prepared and chilled in the Main Kitchen, then transferred to the licensed care facility kitchen where the chilled food was plated, placed on trays, placed in a cart, then stored in a cooler. The carts were plugged into docking stations for retherm about 45 minutes prior to food service. These carts were designed to reheat hot food and maintain cold food on the same tray. An observation and interview on 3/3/25 at 11:55 a.m., showed the retherm carts were labeled with ward numbers. The 1C cart was unplugged and staff began to transport the cart out of the kitchen to the resident ward for lunch food service. The surveyor measured food temperatures on two random trays with a calibrated thermometer before the cart was taken out of the kitchen. The hot food temperatures on the first tray were above 165 degrees F. The temperatures on second tray were as follows: milk 46.6 degrees F, ground green bean medley 126 degrees F, chopped beer battered cod 147.7 degrees F, and rice 138.2 degrees F. FSS 1 stated the hot food needed to be at least 165 degrees F and the tray observed with food less than 165 degrees F had to be reheated. In a consecutive interview on 3/3/25 at 12:05 p.m., when asked how the staff monitored temperatures of the food before it was served, Food Service Technician (FST) 1 stated temperatures were measured on one test tray on one of the five retherm carts. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 3/3/25 at 12:10 p.m., showed cart 1D was unplugged and pushed by a staff toward the door out of the kitchen. The surveyor measured the temperature of food on three random trays, with FSS 1, before it was transported out of the kitchen and the temperatures were as follows: Tray 1: pureed fish filet patty 138.2 degrees F; pureed green beans 148.5 degrees F; pureed corn 155.7 degrees F. Tray 2: chopped beer battered Cod: 147.4 degrees F, mashed potatoes 140.9 degrees F, ground green bean medley 134.8 degrees F. Tray 3: hot food temperatures were above 165 degrees F. The cart was transported out of the kitchen by kitchen staff without reheating any food on the cart. Review of the test tray documentation log titled Food and Nutrition Services HACCP [Hazard Analysis Critical Control Point] Data Collection .], dated 3/3/25, showed FST 1 documented food temperatures were as follows: Beer Battered Cod: 167 degrees F, Crinkle Fry: 169 degrees F, [NAME] Bean Medley: 168 degrees F, Chicken Noodle Soup: 178 degrees F, Milk: 37 degrees F. Although, the temperatures on the facility's test tray were appropriate, it was identified the test tray temperatures did not reflect the temperature of the food on all the trays in the carts. On 3/5/25 beginning at 11:30 a.m., surveyors measured the temperatures of food on requested test trays on three retherm carts with a calibrated thermometer. The test tray food temperatures on carts 2C and 2D were above 165 degrees F. On 3/5/25 at 12:07 p.m., food temperatures were measured with a calibrated thermometer on the third requested test tray for ward 1D. These temperatures were measured immediately when the cart was unplugged from the docking station and before the cart was transported to the ward. The temperatures were as follows: Tray 1: pureed orange chicken 116.6 degrees F, whipped potatoes 109.4 degrees F, pureed pees 122.2 degrees F. Tray 2: jasmine rice with ground orange chicken 127.8 degrees F, ground Asian vegetable blend 136.6 degrees F. Tray 3: orange chicken 161.6 degrees F, Asian vegetable blend 154.2 degrees F. During an interview on 3/5/25 at 3:08 p.m., the Director of Dietetics (DD) stated hot food was required to be reheated to 165 degrees F and cold food had to be held at 41 degrees or below. DD stated the HACCP temperature log for the retherm carts was the policy and procedure used for retherm of food. DD confirmed in the licensed kitchen only one test tray was conducted on one retherm cart per meal. DD stated the test tray was rotated on different retherm carts. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the test tray documentation log titled, Food and Nutrition Services HACCP [Hazard Analysis Critical Control Point] Data Collection .] showed the minimum temperature for hot food including entree, starch/cereal, vegetables, and soup, after retherm was 165 degrees F. The maximum temperature for cold food including salad and milk was 41 degrees. 