STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555122	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Park Care Center	3700 H Street Sacramento, CA 95816

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46242 Based on observation, interview, and record review, the facility failed to provide care and services in accordance with acceptable professional standards of quality for three (3) of 20 sampled residents (Resident 25, Resident 73, Resident 63) when: 1. Magnetic resonance imaging (MRI, a non-invasive medical imaging technique) prescriber's order for osteomyelitis (a type of bone infection) for Resident 25 was not processed promptly per facility policy. 2. Resident 73's medication order was not clarified with the prescribing physician. 3. Resident 63's feeding formula was not labeled. These failures had the potential for Resident 25, Resident 73, and Resident 63 to received inaccurate and inadequate care. Findings: 1. The following documents were reviewed in Resident 25's medical record: - Admission Record, dated 10/1/24 (print date), indicated Resident 25 was admitted to the facility in August of 2024 with diagnoses including pneumonia (a lung infection) and type 2 diabetes (inability to properly process blood sugar). - A review of prescriber's handwritten orders, dated 9/30/24 and signed by a Nurse Practitioner (NP), indicated MRI of Right foot to r/i [rule in (confirm diagnosis)] osteomyelitis. During concurrent interview and record review on 10/4/24 at 9:18 a.m. with Infection Preventionist (IP), Resident 25's order history and scanned prescriber orders, diagnostic imaging results, and progress notes were reviewed. The IP confirmed that previously ordered x-ray results were available on 9/30/24 and suggested osteomyelitis in the right toe, and MRI order was written by NP on 9/30/24. IP was not able to find evidence if MRI order was processed or cancelled. The IP walked over to Social Services Director (SSD), who also checked the records and was not able to show the evidence that the MRI order was processed and an appointment for the imaging services outside of the facility was scheduled. (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/04/24 at 10:32 a.m. with the Director of Nursing (DON), Resident 25's progress notes were reviewed. The progress notes indicated there was a note written by SSD on 10/4/24 at 10:01 a.m. Followed up with the SSA [Social Services Assistant] for update on resident's MRI status. Provided hx [history]: referral faxed and awaiting decision. PCP (Primary Care Physician) was contacted for additional and expedited services .DON confirmed that SSD wrote notes addressing MRI order after surveyor enquired about it on 10/4/24 and few days have passed since the order was written by the prescriber. In an interview on 10/4/24 at 12:13 p.m. NP confirmed that she wrote the order for Resident 25's MRI and she expected it to be processed either on the same day or on the following day if the order was written late in the day and social services were not available to process it and schedule an MRI appointment with the hospital. The NP also stated that she expected the MRI results to be available at this time and she wanted to follow up with nursing staff on the status of this order. A review of facility's policy and procedure titled, Request for Diagnostic Services, dated April 2007, indicated, All orders for diagnostic services must be entered into the resident's medical record and signed by the Attending Physician . Orders for diagnostic services will be promptly carried out as instructed by the physician's order . 34328 2. Resident 73 was admitted to the facility with diagnoses including Displaced Fracture of Medial Malleolus (fracture on the bone on the inside of ankle) and difficulty in walking. During a record review of Resident 73's Physician's orders, indicated on 8/10/24, Resident 73 was prescribed a medication of Valacyclovir (medication to treat herpes virus infections) 500 mg by mouth one time a day for herpes suppression (no end date). Further review of the Physician's orders indicated there was no date or duration on the the administration of the medication ordered. Further review of the Nurse's progress notes did not indicate there were any documented attempts made by the Licensed Nurses (LN) to clarify the medication order of Valacyclovir with the physician when the order indicated no end date. During an interview with the Registered Nurse Consultant (RNC) on 10/04/24 at 12:47 p.m., she confirmed the medication Valacyclovir was prescribed on 8/10/24 with No End Date. The RNC stated the LN must confirm with the physician on the duration of the medication treatment. The RNC stated she would clarify with the MD why there was no indication on the duration of treatment. During an interview with the RNC and