Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555108	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Christian Home	1950 S. Mountain Ave Ontario, CA 91762

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)
F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47360 Based on interview and record review, the facility failed to provide three of three residents (Residents 8, 17, and 23) with the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN: CMS-10055 - a document that provides information about skilled services provided by the facility that may no longer be covered by Medicare Part A), when residents remaining admitted to the facility were not informed of Medicare Part A benefits ending. This failure resulted in the facility not meeting the obligation to notify Residents 8, 17, and 23 of their choices regarding their claim appeal rights and financial liability for services no longer covered by Medicare Part A. Findings: During a concurrent interview and record review, on May 9, 2024, at 2:15 PM, with the Social Services Director (SSD), the SNF Beneficiary Protection Notification Review for Residents 8, 17, and 23 was reviewed. The SNF Beneficiary Protection Notification Review, indicated Residents 8, 17 and 23 were not provided the SNF ABN form from the facility prior to discharge of Medicare Part A Services. The SSD stated she was not aware of the SNF ABN form and did not know the facility was to provide the form to the residents prior to their Medicare Part A benefits ending. During a concurrent interview and record review, on May 10, 2024, at 11:16 AM, with Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Advance Beneficiary Notices, undated was reviewed. The P&P indicated, .Policy: It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage .4. The facility shall inform Medicare beneficiaries of his or her potential liability for payment .5. The current CMS-approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative) .a. For Part A items and services, the facility shall use the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN), Form CMS-10055 . The DON stated, the facility's policy and procedure was not followed. The DON further stated, residents requiring the notification regarding their financial responsibility and right to appeal was not provided to residents.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interview and record reviews, the facility failed to ensure the correct amount of enteral feeding nutrition (a liquid nutrition formula for tube feeding administered directly into the stomach) was administered as ordered for two of two sample residents (Resident 45 and 13) when the nursing staff did not give the correct amount of feeding formula as prescribed and in accordance with their care plans (the individualized plan for medical care of a resident). These failures resulted in Resident 13 and 45 to not receive the daily calories as ordered and had the potential to cause sub-optimal (less than ideal) nutritional status that may negatively affect Resident's health and well-being. Findings: 1. During a review of Resident 45's Admission Record (contains demographic and medical information), the admission record indicated Resident 45 was admitted to the facility on [DATE], with diagnoses of acute cerebrovascular insufficiency (a reduction in blood flow in the brain), gastrostomy status (having a gastrostomy tube also known as a G-tube, this tube is inserted through the abdomen into stomach to provide nutrition and fluids directly when a person is unable to eat or drink normally) and dysphagia (difficulty of swallowing food or liquids). During a review of Resident 45's MDS (Minimum Data Set - a clinical assessment of all residents in nursing homes) 3.0 Section C -Cognitive dated February 29, 2024, the MDS indicated Resident 45 had a BIMS (brief interview for mental status) score of 8 (A score of 8-12 indicated moderate cognitive impairment). During an observation on May 7, 2024, at 12:15 PM, Resident 45 was observed in bed, a bottle of enteral nutrition was at her bedside. The bottle was connected to a feeding pump (pump which administers enteral nutrition) which was not on and was no longer administering enteral nutrition. The label on the enteral nutrition bottle indicated [Brand Name] 1.2 calories with the total amount of 1000 milliliters (ml-unit of measurement) liquid formula. The label also indicated, the nursing staff administered the enteral nutrition at the infusion rate of 50 ml per hour started on May 6, 2024, at 2:00 PM. The enteral nutrition bottle contained 300 mls of liquid formula. During an interview on May 7, 2024, at 3:10 PM,with License Vocational Nurse, LVN 3, inspected a photograph of Resident 45's bottle of [Brand name] 1.2 calories, taken on May 7, 2024, at 12:15 PM, and acknowledged that there was 300 mL remaining in the bottle. LVN 3, stated Resident 45 did not receive the fluid for six hours based on how much was left in the bottle. LVN 3 further stated, Resident 45 should have received 1000 mls instead of only 700 mls. LVN 3 further stated, Resident 45 may not have received the full amount of enteral feeding, as her feeding may have been placed on hold during personal care activities or when receiving oral gratification. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on May 9, 2024, at 9:30 AM, with the Registered Dietitian (RD), RD stated for Resident 45 the enteral nutrition feeding was her primary source of her diet. RD further stated, mentioned that her expectation was 50 mL to be administered in 20 hours. If this amount was not administered within 20 hours, they should extend the hours until it was completed. The RD stated, it was important for staff to document a rationale if the full amount was not administered. Furthermore, the RD stated, if the full amount of feeding was not received the resident would lose weight. During a review of Resident 45's physician orders, dated May 10, 2024, a physician order indicated Enteral feeding [Brand Name] 1.2 [calories per milliliter Cal/mL of the liquid formula] @ [at] 50 mL/hr. x [for] 20 hours [The resident is receiving 50 milliliters of liquid nutrition per hour through a feeding tube for 20 hours} Flush with Fluid 70 mL Q [every] 4H(hour). Feeding will provide 1000ml [Volume of liquid nutrition] /1200 Kcal, [Liquid nutrition will provide 1200 kilocalories, Kcal is a measure of energy from the food] 60g protein, [the liquid nutrition contains 60 grams of protein], 1155 mL water. ((milliliters of water) Enteral feeding. During a record review of Resident 45's Weight Summary, dated March 1, 2024, through May 2, 2024, the Weight Summary indicated the following: On April 25, 2024, at 11:15 AM: weight 107 lbs (pounds-unit of measurement) On May 2, 2024, at 10:01 AM weight 101 lbs. (6 pound weight loss in 1 week) During a record review of Resident 45's Care Plan dated February 23, 2024, the CarePlan indicated Enteral Feeding -requires enteral feeding for nutrition Gastrostomy tube due to CVA (cardiovascular accident-Stroke occurs when the blood flow for a part of the brain is interrupted), swallowing problem . Interventions .Provide enteral feeding via enteral tube per MD order . During a concurrent interview and record review on May 9, 2024, at 3:30 PM, with the Director of Nurses (DON), the DON reviewed and acknowledged the facility's policy and procedure titled Enteral Nutrition dated November 2018, and stated the policy was not followed, because Resident 45 did not receive the amount of enteral nutrition the physician had ordered. During a review of the facility's policy and procedure (P&P) titled Enteral Nutrition, dated November 2018, the (P&P) indicated Adequate nutritional support through enteral nutrition is provided to resident as ordered . 3. The dietitian, with input from the provider and nurse: a. estimates calorie, protein, nutrient and fluid needs; b. determines whether the resident's current intake is adequate to meet his or her nutritional needs; c. recommends special food formulations; and d. calculates fluids to be provided (beyond free fluids in formula) . 11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include a. the enteral nutrition product; b. delivery site (tip placement); c. the specific enteral access device . gastric [through the stomach] . d. administration method (continuous, (constant flow) bolus, (a large dose) intermittent [given in separate doses] .; e. Volume and rate of administration; f. the volume / rate goals and recommendations for advancement toward these; and g. instructions for flushing (solution, volume, frequency, timing and 24-hour volume) . 40171 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 13's Admission Record, (contains demographic and medical information), indicated Resident 13 was initially admitted to the facility on [DATE], with diagnoses which included surgical aftercare following surgery on the digestive system, malignant neoplasm of pancreas (pancreatic cancer), and dysphagia (difficulty swallowing). During an observation on May 6, 2024, at 10:12 AM, in Resident 13's room, Resident 13 had a 1000 milliliters (mls - unit of measure) bag of enteral nutrition (liquid nutrition administered via a feeding tube inserted into the stomach) at his bedside, the bag was connected to a feeding pump (pump which administers enteral nutrition) which was not on and was no longer administering enteral nutrition to Resident 13. The enteral nutrition bag was labeled with the date May 5, 2024, and time 1900 [7:00 PM] (date and time the feeding was started), the residents name, and the rate of administration which was 70 mls an hour (70 ml/hr - rate of enteral nutrition administration via feeding pump). The enteral nutrition bag contained 400 ml of nutrition still in the bag. During a review of Resident 13's physician's orders, dated April 30, 2024, the order indicated, .[brand name of enteral nutrition] 2.0 via [by] GT [Gastrostomy tube - a feeding tube inserted directly into the abdomen and into the stomach to deliver nutrition] at a rate of 70 ml/hr x [times] 12 hours via enteral pump. Infuse until dose completed to yield 840 ml . During a review of Resident 13's care plan (an individualized plan for the medical care of a resident), titled, Requires enteral feeding for nutrition . updated March 18, 2024, the care plan indicated the resident required enteral nutrition due to .Poor PO (by mouth) intake, malnutrition (lack of proper nutrition), history of swallowing problem. During an interview on May 9, 2024, at 3:23 PM, with the Director of Nursing (DON), the DON stated, his expectation was that staff follow the physician's orders when administering enteral nutrition. The DON further stated, enteral nutrition was supposed to be administered until the prescribed dose was complete. The DON stated, it was important that the resident's receive the amount of enteral nutrition as prescribed, so the resident received the correct amount of calories daily. The DON stated, if a resident did not receive a dose of enteral nutrition entirely as prescribed, the staff was supposed to notify the physician that the resident did not get the full dose and document in the resident's medical record. During a concurrent interview and record review on May 9, 2024, at 3:34 PM, with the DON, Resident 13's medical record was reviewed, The DON stated there was no documentation or evidence in Resident 13's medical record to indicate why the full dose of enteral nutrition was not administered on May 5, 2024. The DON further stated, after the prescribed 840 ml dose, the bag should have contained only 160 ml of enteral nutrition. Therefore, there was an excess of 240 ml of enteral nutrition left in the bag which should have been administered to the resident but was not (equivalent to 3.4 hours of administration at the physician's prescribed rate).