2. An observation in the Main Kitchen on 3/4/25 at 10:47 a.m., showed two ceiling air vents in the ware wash area had a black, fuzzy substance resembling dust on the vent cover and the ceiling surrounding the vent. One vent was located above a tall storage rack used to store clean pots and pans. The black substance observed around this vent extended to and down the wall to the top of the storage rack. An observation in the Main kitchen on 3/4/25 at 10:49 a.m., showed a black, fuzzy substance resembling dust spread out from a wall air vent located in the hallway/food preparation area adjacent to the warewashing room. In a consecutive interview with Food Manager (FM) 1 on 3/4/25 at 10:50 a.m., FM1 confirmed the air vents needed to be cleaned. When FM 1 was asked what the process was for having the air vents cleaned, FM 1 stated maybe kitchen staff needed to put in a work order for cleaning. In an interview with the Housekeeping Custodian (HC) on 3/4/25 at 2:35 p.m., HC stated he was responsible for cleaning the outside of the vents in the Main Kitchen. HC stated Plant Operations was responsible for cleaning the inside of the vents because tools were needed to remove the vent covers. HC stated cleaning of the outside of the air vents was not on a schedule and he did not receive work orders for cleaning the vents, however HC stated he usually went into the Main Kitchen monthly and cleaned the outside of the vents. HC stated the air vents were always dirty when he went into the Main Kitchen to clean them. In an interview with the Direct Construction Supervisor (DCS) on 3/4/25 at 3:10 p.m., DCS stated he was temporarily doing the duties of the Chief Direct Operation Supervisor because the position was vacant. DCS stated the inside of vents were cleaned one time per year. DCS stated the janitor placed a work order when the vents needed cleaning. DCS stated he thought a work order was received a couple of weeks ago, but the vents had not been cleaned yet because of a staffing shortage. DCS stated air filters in the air handlers (a part of a heating, ventilation, and air conditioning [HVAC] system that circulated conditioned air throughout a building) were replaced twice a year. On 3/4/25 at 3:32 p.m., documentation of the most current work order for cleaning of the vents, the last cleaning of the air vents, and changing air filters for the air handling units was requested from DCS. In an interview with the Infection Control Preventionist (IP) on 3/5/25 at 9:51 p.m., IP stated he inspected all areas, mostly nursing areas, for infection control prevention. IP stated sometimes he inspected other areas such as the kitchen but stated he never went into the Main Kitchen. IP stated he only inspected licensed areas. Review of documentation titled, Annual Air Handler Maintenance Log showed air filters were changed throughout the kitchen from 12/23/24 to 12/29/24. No work orders or documentation to show the last cleaning of the air vents was provided. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Policy and Procedure (P&P) titled, Food & [and] Nutrition Services - Equipment (All Homes), dated 8/7/24, showed all kitchen areas shall be kept clean. According to the 2022 Federal Food Code, physical facilities, including air conditioning systems, shall be cleaned as often as necessary to keep them clean. 3. An observation on 3/5/25 at 11:30 a.m., showed FSS 3 was working in the kitchen, monitoring food carts in the trayline area. FSS 3 did not have his beard covered with a hair restraint. In an interview with DD on 3/6/25 at 9:25 a.m., DD stated everyone in the kitchen needs to have hair and beards covered. Review of the P&P titled Food & [and] Nutrition Services - Staff Operations and Training (All Homes) last revised 1/23/24, showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair . beards and mustaches must be covered. 4. An observation on 3/3/25 at 10 a.m., showed a stack of trays, in multiple colors, on a storage rack for clean equipment. The trays were cracked and chipped. In addition, the trays had a build-up of worn and frayed tape on the tray surfaces. During a concurrent interview on 3/3/25 at 10 a.m., FSS 1 stated the trays were used to hold desserts on trayline food service. FSS 1 confirmed the trays were cracked and had tape build-up. According to the 2022 Federal Food Code, multi-use food-contact surfaces are to be smooth, free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. Equipment and utensil food-contact surfaces are to be clean to sight and touch. Nonfood-contact surfaces are to be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance. Nonfood-contact surfaces of equipment are to be kept free of an accumulation of food residue and debris. 5. An observation on 3/3/25 at 9:53 a.m., showed an industrial can opener stored in a holder attached to a food preparation table. There was orange and black, sticky residue on the surface of the blade. The residue transferred to a paper towel when the blade was wiped. During a concurrent interview on 3/3/25 at 9:53 a.m., FSS 1 stated the can opener was supposed to be cleaned after each use. FSS 1 confirmed the can opener was not clean. According to the 2022 Federal Food Code, equipment and utensil food-contact surfaces are to be clean to sight and touch. Nonfood-contact surfaces of equipment are to be kept free of an accumulation of food residue and debris.