the Director of Nursing (DON) on 10/04/24 at 1:09 p.m., the RNC stated the LNs' should have clarified with the physician why the Valacyclovir medication was prescribed without a medication stop date. The RNC confirmed there were no nursing progress notes that the nurses had attempted to clarify the medication Valacyclovir medication order with the physician. The RNC stated the medication Valacyclovir prescribed on 8/10/24, Resident 73 had received the medication a total of 54 days without the LNs' clarification of orders from the physician. The DON and the RNC both stated it was an expectation the LNs' were to call and clarify with the physician any medication order without a stop date. The DON was asked for a copy of the policy and procedure that the facility follows for stop orders of the resident's medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated (Name of Pharmacy) General Policies and Procedures provided by the DON indicated: .New medication orders are subject to automatic stop orders unless the medication orders specify the number of doses or duration .A. New medication orders are subject to automatic stop orders unless the medication orders specify the number of doses or duration of medication .Procedures .All other medications are stopped automatically after forty-five (45) days unless reordered .All medication orders that do not specify duration or number of doses are automatically discontinued in accordance with the the Stop Order Policy. When the prescriber gives the order for a medication covered by the Stop Order Policy [sic], the nurse requests a specific duration of therapy for that order . 3. Resident 63 was admitted with diagnoses of Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness or the inability to move on one side of the body) following cerebral (brain) infarction (obstruction of the blood supply to an organ causing tissue death), Encounter for attention to gastrostomy (a small flexible feeding tube inserted into the stomach). During an initial pool tour on 10/1/24 at 9:12 a.m., Resident 63 was observed asleep in bed. Resident 63's bedside was observed to have a feeding pump that was turned off and not connected to the resident. The bottle (name of feeding formula) was connected to the pump. Upon closer observation the feeding formula bottle was found to have a label that was incomplete. The label had no indication of name of the resident, room number, date and time the infusion was begun, and the rate of infusion. On 10/1/24 at 9:15 a.m. during an interview with the DON, the DON confirmed the feeding equipment was for Resident 63. The DON stated the LN who hung the feeding formula should have completed the label on the bottle with the resident's name, date and time when hung and the rate of infusion. The DON confirmed the label was blank and incomplete. The DON confirmed the Resident 63 was the only one receiving tube feedings in the room. During and interview with the DON and RNC on 10/02/24 at 11:19 a.m., the DON and the RNC stated there were no policies on the labeling of the enteral feeding. The DON confirmed that the expectations were for the LN to complete and label the feeding formula with the resident's information. During a review of an article from ASPEN (American Society for Parenteral and Enteral Nutrition) Journal of Parenteral and Enteral Nutrition (EN) published 11/4/2016 indicated: .Practice Recommendations. Include all the critical elements of the EN order on the EN label: patient identifiers, formula type, enteral delivery site (route and access), administration method and type, and volume and frequency of water flushes .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47563 Based on interview and record review, the facility failed to ensure sufficient staffing was provided for a census of 80 residents when: 1. Multiple staff stated the facility was insufficiently staffed; and 2. Resident 55 had five unwitnessed falls in one month. These failures decreased the facility's potential to provide residents with timely, necessary care and services to maintain their highest practicable physical, mental, and psychosocial well-being. Findings: 1. During a concurrent interview and record review on 10/2/24 at 3:44 p.m., with the Staffing Coordinator (SC), the September 2024 staffing spreadsheet was reviewed, the SC stated she writes a schedule to ensure each resident receives a minimum 3.5 hours per patient day (PPD) of direct nursing care. The SC presented the September 2024 staffing spreadsheet which had two columns: projected PPD and actual PPD. The SC confirmed that the projected column indicated how many nursing hours she scheduled and acknowledged 17 of the 29 days on the spreadsheet indicated she scheduled under the goal of 3.5 hours PPD. The SC acknowledged, when she writes a schedule under the minimum 