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40171 Based on observation, interview, and record review, the facility failed to post Direct Care Service Hours Per Patient Day (DHPPD - number of hours of direct care service hours per patient day based upon the facility census [total resident count] and staff working within a 24-hour period) in a prominent place readily accessible to residents and visitors. This failure resulted in the facility's nurse staffing information to not be readily available for review by residents and visitors at any given time as required by regulations. Findings: During a concurrent observation and record review on May 7, 2024, at 9:56 AM, at the facility's nursing station, the facility's staffing information titled [Name of facility]: Skilled Nursing, was posted on the counter in a clear plexiglass type of stand and was visible to anyone walking by. The document was dated May 2, 2024 (dated 5 days prior to the current date). During a concurrent observation and interview on May 7, 2024, at 9:59 AM, with the Director of Nursing (DON) and the Director of Staff Development (DD), both the DON and the DD observed the posted DHPPD staffing information at the nurses' station and acknowledged it was dated May 2, 2024 (5 days prior). The DON stated the DHPPD staffing information was supposed to be updated and posted every day and that it was a task performed by the DD. The DD stated the posted staffing information had not been updated since May 2, 2024, because she had been out of the facility and was unable to update it. The DON stated in the absence of the DD, it was the responsibility of the DON to ensure the DHPPD staffing information was posted. The DD stated there was no other location in the facility where DHPPD staffing information was posted. During a review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing, revised August 2022, the policy indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment .Direct Care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift . During a review of the National Healthcare Safety Network (NHSN) document titled, Nurse Staffing Hours Indicator, dated August 2023, the document indicated, .The NHSN Nurse Staffing indicator, Nursing Hours per Patient Day (NHPPD) has been developed to provide facilities with a tool to assess the value nursing staff provides around patient safety and care quality .