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 39795 Based on interview and record review, the facility failed to ensure Resident 57's medication was documented when Registered Nurse (RN) 6 did not document medications were given. This failure had the potential to cause negative health-related outcomes to Resident 57. Findings: During a review of Resident 57's Minimum Data Set (MDS- a tool for implementing standardized assessment and for facilitating care management in nursing homes) Section I- Active Diagnoses dated 2/6/25, the MDS indicated Resident 57 had the following diagnoses: Anemia (body does not produce enough healthy red blood cells to carry oxygen), Hypertension (high blood pressure), Diabetes Mellitus (high blood sugar), and Hyperlipidemia (too much fat in the blood). During a review of Resident 57's Current Medication Orders, the orders indicated, . Isosorb Mono (isosorbide mononitrate) Tab (tablet) 30 milligram (mg- unit of measure) ER (extended release) Take one (1) tablet by mouth every evening for heartbeat abnl (abnormal) . Atorvastatin Tab 80 mg . Take one (1) tablet by mouth every evening for Hyperlipidemia . During a concurrent interview and record review on 3/5/25 at 11:55 a.m., with Registered Nurse Supervisor (RNS) 1 and RN 3, Resident 57's Medication Administration Record [MAR- a report detailing drugs administered] dated 3/1/25 to 3/31/25 was reviewed. Signature boxes on lines designated for Atorvastatin 80 mg and Isosorb Mono 30 mg medications and scheduled at 6 p.m. were left blank on 3/3/25. RN 3 stated she could not confirm the medications were refused by Resident 57 or administered because the signature boxes were left blank. RN 3 stated night shift RNs were responsible for auditing the MARs every 24 hours. RN 3 stated Resident 57's MAR did not indicate it was audited. During an interview on 3/5/25 at 3:15 p.m., with RN 6, RN 6 stated he reviewed Resident 57's MAR prior to the interview. RN 6 confirmed he worked the PM shift (2:30 p.m. to 11 p.m.) on 3/3/25 and stated he administered to Resident 57 Atorvastatin 80 mg and Isosorbide Mono 30 mg around 6 p.m. that evening. RN 6 stated he forgot to initial the MAR when he administered the medications. RN 6 stated facility policy required nurses to initial signature boxes at the time the medication was administered to residents or circle the boxes if residents refused. RN 6 stated, on 3/3/25, he did not follow facility policy and procedure for medication administration. RN 6 stated it was an omission that placed Resident 57 at risk for a medication dosing error if not identified by night shift. During a review of the facility's policy and procedure (P&P) titled, Medication, Administration Standards, last reviewed 11/21/24, the P&P indicated, . The licensed nurse is responsible to ensure the Six rights of medication administration are followed at all times . Right Documentation [the sixth right] . Medication name, administration time, route and dose of the drug or treatment administered to the Resident will be recorded in the MAR/ TAR by the licensed nurse who administers the drug or treatment .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35030 39795 Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to provide a safe and sanitary environment when: 1. Three of five staff (Contract Staff [CS] 1, Certified Nursing Assistant [CNA] 6, and Custodian Worker [HSK] 1) did not perform hand hygiene or utilize personal protective equipment (PPE- equipment worn to minimize exposure to infectious or hazardous materials, e.g. gown, gloves, mask, eye protection) in accordance with policy and procedure and nationally recognized infection prevention and control guidelines. 2. One of one custodian worker (HSK 1) did not follow facility procedure for the cleaning and disinfection of an occupied room. 3. Five of five staff (Laundry Supervisor [LS] 1, LW 1, LW 2, LW 3, and HSK 1) did not know the dwell time (the amount of time a disinfectant must remain visibly wet on a surface to effectively kill specific germs) of facility products used for disinfection. 4. Enhanced Barrier Precautions was not identified and effectively implemented for one of three sampled residents (Resident 16) who had an indwelling urinary catheter (thin flexible tube inserted into the bladder through the urethra to drain urine continuously) in place. 5. Enhanced Barrier Precautions was not effectively implemented for two of two sampled residents (Resident 35 and Resident 64) having a Gastrostomy Tube (G-tube, a small, flexible tube inserted through the abdominal wall and into the stomach used to provide nutrition and medication to individuals who cannot eat or drink adequately on their own) during nutritional tube feeding administration. 6. Sterile technique (the practice of eliminating microorganisms from an environment or object to prevent infection) was not implemented for one of one sampled residents with a nephrostomy tube (a long, thin, plastic tube inserted through the skin directly into the kidney which drains fluid), when sodium chloride was injected into Resident 71's nephrostomy tube using non-sterile supplies. These failures placed residents at risk for cross contamination and infection and could result in health-related disease. Findings: 1. During an observation on 3/3/25 at 11:06 a.m., in [NAME] 2's hallway, CS 1 exited a resident's room holding a laundry bag with ungloved hands and used a paper tissue as a barrier between his hand and laundry bag. CS 1 emptied the contents of the laundry bag in the biohazard room (room