3.5 hours PPD, it would be unlikely the residents would receive the minimum of 3.5 hours PPD of nursing care. An interview on 10/3/24 at 4:49 p.m., Certified Nursing Assistant 1 (CNA 1) stated she normally worked the night (PM) shift and stated the facility used to schedule more CNAs but have taken one away on the night shift, so even when no staff call out, they feel like they must rush to provide care and doesn't feel she has time to provide all the care residents deserve. An interview on 10/4/24 at 5:45 a.m., Licensed Nurse 2 (LN 2) stated she works the PM shift normally but also will work the overnight (NOC) shift too. LN 2 acknowledged, there have been delays answering resident call lights due to low staffing. An interview on 10/4/24 at 6:10 a.m., CNA 3 stated due to short staffing, care has been provided in a rush and the attention towards residents has been cut shorter. An interview on 10/4/24 at 6:20 a.m., CNA 4 stated she normally works the morning (AM) shift and confirmed, sometimes residents complain that staff took a long time to respond to call lights during the NOC shift. CNA 4 stated she believed the NOC shift is short staffed the most and when she comes in for AM shift, the AM staff have to work hard to provide incontinence care and fix the residents from the short-staffed NOC shift. CNA 4 disclosed she believed there needed to be more CNAs scheduled. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/4/24 at 6:49 a.m., with Human Resources (HR), the September staffing spreadsheet was reviewed. HR stated she is familiar with the spreadsheet with the projected and actual PPD columns. HR explained she is responsible for entering the actual PPD by calculating the actual hours worked for each date. HR confirmed the goal was to provide 3.5 PPD each day to ensure residents are getting the amount of care they require. HR acknowledged, honestly CNA [staffing] always seems a little low. HR confirmed the facility had failed to provide 3.5 PPD on at least 12 dates in September. During a concurrent interview and record review on 10/4/24 at 7:45 a.m., with the Administrator (ADM), the facility assessment (a document with information about the residents served and how the facility will serve them) was reviewed. The ADM stated he was familiar with facility assessment and confirmed the facility assessment indicated the facility's staffing plan included a goal to provide 3.5 PPD. The ADM acknowledged, to ensure appropriate staffing the facility wanted to schedule at least 3.5 PPD. 2. A review of Resident 55's admission record, indicated Resident 55 was admitted to the facility in late August of 2024 with diagnoses including difficulty walking and muscle weakness. A review of Resident 55's admission/re-admission summary note, dated 8/30/24, indicated, .[Resident 55] had an accidental fall and sustained a right pelvis fracture .per [Resident 55's responsible Party: a person who is responsible for making healthcare decisions when someone is not able to make decisions for themselves] are hoping that [Resident 55] can be placed into a LTC [long term care] .that [Resident 55] can be cared better when she is on [sic] a place that can watch her due to her multiple falls . A review of Resident 55's Minimum Data Set (MDS: an assessment tool), dated 9/4/24, indicated Resident 55 had severe memory problems, was always continent with bowel movements, required substantial assistance with transfers to and from the toilet, and had a history of falling with a fracture in the month prior to admission to the facility. A review of Resident 55's fall care plan, initiated 9/19/24, indicated, .Resident is at risk for falls with or without injury related to altered balance while standing and/or walking, decreased muscular coordination, history of falls .goal .will not experience a fall related to risk factors .interventions/tasks .keep within supervised view as much as possible . An interview on 10/4/24 at 5:54 a.m., CNA 2 stated staffing is the problem here and expressed concerns that in September 2024 staffing was bad and staff could not keep an eye on Resident 55, who fell several times during the month. An interview on 10/4/24 at 10:23 a.m., CNA 5 stated she would be worried about residents with fall risks, such as Resident 55, and the inability for staff to keep an eye on them when facility is short staffed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and concurrent record review on 10/4/24 at 11:16 a.m., with the Director of Nursing (DON), Resident 55's medical records were reviewed, the DON stated for staffing the facility has a goal to provide 3. 