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40171

Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 13) received medications in the route (way by which a medication is taken into the body) prescribed by the physician when Licensed Vocational Nurse 2 (LVN 2) administered Tramadol (pain medication) 50 milligram (mg - a unit of measure) PO (by mouth) instead of administering the medication through the residents gastrostomy tube (G-tube - a feeding tube inserted directly into the abdomen and into the stomach to deliver nutrition) as ordered by the physician.

This failure resulted in a medication error and LVN 2 to not follow the five rights of medication administration (right drug, right dosage, right patient, right route, right time). This placed Resident 13 at risk for adverse outcomes associated with medication errors.

Findings:

A review of Resident 13's Admission Record, (contains demographic and medical information), indicated Resident 13 was initially admitted to the facility on [DATE], with diagnoses which included surgical aftercare following surgery on the digestive system, malignant neoplasm of pancreas (pancreatic cancer), chest pain, and dysphagia (difficulty swallowing).

During a medication administration observation on May 8, 2024, at 5:06 AM, with LVN 2, LVN 2 administered to Resident 13, Tramadol 50 mg tablet by mouth (PO).

During a review of Resident 13's physicians orders dated April 30, 2024, indicated, Tramadol HCL [hydrochloride] oral tablet 50 mg .Give 50 mg via [by] G-tube two times a day for pain management.

During a review of Resident 13's clinical record, there was no documentation indicating physician approval to administer Resident 13's Tramadol PO instead of via G-tube.

During an interview on May 9, 2024, at 11:16 AM, with the Director or Nursing (DON), the DON stated staff were supposed to administer medications to residents in the route as prescribed by the physician.

During an interview on May 9, 2024, at 2:25 PM, with the Director of Staff Development (DD), the DD stated staff were supposed to administer medications by the route specified in the physician's orders.