designated to dispose or store infectious or potentially infectious materials and waste) and returned into Resident 109's room. CS 1 did not perform hand hygiene after handling the linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/3/25 at 11:13 a.m., with CS 1, CS 1 stated he bathed Resident 109 and changed the linen on Resident 109's bed before transporting the soiled linen to the biohazard room. CS 1 acknowledged he did not wear gloves to carry the soiled linen bag and did not perform hand hygiene when he exited Resident 109 and biohazard rooms. CS 1 stated his failure to wear gloves and preform hand hygiene was an oversight and hand hygiene should have occurred upon exit of both rooms to reduce the risk of cross contamination. During an interview on 3/4/25 at 2:03 p.m., with the Infection Preventionist (IP), the IP stated all staff were expected to follow facility infection prevention and control policies and procedures, contracted staff included. The IP stated hand hygiene should occur anytime staff entered or left a resident's room or area that stored potentially soiled items. The IP stated although CS 1 used paper tissue as a barrier between the soiled linen bag and hands, staff were expected to wear gloves and perform hand hygiene when handling soiled linen to prevent the spread of disease and illness. During an observation on 3/4/25 at 3:13 p.m., in Resident 57's room, CNA 6 obtained the blood pressure and body temperature of Resident 57. Signage posted on Resident 57's door indicated Enhanced Barrier Precautions (EBP- an infection control intervention to reduce the spread of germs) must be implemented prior to entrance into Resident 57's room. The sign also indicated staff must perform hand hygiene and wear at minimum a gown and gloves for high-contact activities. CNA 6 did not wear a gown or gloves and did not perform hand hygiene before handling another resident's privacy curtain. During an interview on 3/4/25 at 3:20 p.m., with CNA 6, CNA 6 acknowledged she provided care to resident 57 without wearing gown and gloves. CNA 6 stated she was aware of Resident 57's EBP status due to a wound infection on Resident 57's leg. CNA 6 stated she should have worn gloves but forgot. CNA 6 stated EBP required staff wear mask and gloves and perform hand hygiene when providing resident care to prevent cross contamination to other residents, staff, and self. During an observation on 3/6/25 at 8:49 a.m., in [NAME] 2's hallway, HSK 1 performed the cleaning of an occupied resident room (RM 1). HSK 1 wore gloves and face mask to perform the task. After cleaning RM 1, HSK 1 returned the mop used in RM 1 to the housekeeping cart and crossed the hallway to a second occupied resident room (RM 2). HSK 1 entered RM 2 and proceeded to clean RM 2. HSK 1 did not change his gloves during the cleaning process nor was hand hygiene performed in between tasks and the two rooms. HSK 1 touched his clothing, face mask, cleaning equipment, and cart with his contaminated gloves. During an interview on 3/6/25 at 8:53 a.m., with HSK 1, HSK 1 stated he cleaned rooms on [NAME] 2 daily and the procedure observed was his process for cleaning occupied rooms. HSK 1 stated gloves were changed when visibly soiled, however he could not provide additional times hand hygiene should occur. During an interview on 3/6/25 at 9:31 a.m., with the IP, the IP stated all staff were expected to implement standard precautions with resident care tasks, including housekeeping. The IP stated gown use was no longer required for daily cleaning of rooms and bathrooms, unless the room was an isolation room (separate room for residents with a contagious disease) or the risk for self-contamination existed. The IP reinforced the expectation for hand hygiene when entering and exiting resident rooms and in between tasks and glove changes. The IP also stated staff were required to use additional PPE (e.g. gown) for care provided to residents on EBP. The IP stated HSK 1 and CNA 6 did not follow facility policy and procedure for hand hygiene and PPE use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) Hand Hygiene Procedure . dated 12/24/18, the P&P indicated, . Per the Centers for Disease Control (CDC- a national health protection agency and regulating bodies of infection control, prevention, and awareness) keeping hands clean through improved hand hygiene is one of the most important steps we can take to avoid getting sick and spreading germs . Preform Hand Hygiene . Before and after caring for someone who is sick . Before and after removing gloves when caring for a resident . After coming into contact with blood or body fluids or open skin . During review of the CDC document Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24, the document indicated, .Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with . Handwashing with water and soap (e.g., plain soap or with an antiseptic) . Antiseptic hand rub (alcohol-based foam or gel hand sanitizer) . Cleaning your hands reduces . The potential spread of deadly germs to patients . including those resistant to antibiotics .clean your hands . Immediately before touching a patient . After touching a patient or patient's surroundings . After contact with blood, body fluids, or contaminated surfaces . Immediately after glove removal .wear gloves . When needed for Standard Precautions (when you anticipate that you will come in contact with blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment) . change gloves and clean hands . If gloves become soiled with blood or body fluids after a task . Before exiting a patient room . During a review of the facility's Infection Control Guidelines 2.0- Isolation Precautions approved 4/15/08, the guidelines indicated, . Standard precautions constitute the primary strategy for the prevention of healthcare associated transmit function of infectious agents among patients and health care personnel. Standard precaution assumes that every person is potentially infected or colonized with an Organism that could be transmitted in the healthcare setting and applies the following infection control practices during the delivery of healthcare . wear gloves when it can be reasonable to anticipate contact with blood or other potentially infectious materials . During concurrent observation and interview on 3/6/25 at 7:45 a.m., with Laundry Supervisor (LS), LW 1, and LW 2, in the Laundry Service Building, LW 1 and LW 2 demonstrated their process for doffing (remove) contaminated PPE. LW 1 discarded her gloves, unsnapped the overcoat (in place of gown) and placed the overcoat in the staff soiled linen bin, then grasped the front of her face mask and hair net for removal. LW 2 confirmed the sequence of LW 1's PPE removal procedure and stated she followed the same doffing procedure. LS stated LW 1 did not demonstrate proper technique for removal of contaminated PPE and the sequence demonstrated increased the risk for self-contamination and possible transmission of disease. LS stated the overcoat buttoned in the front which required extra handling and LW 1 should have performed hand hygiene prior to removing her mask to prevent self-contamination. During a review of the CDC document How to Safely Remove Personal Protective Equipment (PPE) Example 2, undated, the document indicated, . Gown front and sleeves and the outside of gloves are contaminated . If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer . Front of mask/respirator is contaminated- Do Not Touch . Perform Hand Hygiene Between Steps If Hands Become Contaminated and Immediately After Removing All PPE . (continued on next page)

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	555095	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on 3/6/25 at 8:49 a.m., in [NAME] 2's hallway, HSK 1 performed the cleaning of an occupied resident room (RM 1). The housekeeping cart, stationed outside the room, had four buckets (B1, B2, B3, and B4); three of the buckets (B1, B2, and B3) were half filled with a liquid solution. B4 was empty. The bucket used for mopping floors (B3) had cloudy water with a gray grainy sediment at the bottom of the bucket. The two remaining buckets (B1 and B2) were unlabeled and had a johnny mop (a type of toilet bowl cleaning tool with a fuzzy or soft, absorbent head) placed in the liquid solution. Small brown/ gray particles floated in B1 and B2's liquid. HSK 1 used a string mop to clean RM 1's bathroom and floor. HSK 1 swept the mop in and out of the bathroom onto the RM 1's floor in a series of repeated actions. After completion of the task, HSK 1 returned the mop to B3 and crossed the hallway to a second resident occupied room (RM 2). HSK 1 retrieved a johnny mop from B1 and wiped down the inside of RM 2's toilet bowel, toilet riser, and toilet seat, then returned the johnny mop to B1. Next, HSK 1 retrieved the mop from B3 and mopped RM 2's floor and bathroom, using the same procedure as in RM 1 (repeatedly mopping in and out of the room and bathroom). HSK 1 did not wipe any high touch surfaces nor furniture in RM 2. During concurrent observation and interview on 3/6/25 at 8:53 a.m., with HSK 1, in [NAME] 2's hallway and janitorial room, HSK 1 stated the cleaning procedure demonstrated was the method he used for cleaning resident rooms on [NAME] 2. HSK 1 stated the liquid solution in B1, B2, and B3 were the same, two ounces of floor mop cleaner mixed with three quarters of a bucket of water. HSK 1 stated he used the same liquid until all rooms on [NAME] 2 were cleaned. HSK 1 showed the floor cleaner product used for cleaning resident rooms. One gallon bottle of [Name of Product] Floor Cleaner Concentrate solution sat on the floor of the janitorial room. HSK 1 stated it was the only product available for him to use. HSK 1 stated he did not know if the solution had disinfecting properties. During an interview on 3/6/25 at 9:31 a.m., with the IP, the IP stated the facility's floor cleaner was not a disinfectant (chemical product that destroys germs) and not acceptable for cleaning and disinfecting resident room surfaces and bathrooms. The IP stated HSK 1's practice of using a neutral floor cleaner to clean resident bathrooms placed residents at risk for