5 PPD and if the facility is not meeting that goal, she would be concerned there were less hours available to provide resident care. The DON acknowledged short staffing could also have a concern for resident safety. The DON confirmed in the month of September 2024 the facility had dates where the actual PPD was under the 3.5 PPD goal, and Resident 55 had five unwitnessed falls during the month of September 2024. A review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, revised August 2022, indicated, .Our facility provides sufficient number 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's care plans and the facility assessment . A review of the facility's P&P titled, Safety and Supervision of Residents, revised July 2017, indicated, .Our facility strives to make the environment as free from accident hazards as possible. Resident Safety and supervision and assistance to prevent accidents are facility-wide priorities .Individualized, Resident-Centered Approach to Safety .the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision .implementing interventions to reduce accident risks and hazards shall include the following .ensuring that interventions are implemented correctly and consistently .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47563 Based on observation, interview, and record review the facility failed to provide food that was palatable when one of 20 sampled residents (Resident 60) was served a burnt cookie. This failure had the potential for Resident 60 to experience dissatisfaction with food served, leading to decreased intake with possible weight loss. Findings: During a concurrent interview and observation on 10/1/24 at 10:35 a.m., in Resident 60's room, Resident 60 stated the food served in the facility is sometimes served burnt. Resident 60 showed a cookie the facility had served her that was black on the bottom. During a concurrent interview and observation on 10/1/24 at 10:45, in Resident 60's room, the [NAME] Clerk 1 (WC 1) confirmed Resident 60's cookie was burnt and stated she would not eat a burnt cookie like that. During an interview on 10/1/24 at 12:51 p.m., Resident 10 stated food provided by facility is sometimes served burnt. An interview on 10/4/24 at 11:08 a.m., the Registered Dietician (RD) stated she was aware the facility had an issue with an oven affecting the foods not being cooked evenly. The RD stated burnt foods being served to residents is a concern not only because residents could be disappointed but also because the residents may not eat enough food. An interview on 10/4/24 at 11:16a.m., the Director of Nursing (DON) stated she expected that staff would not serve burnt food to residents. An interview on 10/4/24 at 11:49 a.m., the Certified Dietary Manager (CDM) confirmed there was an issue with the oven causing foods to be burnt and she expected staff to not serve burnt foods. The CDM added she recently did an in-service training with kitchen staff regarding complaints about residents being served burnt foods. A review of food and nutrition services in-service sign in sheet, dated 9/24/24, indicated topic of in-service was food prep. Complaints of burnt food facilitated by the CDM and indicated five staff members attended the in-service. A review of the facility's policy and procedure titled, food preparation, undated, indicated, .Food shall be prepared by methods that conserve nutritive value, flavor, and appearance .Poorly prepared food will not be served-such food is to either be improved, prepared again, or replaced with an appropriate substitution .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50282 Based on observation, interview, and record review the facility failed to store, prepare, and serve food in accordance with professional standards when: 1. Food equipment was not working properly, 2. Employees were unable to state sanitation process, 3. Expired food, food without proper labeling/dating, and foods that were not covered were found in food storage, 4. A dirty lid, and 6 wet containers were found in the ready to use storage area, 5. Worn food preparation equipment that was no longer able to be sanitized was not discarded, 6. Vents and sprinklers over trayline and residents' microwave found dirty, 7. Buckets containing sanitizer found on food preparation counter, and 8. An air gap was not found under the fruit/vegetable preparation sink. These failures had the potential to lead to food borne illness for the 78 residents eating facility prepared meals. Findings: 1. During the initial kitchen tour on [DATE], beginning at 8:20 a.m., Dietary Aide 1 (DA 1) was cleaning the pots and pans from breakfast. As she demonstrated the process for putting them through the dish machine, she noted that she needed to log the wash/rinse temperatures before running dishes through the machine. As she ran several items through the dish machine, the temperature gauge was noted to be between , d+[DATE] degrees Fahrenheit (F, a unit of measurement), even when the door was left open and the machine was not running. During