During a review of the facility's policy and procedure titled, Specific Medication Administration Procedures, dated October 2012, the policy indicated, Policy - To administer medications in a safe and effective manner . Procedures .C. Review 5 Rights [the right patient, the right medication, the right time, the right dose, and the right route - all of which are generally regarded as a standard for safe medication practices] .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on interview, and record review, the facility failed to ensure pharmacist recommendations made during monthly resident Medication Regimen Reviews (MRR - medication reviews done by a pharmacist to identify irregularities in each resident's medication regimen) were communicated to the physician for two of five residents (Residents 41 and 43) sampled for unnecessary medications when: 1) For Resident 41, there was no indication that a physician was notified regarding the pharmacist's MRR recommendations dated October 18, 2023, which included: 1a) Assessment of the risk versus benefits of therapy related to the increased risk of death associated with elderly residents with dementia who receive antipsychotics (medications which alter brain chemistry to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking). 1b) Assessment of the continued use of dual antipsychotic therapy (use of two antipsychotic medications for treatment) for the resident who was receiving two antipsychotic medications. 1c) Consideration for the adjunctive use of an antidepressant medication (medication used to treat depression) for the resident who was receiving Abilify (an antipsychotic medication) to treat depression. 2) For Resident 43, there was no indication that a physician was notified regarding the pharmacist's MRR recommendations dated October 18, 2023, to request Resident 43 have laboratory testing of her Thyroid Stimulating Hormone (TSH - a hormone produced by the pituitary gland). These failures had resulted in a delay of notification to the physician to evaluate residents' medication regimen which had the potential to increase residents' risk of harm and injury without proper dosing adjustment and monitoring. Findings: 1) A review of Resident 41's Admission Record, (contains demographic and medical information), indicated the resident was initially admitted to the facility on [DATE], with diagnoses which included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities), unspecified psychosis (a mental disorder characterized by a disconnect from reality), and depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1a) During a review of Resident 41's pharmacist MRR recommendations titled, Note to Attending Physician/Prescriber, dated October 18, 2023, the document indicated, The resident has orders for Aricept [medication used to treat dementia] for dementia and the antipsychotics Abilify and Seroquel [type of antipsychotic medication]. A review of the literature by the FDA suggests an increased risk of death in elderly patients with dementia who receive atypical and traditional antipsychotics. The statement by the FDA stated that the literature revealed a 1.6 - 1.7 x [times] relative increased risk of death (4.5% vs 2.6%), with more recent studies showing similar results. In addition, be aware that the use of this class of medication for dementia-related behaviors is not FDA-approved. Please assess the risks versus benefits of therapy in this patient in order to keep the facility in compliance . The document included a section titled, Physician/Prescriber Response, which indicated three separate checkboxes. One checkbox indicated agree, while the second checkbox indicated disagree and the third checkbox indicated, Other,. None of the three checkboxes were checked or completed. In addition, the physician signature and date for physician/Prescriber Response, were also left blank. Resident 41's clinical record was then reviewed and there was no evidence that a physician was made aware of the pharmacist's recommendation. During an interview on May 9, 2024, at 10:56 AM, with the Director of Nursing (DON), the DON stated the pharmacist sends the results of the client's MRR's to him (the DON) and he in turn gives them to the nursing staff. The DON stated Licensed Vocational Nurse 4 (LVN 4) was responsible to ensure the pharmacist recommendations were conveyed to the physicians every month. The DON further stated, documentation regarding follow through of the recommendations was documented on the pharmacist recommendation forms and copies placed in the residents' clinical record. During a concurrent interview and record review on May 9, 2024, at 11:06 AM, with the Director of Nursing (DON), Resident 41's pharmacist medication regimen review recommendations titled, Note to Attending Physician/Prescriber, (regarding the assessment of the risk versus benefits related to the increased risk of death for elderly residents with dementia who receive antipsychotics) dated October 18, 2023, was reviewed. The DON stated, follow through was supposed to be documented in the physician response section, but it was not. The DON acknowledged the Physician/Prescriber Response section was blank. The DON then reviewed Resident 41's clinical record and stated he was unable to find documented evidence to indicate the pharmacist's recommendation was conveyed to the physician for consideration. 1b) During a review of Resident 41's pharmacist MRR recommendations titled, Note to Attending Physician/Prescriber, dated October 18, 2023, the document indicated, This resident is currently on routine Abilify and Seroquel. Although there may be a good rationale for dual antipsychotic therapy, without such documentation, the use of two antipsychotics may be viewed as duplicate (and unnecessary therapy by surveyors). Please consider either treating this resident's psychosis with a single antipsychotic or documenting in your progress notes your rationale for using two antipsychotics. This will keep the center in compliance . The document included a section titled, Physician/Prescriber Response, which indicated three separate checkboxes. One checkbox indicated agree, while the second checkbox indicated disagree and the third checkbox indicated, Other,. None of the three checkboxes were checked or completed. In addition, the physician signature and date for Physician/Prescriber Response, were also left blank. Resident 41's clinical record was then reviewed and there was no evidence that a physician was made aware of the pharmacist's recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on May 9, 2024, at 11:10 AM, with the DON, Resident 41's pharmacist MRR recommendations titled, Note to Attending Physician/Prescriber, (regarding the assessment of the continued use of dual antipsychotic therapy) dated October 18, 2023, was reviewed. The DON acknowledged the Physician/Prescriber Response section was blank. The DON then reviewed Resident 41's clinical record and stated he was unable to find documented evidence to indicate the pharmacist's recommendation was conveyed to the physician for consideration. 1c) During a review of Resident 41's pharmacist MRR recommendations titled, Consultant Pharmacist's Medication Regimen Review, dated October 18, 2023, the document indicated, Resident is currently on Abilify for depression. Note that when an Anti-psychotic such as Abilify is being used for depression, it is typically used in adjunct to an Antidepressant. Please consult with MD to evaluate. A column titled, follow-through was next to this comment but was blank. Resident 41's clinical record was then reviewed and there was no evidence that a physician was made aware of the pharmacist's recommendation. During a concurrent interview and record review on May 9, 2024, at 11:13 AM, with the DON, Resident 41's pharmacist MRR recommendations titled, Consultant Pharmacist's Medication Regimen Review, dated October 18, 2023, was reviewed. The DON acknowledged the follow-through section was left blank. The DON then reviewed Resident 41's clinical record and stated there was supposed to be follow through information documented on the form, but there was not. The DON reviewed Resident 41's clinical record and stated there was no documented evidence indicating the physician was made aware of the pharmacist's recommendation. 2) A review of Resident 43's Admission Record, indicated the resident was initially admitted to the facility on [DATE], with diagnoses which included hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), cerebral infarction (also known as stroke is damage to tissues in the brain due to a loss of oxygen to the area), and depression. During a review of Resident 43's pharmacist MRR recommendations titled, Consultant Pharmacist's Medication Regimen Review, dated October 18, 2023, the document indicated, Category: Lab order request . Please ensure to obtain .TSH level . A column titled, follow-through was next to this comment but was blank. Resident 43's clinical record was then reviewed and there was no evidence that a physician was made aware of the pharmacist's recommendation. During a concurrent interview and record review on May 9, 2024, at 10:59 AM, with the DON, Resident 43's pharmacist MRR recommendations titled, Consultant Pharmacist's Medication Regimen Review, dated October 18, 2023, was reviewed. The DON acknowledged the follow-through section was left blank. The DON then reviewed Resident 43's clinical record and stated he was unable to find documented evidence indicating the physician was made aware of the pharmacist's recommendation to obtain a TSH level. During an interview on May 9, 2024, at 11:03 AM, with the DON, the DON reviewed Resident 43's clinical record and stated he was unable to find documented evidence Resident 43's TSH level was assessed between October 18, 2023 (the date of the pharmacist's recommendation) through the current date of interview (May 9, 2024). The DON stated, the pharmacist's recommendation was supposed to be followed up on, but it was not. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Consultant Pharmacist Reports, dated October 2012, the policy indicated, The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion .The consultant pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review .B. Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review .prescriber response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record. C. Recommendations are acted upon and documented by the facility staff and/or prescriber .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40171 Based on observation, interview, and record review, the facility failed to ensure expired medications were removed from one of one the facility's medication supply rooms when an expired bottle of [brand name] docusate sodium (a stool softener commonly used to treat constipation) was observed to be in the medication supply room available for use. This failure had the potential for the medication to have decreased efficacy (ability to produce a desired result) and sub-therapeutic (less than optimal) effects when administered. Findings: During a concurrent observation and interview on May 9, 2024, at 9:00 AM, in the facility's medication supply room, with the Director of Staff Development (DD), one medication bottle of [brand name] docusate sodium was observed to be in the medication cabinet on a shelf where medications available for use were stored. The medication bottle of [brand name] docusate sodium had an expiration date of September 2023. The DD verified and confirmed the expiration date was September 2023 and stated expired medications were supposed to be removed from the medication supply and discarded. During an interview on May 9, 2024, at 9:20 AM, with the Director of Nursing (DON), the DON stated it was the responsibility of the nursing staff to ensure expired medications were removed from the medication supply room. During a review of the facility's policy and procedure titled, Medication Labeling and Storage, revised February 2023, the policy indicated, Medication Storage .2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49001 Based on observation, interview, and record review the facility did not follow the menu when residents on a Consistent Carbohydrate Order (CCHO) diet (diet involves eating the same number of carbohydrates every day to manage blood sugar levels) received 1/4 cup serving of Yukon whipped potatoes instead of 1/2 cup serving and residents on a regular diet received 2.6 ounces of baked ham instead of 3 ounces that the menu indicated, for lunch on Monday May 6, 2024. This failure caused residents to not get the nutrients that their physician ordered diet included and affected 29 of 52 medically compromised residents who received food from the kitchen. Findings: During lunch meal observation on May 6, 2024, at 11:50 a.m., the cook used a #16 scoop (2 ounces (oz)) to serve the Yukon whipped potatoes for residents 23, 13 and 251 on a CCHO diet . The cook also served resident 204, 2.6 ounces of baked ham. During observation and concurrent interview with Dining Service Director (DSD), on May 6, 2024, at 12:05p. m., the DSD weighed the baked ham and stated it is 2.6 oz. DSD stated, The cook should have followed the menu and served 3 oz or more of the baked ham. During interview with Director of nutrition (DN), Registered Dietitian (RD), Nutrition Care Manager (NCM) and Dining Service Director (DSD), on May 8, 2024, at 9:22 am, RD stated the resident should receive the correct portions according to the menu. During record review of lunch menu titled Diet Extensions: Monday, Week 4, ICH 2024 SS for May 6, 2024, menu includes Baked ham 3 oz, Yukon Whipped potatoes 4 oz for CCHO diet Residents.