gastrointestinal (relating to stomach and intestines) diseases and illnesses. The IP stated a diluted bleach solution should be used to clean and disinfect environmental surfaces in resident rooms and bathrooms. The IP also stated reuse of cleaning solutions had limitations; that cleaning and disinfecting solutions became less effective each time used equipment was placed into the solutions becoming a potential source and reservoir for germs. The IP stated dirty bucket water should be changed at regular intervals to ensure cleaning solution products remained clean and effective. During an interview on 3/6/25 at 2 p.m., with the Housekeeping Supervisor (HSKS) and HSK 2, HSKS stated the facility followed CDC's guidelines for environmental cleaning and described the procedure for cleaning resident rooms in the facility. HSKS stated housekeepers were expected to sweep dusty air vents, clean and disinfect doorknobs, high touch surface areas, and mop daily. HSKS stated housekeepers were expected to use two johnny mops and two string mops for the various cleaning tasks in each room. The HSKS stated one string mop should be used for a resident's bathroom floor and another for the room's floor. It was not acceptable to use one string mop for both resident bathroom and room floors. The HSKS stated the facility used bleach and [Name of Product] disinfectant solutions to clean and disinfect resident rooms and bathrooms, and floor cleaner was not an acceptable product to use for disinfection. The HSKS stated bucket water should be changed every third room to avoid neutralizing solutions and spreading germs throughout the facility. HSKS stated HSK 1 did not follow facility policy and procedure for the cleaning of occupied resident rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During and interview on 3/6/25 at 8:53 a.m., with HSK 1, HSK 1 stated he used various cleaners and disinfectants throughout the day. HSK 1 stated he applied the disinfectant products and allowed them to airdry. HSK 1 stated he was not familiar with dwell times. During an interview on 3/6/25 at 2 p.m., with the HSKS and HSK 2, HSKS stated disinfectants utilized in the facility were under the supervision of the facility IP. The HSKS stated housekeeping used a diluted bleach solution as the primary disinfectant for the facility. The HSKS stated the bleach solution had a dwell time of 10 minutes. The HSKS stated he did not evaluate the total contact time the disinfectant remained wet on surfaces. HSKS stated the disinfectant was effective if allowed to airdry. During review of the information for use (IFU) [Name of Product] bleach germicidal wipes, undated, the IFU indicated, . Directions . Remove gross soil if present or if disinfecting for C. difficile [Clostridioides difficile- a bacteria that c spores . Wipe the surface until completely wet . Wait for the contact time (3 minutes for C. diff, fungi, TB and select viruses; 30 second for bacteria; 1 minute for most viruses) . Discard the wipe . During a review of the IFU [Name of product] hydrogen peroxide disinfectant, dated 9/22/21, the IFU indicated, . When used as directed, this product is effective against (a broad spectrum of) pathogenic microorganisms . viruses, and fungi . To Use as a One- Step Cleaner/ Disinfectant . Pre- clean heavy soiled areas . Allow surface to remain wet for 1 minute. (For certain listed viruses, Allow treated surfaces to remain visibly wet for one-minute, additional towelettes if needed to ensure the correct visibly wet surface contact time . During a review of the CDC's document TOPIC 12: Environmental Cleaning & Disinfection: What is Contact Time?, undated, the document indicated, . Sometimes called dwell time, this is the amount of time a disinfectant needs to sit on a surface, without being wiped away or disturbed, to effectively kill germs . Wait until contact time is complete before using objects or surfaces or before a new patient comes into a room . Follow the instructions on the disinfectant label - especially instructions for contact time . 41816 50674 4. During a concurrent observation and interview on 3/3/25 at 3 p.m. with Resident 16 in Resident's room, Resident 16 was lying awake in bed and had an indwelling urinary catheter bag attached to the lower rail of the bed frame. Resident 16 stated she was currently using an indwelling urinary catheter, and staff was assisting with care by changing and emptying the bag as needed. There was no Enhanced Barrier Precautions (EBP) sign to indicate appropriate use of Personal Protective Equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) was posted outside the Resident's room door. There was no isolation cart for PPE storage noted outside of Resident 16's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/5/25 at 9:24 a.m. with Certified Nursing Aide (CNA) 3 outside of Resident 16's room, CNA 3 stated Resident 16 was dependent on staff and required help with bathing and toileting. CNA 3 stated that only gloves and masks were worn when giving direct care because the Resident was not on any isolation precautions. CNA 3 stated Resident 