a subsequent interview on [DATE] at 8:53 a.m., with the Certified Dietary Manager (CDM), the CDM confirmed that the gauge was not working and stated she would have maintenance take a look. She further added that this was an issue to make sure washing and sanitizing temperature were effective. A review of the facility's policy and procedure titled Dishwashing/3-Compartment Procedure For Manual Dishwashing, (Healthcare Menus Direct, LLC 2023), indicated dishwasher to be serviced regularly by a technician to ensure accurate sanitizing measurements .temperatures should be within manufacturer's recommendations .and if temperatures are not achieved, alert maintenance for help .follow and use appropriate policy, procedures, and supplies during manual dishwashing . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During this same observation on [DATE] at 9:01 a.m., the sink faucet dish sprayer was noted to be leaking moderate amount of water in off position. DA 1 stated that this had been a problem and that maintenance had changed it last week but it continues to leak. During an interview with the Maintenance Supervisor (MS) on [DATE] at 11:06 a.m., the MS confirmed the leaking dish sprayer stated that is an easy fix, it's brand new, we can tighten that up. During observation of the meat freezer (freezer #1) on [DATE] at 10:44 a.m., noted an approximate 6-inch length of ice buildup lining the inside lower frame of door. During a subsequent interview with CDM at 10:49 a.m., the CDM confirmed the ice buildup, and stated an outside vendor ordered new parts for freezer a couple of weeks ago. She further stated ice buildup may indicate freezer temperature fluctuation which may affect food quality and safety. During an interview with MS on [DATE] at 10:56 a.m., the MS stated it is because food is being stacked too high interfering with the blower to do its job. During a review of recent invoice from outside vendor for freezer #1, dated [DATE], indicated .Unit has been serviced .Temp control replaced .Unit does need 2 gaskets and one hinge pin . CDM confirmed that there is only one repair invoice for freezer #1. A review of the facility's policy and procedure titled Procedure For Refrigerated Storage/Sanitation, (Healthcare Menus Direct, LLC 2023), indicated .employees are to alert dietary manager immediately for any kitchen equipment repair .maintenance will assist with kitchen item repairs, cleaning/janitorial duties and maintain records .equipment will be kept clean, in good repair, and free from breaks/corrosions/cracks/chipped areas and will be discarded if hazardous or can't be kept clean . According to the Food and Drug Administration (FDA) Food Code 2022, ,d+[DATE].11 Good Repair and Proper Adjustment. 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 . 2. During the initial kitchen tour on [DATE] at 8:53 a.m., DA 1 performed the red bucket quaternary (Quat, a type of sanitizing solution) sanitizer test. When asked to test the Quat solution, DA 1 took a test strip and held it in the solution for one second. When asked to read the directions, DA 1 noted that it should be place in solution for 10 seconds. DA 1 did the test two more times with the second test strip being held in solution for six seconds, and the third test strip for over 20 seconds. The fourth attempt was done with the surveyors counting aloud for 10 seconds. Once removed, the strip correlated to the color at 500 parts per million (ppm) and DA 1 stated the goal should be between ,d+[DATE] ppm. Concurrent interview with the CDM, the CDM confirmed that the sanitizer solution was too high, stating it is not safe for seniors to be exposed to too much sanitizer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the initial kitchen tour on [DATE] at 9:04 a.m., DA 1 was asked to describe the 3-compartment manual dish washing process. The CDM stated that while they had only 2 sinks, a third basin would be brought over to ensure all steps were taken. DA 1 was not able to accurately describe the facility's process as she was unsure as to when she would rinse the dishes. During a concurrent interview with the CDM, the CDM stated this confusion could affect the sanitizing of dishes washed manually. During a concurrent observation and interview on [DATE] at 4:50 p.m., DA 2 was asked to test the red bucket Quat sanitizer. DA 2 stated she was unsure and that DA 3 may know. DA 2 and DA 3 were not able to find the testing strips so [NAME] 1 (C 1) brought over an unopened new test strip container. DA 3 held the test strip in the solution for approximately 6 seconds and stated, it is between 200 and 400. The Registered Dietitian (RD) who was standing nearby, provided additional prompting regarding manufacturer's testing strip and solution guidelines. DA 3 tried again and held the test strip in the solution for 