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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. 49001 Based on observation, interview and record review, the facility failed to store food by methods that conserve nutritive value, flavor, and appearance when a tray of pudding and cut melon was stored in the refrigerator uncovered and undated. There was a bag of hot dogs with a mold like substance, tortillas were stored uncovered and leftover pork from May 4 was stored in the refrigerator drawer, ready for use. These failures had the potential for food to not be palatable when served to 52 of 53 vulnerable residents who receive food from the kitchen. Findings: During an observation on May 6, 2024, at 8:50 a.m., inside the reach-in refrigerator, there were tray of pudding and cut melons uncovered and undated ready to use. During an observation on May 6, 2024, at 8:52 a.m., in the lower refrigerator noted, one plastic bag hot dogs with a mold-like substance undated, and one bag of tortillas uncovered, and a small container of leftover pork from May 4 stored in the lower refrigerator drawer ready to use. During an interview with Nutrition Care Manager (NCM) on May 6, 2024, at 9:09 a.m., NCM stated that the hot dogs and tortillas should have been thrown out. During an interview with the Dining Service Director on May 6, 2024, at 9:33 a.m., DSD stated that no food should have been uncovered left in the refrigerator. DSD, further stated, leftovers need to be used within three days. During an interview with the Dining Service Director on May 8, 2024, at 9:20 a.m., DSD stated leftovers should only be kept for three days and all food in the refrigerator should be covered. During a review of the facility policy titled Production, Purchasing, Storage, dated January 2024, indicated, All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Under procedures of the policy indicated, Cover, label and date unused portions and open packages.