16 had no isolation sign posted or cart outside of the Resident's room, so the Resident was not on isolation. During a concurrent observation and interview on 3/5/25 at 9:30 a.m. with Licensed Vocational Nurse (LVN) 1 outside of Resident 16's room, LVN 1 stated there was no isolation cart or isolation precautions sign posted on the door to indicate Resident 16 was on isolation precautions. LVN 1 further stated if there was an isolation cart and sign posted outside the door, then the staff would wear what was posted every time the staff would go in the room to give care to Resident 16. During a concurrent interview and record review on 3/6/25 at 11:20 a.m. with Infection Control Preventionist (IP), the facility provided list of Residents with isolation precautions was reviewed. The list indicated Resident 16 was on Enhanced Barrier Precautions and the reason for precautions indicated, Indwelling Device-Catheter. The record also indicated, Potential Clearance Date for Resident 16 was Indefinite. IP stated the Residents who are on EBP have signs posted to their doors to notify staff and people of what to wear when they enter the room to prevent transmission of infection. During a record review of Resident 16's Minimum Data Set (MDS- A resident assessment tool), dated 1/24/25, the MDS indicated the Resident had an indwelling catheter and was dependent on staff for toileting hygiene and personal hygiene. During a record review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions (EBP), dated 6/25/24, the P&P indicated, EBP are essential infection control measures designed to minimize the transmission of multidrug-resistant organisms (MDROs) and protect both residents and staff in heathcare settings. The P&P indicated, Use EBP for residents with chronic wounds or indwelling medical devices, regardless of MDRO status. The P&P further indicated, Staff will . Display clear signs outside the resident's room indicating EBP and required PPE (gown and gloves). 5. During a concurrent observation and interview on 3/5/25 at 5 p.m. with RN 9 on [NAME] 2D while observing the start of Resident 64's tube feeding process. There was signage noted on the wall in front of Resident 64's room indicating EBP precautions were required during tube feedings. RN 9 stated she did not need to wear a gown for administration of the fluids. RN 9 stated, I use them when I do a dressing change and while suctioning, not with feeding. No cart was located near the resident room. RN 9 read the signage and confirmed it was required and donned the required protection. She stated staff have not been wearing gowns for this process. RN 9 stated, I was not aware it was required. During an interview on 3/5/25 at 5:10 p.m. with Resident 64, Resident 64 stated, The nursing staff have not been wearing gowns for this [delivering of formula through the tube]. Resident 64 stated, I know it is for my safety that they do. During a review of the facility Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, dated 6/25/24, the policy indicated the use of EBP was mandated for residents identified as high risk for multidrug resistant organisms ([NAME]), including residents with indwelling devices [G-tube], during high contact resident activities. The policy indicated indwelling devices such as feeding tubes provide a direct pathway for pathogens to enter the body and cause infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the signage in front of Resident 64's room titled, Enhanced Barrier Precautions, undated, the signage indicated, All providers and staff must wear at least a gown and gloves for these High Contact Resident Care Activities: [including] Indwelling Device Care or Use: [including] Feeding tube. 52357 5. During a review of Resident 35's Face Sheet (demographics), dated 12/18/24, the Face Sheet indicated Resident 35 was admitted on [DATE] with diagnoses which include tongue carcinoma (a type of cancer of the tongue), dysphagia (difficulty swallowing foods and liquids), and gastrostomy tube (G-tube - a small flexible tube that is inserted through the skin into the stomach to provide nutrition and fluids). During an observation on 3/3/25 at 9:34 a.m., in Resident 35's room, a sign was observed outside of the room alerting staff that Resident 35 required Enhanced Barrier Precautions (EBP - infection control practice that uses PPE-personal protective equipment including gloves and gowns to reduce the spread of infection). The EBP sign indicated that staff are required to wear a gown and gloves when performing High-Contact Activities including providing care for indwelling medical devices such as G-tubes. During a concurrent observation and interview on 3/6/25 at 12:02 p.m. with LVN (Licensed Vocational Nurse (LVN) 2 in Resident 35's room, LVN 2 was observed administering medications through Resident 35's G-tube; LVN 2 was not wearing a gown. LVN 2 confirmed she did not wear a gown while administering G-tube medications to Resident 35 and stated she was unaware a gown was required. During an interview on 3/6/25 at 2:02 p.m. with Nursing Supervisor (NS) 3, NS 3 stated staff must wear gloves and a gown when providing care for residents with a G-tube or other indwelling medical device. NS 3 stated it was important to use EBP to protect the resident from infection. During a review of the facility's Enhanced Barrier Precautions (EBP) Policy, approved on 6/25/24, the policy indicated, This policy mandates the use of EBP, including the donning of gowns and gloves during high-contact resident care activities, for residents identified as high-risk due to .indwelling medical devices. Examples provided of indwelling medical devices included G-tubes. 