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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. 49001 Based on observation, interview and record review, the facility failed to maintain a sanitary kitchen when: 1. Floor behind the cooking line had a build-up of grease and food crumbs. This had the potential to attract pest and for microorganism growth. 2. Floor under the shelves in the dry storage had build-up of food crumbs. This had the potential to attract pests. 3. In the walk-in refrigerator, thawing meat was not labeled or dated. This had the potential to cause food borne illness (illnesses contracted from eating contaminated food or beverages). 4. Ice machine had a brown slime build-up underside of icemaker, in the top portion of the ice bin. This had the potential to cause food-borne illness. These failures had the potential to cause food borne illness to 52 of 53 medically compromised residents who received food from the kitchen. Findings: 1. During an observation and concurrent interview on May 6, 2024, at 08:58 AM, at the kitchen the cooking line, there was a build-up of grease and food build-up behind stove. Nutrition Care Manager (NCM) stated, it should be kept clean. During interview with Dinning Services Director (DSD) on May 8. 2024 9:12 AM, She stated she had cleaned the area under the cooking line with grease build-up about two weeks ago. DSD stated, it should be cleaned more often under the cooking line on the floor to eliminate the grease build-up. DSD further stated that area is not on the cleaning schedule, the grease build- up. DSD stated, she needed to add those areas that were identified to their cleaning list. During a review of the facility policy titled Sanitation and Infection Prevention/Control, revise date January 2024, indicated Nonfood contact surfaces of equipment .shall be cleaned as often as is necessary. Kitchen floors will be swept and mopped at a minimum daily or as needed. During a review of the FDA Federal Food Code 2022, 4-101.19 indicates, Nonfood-contact surfaces of equipment routinely exposed to splash or food debris are required to be constructed of nonabsorbent materials to facilitate cleaning. Equipment that is easily cleaned minimizes the presence of pathogenic organisms, moisture, and debris and deters the attraction of rodents and insects. 2. During an observation in the kitchen, on May 6. 2024 9:12 a.m., floor under the shelves in dry storage had build-up of food crumbs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with DSD on May 6, 2024, at 9:32 a.m., DSD stated there should not be any crumbs in hard-to-reach areas of the dry storage. During a review of the facility policy titled Sanitation and Infection Prevention/Control, revised date January 2024, indicated Nonfood contact surfaces of equipment .shall be cleaned as often as is necessary. During a review of the FDA Federal Food Code, dated 2022, 4-601.11indicated 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. 3. During an observation in the walk-in refrigerator on May 6, 2024, at 09:05 AM, there were two pieces of steak in 2-gallon bag unlabeled and undated. Four bags of beef not labeled or dated, five tubes ground beef thawing unlabeled and undated and two pans of chicken unlabeled and undated. During interview with the AM Cook, on May 6, 2024, at 9:13 a.m., the cook usually pulls the meat at least three days prior to use. AM Cook further stated the meat should be labeled and dated when put in refrigerator to thaw. During an interview with Dining Food Services Director (DSD), on May 8, 2024, at 9:20 a.m., DSD stated, they defrost the meat 3 days before, but should always be labeled and dated. During a review of the facility policy titled Production, Purchasing, Storage (HACCP) revised date January 2024 indicated Count the day the raw meat is removed from freezer as Day 1; it must be cooked by the end +4 days. Label with the date it was removed from the freezer, and the date by which it must be used. During a review of the FDA Federal Food Code, dated 2022, 3-501.17, indicated refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. In addition, Food which is prepared and held, or prepared, frozen, and thawed must be controlled by date marking to ensure its safety based on the total amount of time it was held at refrigeration temperature, and the opportunity for Listeria monocytogenes to multiply, before freezing and after thawing. 4. During an observation of Ice Machine in the kitchen on May 6, 2024, at 3:14 p.m., noted, in the area where ice was formed there was a black substance and yellow build-up underside the top portion of the ice bin where ice enters the bin. There was a stainless-steel plate that had a slimy substance. During observation and concurrent interview with Dining service Director (DSD), on May 6, 2024, at 3:20 p.m. , DSD stated she cleans the ice machine, but did not clean inside where the build-up and slime was found. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation and concurrent interview with DSD, on May 8, 2024, at 9:20 a.m., DSD stated her expectation is that the ice machine is always clean and has no build-up. During interview with Infection Preventionist Nurse on May 6, 2024, at 3:32 p.m., stated there are no documented cases of norovirus in the last 6 months. During a review of the facility policy titled Instruction Manual, revised date August 7, 2017 under Monthly Maintenance Schedule, it indicated, Underside of Icemaker and Top Kits, Bin Door and Snout. Wipe down with a clean cloth and warm water. During a review of the FDA Federal Food Code, dated 2022, 4-602.11 indicated, Equipment food-contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred. 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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on interview, and record review, the facility failed to ensure the medical record for one resident (Resident 13) was complete and accurate when staff did not document a physician's telephone order (a physicians order received by a nurse over the phone) regarding a change in the route of medication (means by which a medication is taken into the body) in Resident 13's clinical record. This failure resulted in Resident 13's medical record to be incomplete regarding physician's orders which had the potential for staff to not provide Resident 13 care as specified by the physician. Findings: A review of Resident 13's Admission Record, (contains demographic and medical information), indicated Resident 13 was initially admitted to the facility on [DATE], with diagnoses which included surgical aftercare following surgery on the digestive system, malignant neoplasm of pancreas (pancreatic cancer), and dysphagia (difficulty swallowing). During an interview on May 9, 2024, at 11:21 AM, with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated he changed the route of multiple medications for Resident 4 to be administered by gastrostomy tube (G-tube - a feeding tube inserted directly into the abdomen and into the stomach to deliver nutrition) instead of by mouth after receiving a telephone order from the physician to do so. During a follow up interview on May 9, 2024, at 11:28 AM, with LVN 4, LVN 4 stated he could not recall which of Resident 4's medications he changed the route for or how many in total he changed. LVN 4 further stated he did not document the telephone order anywhere in Resident 13's medical record. LVN 4 stated he should have documented the order and the interaction with the physician, but he did not. During an interview on May 9, 2024, at 11:31 AM, with the Director of Nursing (DON), the DON stated the nurses were supposed to document physician's orders in the resident's medical record. During an interview on May 9, 2024, at 2:27 PM, with the Director of Staff Development (DD), the DD stated, when staff received a telephone order from a physician, they were supposed to document the order in the resident's medical record and then carry out the order. During a review of the facility's policy and procedure titled, Charting Errors and/or Omissions, Revised September 2006, the policy indicated, Accurate medical records shall be maintained by this facility . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Telephone Orders, revised February 2014, the policy indicated, Verbal telephone orders may be accepted from each resident's attending physician .1. Verbal telephone orders may only be received by licensed personnel .Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record. 2. The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. 3. Telephone orders must be countersigned by the physician during his or her next visit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47360 Based on observation, interview and record review, the facility failed to provide a safe, sanitary and comfortable environment when a used syringe (a small hollow tube with plunger used for injecting or withdrawing fluid) was left on the bedside table for one of five sampled residents (Resident 251). This failure had the potential to expose residents and staff to used medical equipment that may be contaminated with human blood, body fluids or other infectious material. Findings: During a review of Resident 251's Admission Record (contains demographic and medical information), the Admission Record indicated, Resident 251 was admitted on [DATE], with diagnoses which included urinary tract infection (an infection in the organs that produce urine), altered mental status (a change how your brain works that causes a change in behavior) and hydronephrosis (swelling of the kidney(s). During an observation on May 6, 2024, at 11:18 AM, in Resident 251's room, an unlabeled, unpackaged, used syringe that contained approximately 2 milliliters (mL -unit of measure) unknown fluid was sitting on Resident 251's bedside table next to a pitcher of water and a box of tissues. During a concurrent observation and interview on May 6, 2024, at 11:30 AM with Licensed Vocational Nurse (LVN1), in Resident 251's room, a used syringe was sitting on the bedside table. LVN 1 stated, she was uncertain when and what the syringe was used and why it was on the bedside table. LVN 1 further stated, the syringe should not be on the table and should have been discarded in the sharps container immediately after it was used. During a concurrent interview and record review, on May 8, 2024, at 9:30 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Sharps Disposal, undated, was reviewed. The P&P indicated, .once used, the syringe and needle are both contaminated and must be discarded . The DON stated, the facility's policy and procedure was not followed and used syringe should not be left at the bedside and should always be discarded immediately after use

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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. 49001 Based on observation, interview and record review, the facility failed to ensure the walk-in refrigerator was in safe operating condition when there was ice build-up across the bottom portion of one wall. This failure had the potential to cause the refrigerator to not cool properly and put 52 of 53 vulnerable residents who receive food from the kitchen at risk of food-borne illness (illnesses that can cause upset stomach, vomiting and diarrhea within hours of eating contaminated food). Findings: During an observation on May 6, 2024, at 9:00 a.m., inside the walk-in refrigerator, noted ice build-up on the bottom six inches of the wall behind the shelves. During observation with Nutrition Care Manager (NCM) on May 6, 2024, at 9:09 a.m., NCM stated, they try to undo it every once in a while, but the ice it builds up so quickly. During an interview with the Dining Service Director (DSD), on May 8, 2024, at 9:20 a.m., DSD stated, there should not be ice build- up in the walk-in refrigerator. During interview with Nutrition Care Manager (NCM) on May 8, 2024, at 9:20 a.m., NCM stated, they don't have a previously submitted work order for the ice buildup in the fridge. During a review of the FDA Federal Food Code, dated 2022, 4-501.11 indicated (A) equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. In addition, Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk. For example, refrigeration units in disrepair may no longer be capable of properly cooling or holding time/temperature control for safety foods at safe temperatures.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40171

Based on observation, interview, and record review, the facility failed to ensure the call system (a system that triggers a visual and/or auditory queue when a resident requests assistance) was functional and accessible in 6 resident restrooms and three shower/bathing rooms, when the call system pull cords (a cord which when pulled, activates the call system) were too short and not accessible to a resident from the floor.

This failure had the potential to delay staff response time when residents were experiencing an emergency or needing assistance which could jeopardize residents' health and safety.

Findings:

During an interview on May 7, 2024, at 10:07 AM, with the Maintenance Director (MD), the MD stated the facilities call system was to be used in case of an emergency or for residents or staff to call for assistance.

During a concurrent observation and interview on May 7, 2024, at 10:08 AM, in the restroom of room [ROOM NUMBER], with the MD, there were two separate call lights with cords on them. Both call light cords were wrapped in a bundle which was secured with a green tape like material. The MD, using a measuring tape, measured the distance from the floor to the bottom of each of the pull cords. One pull cord was measured 49.5 inches from the floor and the other was 32 inches from the floor as confirmed and verified by the MD.

During a concurrent observation and interview on May 7, 2024, at 10:09 AM, in Whirlpool room [ROOM NUMBER] (a room with a whirlpool type bathing tub and a shower), with the MD, the room had two separate call lights with cords on them. Both call light cords were wrapped in a bundle which was secured with a green tape like material. The MD measured the distance from the floor to the bottom of each of the pull cords. One pull cord was measured 41.5 inches from the floor and the other was 44 3/4 inches from the floor as confirmed and verified by the MD. The MD stated, the pull cords were supposed to be accessible to residents while on the floor, but they were not.