6. A review of Resident 71's Face Sheet (demographics), dated 01/21/25, indicated Resident 71 was admitted on [DATE] with diagnoses that included urinary tract infection (UTI - an infection of the bladder and or kidneys) and severe sepsis with septic shock (life threatening condition resulting from an infection). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/6/25 at 11:00 a.m. with Registered Nurse (RN) 10 in Resident 71's room. RN 10 was observed preparing to flush Resident 71's nephrostomy tube (a long, thin, plastic tube inserted through the skin directly into the kidney which drains fluid). RN 10 donned clean gloves, opened a small sterile drape, (a sterile sheet used to create a sterile field during procedures with the purpose of preventing the spread of infection from non-sterile areas and protecting the resident from contamination) and placed the sterile drape under Resident 71's nephrostomy tubing. RN 10 removed a green cap from the port attached to the nephrostomy tubing and placed the green cap on the bedside table. RN 10 donned sterile gloves (gloves which have been sterilized to eliminate any bacteria to protect residents from infection during procedures. Once sterile gloves are donned, staff should not touch anything except other sterile supplies) and opened an alcohol wipe (non-sterile) and used it to clean the port of the nephrostomy tube. RN 10 then picked up a syringe filled with sodium chloride (solution to flush the nephrostomy tube) which was wrapped in plastic (non-sterile). RN 10 unwrapped the syringe with her sterile gloves and proceeded to use the port to inject sodium chloride into Resident 71's nephrostomy tube. RN 10 then placed the green cap (non-sterile) back on the port of the resident's nephrostomy tube. During an interview on 3/6/25 at 11:15 a.m. with RN 10, RN 10 confirmed she used sterile gloves to open the alcohol swab wrapper and to remove the plastic overlay from the sodium chloride syringe. RN 10 confirmed these supplies were not sterile and her sterile gloves were contaminated by handling the non-sterile supplies. RN 10 further stated the green cap she removed from the bedside table and placed back on Resident 71's nephrostomy tube port was not sterile. During an interview on 03/06/2025 at 2:02 p.m. with Nursing Supervisor (NS) 3, NS 3 stated it was important to use sterile technique when flushing Resident 71's nephrostomy tube because the nephrostomy tube was inserted through the skin directly into the resident's kidney. NS 3 stated failure to use sterile technique when flushing the nephrostomy tube could result in Resident 71 developing a serious infection. During a review of the facility's policy and procedure (P&P) titled Nephrostomy Tube, Management, dated 04/09/2024, the P&P indicated, Flushing of Nephrostomy . flushing of the nephrostomy tube is a sterile procedure.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 34975 Based on observation, interview, and facility document review, the facility failed to maintain a walk-in freezer when there was a large amount of ice build-up on the ceiling as well as ice build-up on boxes of food. The failure to maintain one freezer in one out of two kitchens had the potential to result in decreased quality and contamination of food. Findings: An observation in a walk-in freezer (referred to as the warehouse freezer) located in the Main Kitchen (where food was stored and prepared for the licensed care kitchen) on 3/4/25 at 10:25 a.m., showed ice build-up on the ceiling between wall mounted fans. The ice measured more than 24 inches long, 18 inches wide, and 2 inches thick. In addition, boxes of food stored below the fan had a layer of ice build-up on the top surface of the boxes. During a concurrent interview on 3/4/25 at 10:25 a.m., Food Manager (FM) 1 stated he did not know what the ice build-up was from. FM 1 confirmed there was ice build-up on boxes of food and stated he was unaware of the ice build-up. During an interview on 3/6/25 at 3:08 p.m., the Dietary Director (DD) stated freezers need to be free of ice-build-up. During an interview with the Direct Construction Supervisor (DCS) on 3/4/25 at 3:10 p.m., DCS stated his staff usually went into the warehouse freezer every other week but right now about every month because of a staff shortage. DCS stated he was not aware of ice build-up. During a review of the policy and procedure titled, Food & [and] Nutrition Services - Equipment (All Homes), dated 9/18/24, showed equipment will be maintained in good working order.