During a concurrent observation and interview on May 7, 2024, at 10:12 AM, in the shared restroom of rooms [ROOM NUMBERS], with the MD, there was one call light with a pull cord on it. The call light cord was wrapped in bundle secured with a green tape like material. The MD measured the distance from the floor to the bottom of the pull cord and confirmed and verified the pull cord was 33 inches from the floor.

During a concurrent observation and interview on May 7, 2024, at 10:13 AM, in the shared restroom of rooms [ROOM NUMBERS], with the MD, there was one call light with a pull cord on it. The call light cord was wrapped in a bundle secured with green tape like material. The MD measured the distance from the floor to the bottom of the pullcord and confirmed and verified the pullcord was 28.5 inches from the floor. The MD stated the green tape material wrapped around each of the pullcords was from the factory manufacturer. The MD further stated, when the pullcords were installed, the green tape was not cut off (therefore preventing the cord from hanging its full length).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on May 7, 2024, at 10:16 AM, in the shared restroom of rooms [ROOM NUMBERS], with the MD, there was one call light with a pull cord on it. The pull cord was tied to a handrail. The MD measured the distance from the floor to the bottom of the pull cord and confirmed and verified the pull cord was 21 inches from the floor. During a concurrent observation and interview on May 7, 2024, at 10:17 AM, in Shower room [ROOM NUMBER], with the MD, there was one call light with a pull cord on it. The cord was wrapped in a bundle secured with green tape like material. The MD measured the distance from the floor to the bottom of the pull cord and confirmed and verified the pull cord was 40.5 inches from the floor. During a concurrent observation and interview on May 7, 2024, at 10:19 AM, in the shared restroom of rooms [ROOM NUMBERS], with the MD, there was one call light with a pull cord on it. The call light cord was wrapped in bundle secured with a green tape like material. The MD measured the distance from the floor to the bottom of the pull cord and confirmed and verified the pull cord was 28.5 inches from the floor. During a concurrent observation and interview on May 7, 2024, at 10:20 AM, in Shower room [ROOM NUMBER], with the MD, there was one call light with a pull cord on it. The cord was wrapped in a bundle secured with green tape like material. The MD measured the distance from the floor to the bottom of the pull cord and confirmed and verified the pull cord was 52.5 inches from the floor. During an interview on May 7, 2024, at 10:21 AM, with the MD, the MD stated, multiple new call lights were installed in the facility approximately a month ago. The MD further stated the green tape like material seen on the new call lights was not removed at that time they were installed. During a concurrent observation and interview on May 7, 2024, at 10:22 AM, in the restroom of room [ROOM NUMBER], with the MD, there was one call light with a pull cord on it. The call light cord was wrapped in a bundle secured with green tape like material. The MD measured the distance from the floor to the bottom of the pull cord and confirmed and verified the pull cord was 56.5 inches from the floor. During an interview on May 7, 2024, at 10:24 AM, with the Director of Nursing (DON), the DON stated call light pull cords were to be used in case a resident needed help. The DON further stated the call light pull cords were supposed to be reachable by the residents while on the floor. During an interview on May 7, 2024, at 10:31 AM, with the Administrator (ADMIN), the ADMIN stated the purpose of the call light pull cord was for residents to use if they needed help. The ADMIN further stated the pull cords could be used if a resident fell and the purpose of the pull cord was to activate the call system in case the call button itself could not be reached. The ADMIN stated the pull cord was supposed to be positioned in such a way so that a resident on the floor would be able to reach it and pull it. Pictures and measurements of the pull cord lengths from the floor in all restrooms and shower/bathing rooms as measured by the MD were reviewed with the ADMIN. The ADMIN stated she thought the pull cords would not be accessible to a resident if they were on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
NAME OF PROVIDER OR SUPPLIER Inland Christian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 S. Mountain Ave Ontario, CA 91762	

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Call System, Residents, dated September 2022, the policy indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station .1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49001 Based on observation, interview, and record review the facility failed to maintain an effective pest control program when a roll up door in the paper goods storage closet had a gap where light could be seen coming through. This failure is a potentially for pest entry into the kitchen which could contaminate food and cause food borne illness to 52 of 53 residents that received food from the kitchen. Findings: During kitchen observation on May 6, 2024, at 9:32 a.m., in the paper storage room, there was a roll up garage type door with light coming through the floor. Noted small gap between the roll up door and the floor. The floor partially wet. During observation the outside roll up door on May 7, 2024, at 3:00 p.m., the roll up door has a gap between the door and the floor. The ground was wet. During interview with Dining Service Director DSD, on May 6, 2024, at 9:40 a.m., DSD stated that there should be no gap that could allow pest entry. During an interview with Dining Service Director DSD, on May 8, 2024, at 9:20 a.m., DSD stated, the gap needs to be closed. During a review of the facility policy titled Sanitation and Infection Prevention/Control, dated January 2024, indicated, The Food and Nutrition Services Department shall be free of all rodents and insects ., Ensure that all holes and cracks in walls and floors where pests and rodents could gain entry are repaired/sealed ., Ensure that exterior department doors including those leading to outside receiving area and garbage area have less than 1/4-inch gap between door and floor to prevent pest and rodent entry .