10 seconds, which resulted in a reading of 500 ppm per comparison to colored coded container. Neither DA 2 nor DA 3 could explain what the results meant. When asked to troubleshoot the issue, DA 2 and DA 3 decided to take the temperature of the solution water. Their thermometer read 120 degrees F. DA 2 and DA 3 stated that the water was cold and that caused the elevated ppm. DA 2 and DA 3 decided to change the Quat solution in the red bucket. Upon testing with a new test strip, it continued to read 500 ppm. DA 3 stated this has never happened to me before. The RD continued to provide prompting questions to assist staff in finding the correct answer with no success. DA 2 and DA 3 were not aware that the laminated instructions were posted above the sink. DA 2 and DA 3 were also not able to describe the facility's process for 3-compartment manual dishwashing. Subsequent interview with RD on [DATE] at 5:06 p.m., RD acknowledged that the dietary aides had failed to perform red bucket Quat solution testing correctly, did not know where to find those instructions, and how to correctly perform the manual dishwashing process. The RD stated high concentrations of sanitizer could make the residents sick. Review of the in-service binder on [DATE] at 10:08 a.m., showed that there were no documented in-services for kitchen staff related to red bucket sanitizing and manual dishwashing. During an interview on [DATE] at 5:11 p.m., the RD acknowledged that there were no documented in-services for kitchen staff related to red bucket sanitizing and manual dishwashing. During an interview with CDM and RD on [DATE] at 2:00 p.m., the CDM acknowledged that staff were not clear on how to perform Quat testing and manual dishwashing which could result in lack of proper sanitation. A review of the facility's policy and procedure titled Multi-Quat Sanitizer: for red buckets and 3 compartment sink, (undated), indicated .test strips are located under the air conditioning unit .testing solution should be at room temperature .dip the paper test strip in the solution for 10 seconds .test should read between , d+[DATE] ppm .if not the correct ppm, either dilute or add more solution . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During the initial kitchen tour on [DATE] at 10:49 a.m. with the CDM, the meat freezer (freezer #1) was observed with a dried, frozen, reddish substance that had dripped from the bottom shelf onto the freezer floor. The two ceiling air vents over the food trayline area were observed dark and discolored. A ceiling fire extinguisher sprinkler head was noted with dark, dusty spots. During an observation of the resident refrigerator on [DATE] at 3:05 p.m., the resident's microwave was opened and noted to have orange and black spots along the back wall and ceiling as well as dried food particles on the food tray. During an interview on [DATE] at 11:10 a.m., with the MS, the MS acknowledged that the vents, sprinkler, and microwave needed cleaning. The MS stated that vents are cleaned monthly. MS reached up and rubbed one of the vents, the index fingertip was covered with a greasy, black substance. The MS stated that the resident's microwave is cleaned by housekeeping and that that Maintenance Staff 1 (MS 1) would have the information regarding the monthly cleaning logs for his department. During an interview on [DATE] at 11:22 a.m., with MS 1, MS 1 stated that There are no logs, and that cleaning of kitchen vents, lighting, and sprinklers are cleaned monthly. A review of the facility's policy and procedure titled Procedure For Refrigerated Storage/Sanitation, (Healthcare Menus Direct, LLC 2023), indicated .refrigeration should be routinely cleaned . all utensils, equipment will be kept clean, in good repair, and free from breaks/corrosions/cracks/chipped areas and will be discarded if hazardous or can't be kept clean . 7. During initial tour on [DATE] at 9:20 a.m., with the CDM, a red sanitation bucket full of liquid and towels was observed on food preparation counter near the food processor and blender. The CDM confirmed the chemical sanitation solution was sitting on the food prep counter and stated that this was a risk for cross contamination. A review of the facility's policy and procedure titled Procedure For Refrigerated Storage/Sanitation, (Healthcare Menus Direct, LLC 2023), indicated .do not use cleaning products or sanitizers in the food preparation area . According to the Food and Drug Administration (FDA) Food Code 2022, ,d+[DATE].14 Food Preparation. Food preparation activities may expose food to an environment that may lead to the food's contamination. Just as food must be protected during storage, it must also be protected during preparation. Sources of environmental contamination may include splash from cleaning operations, drips form overhead air conditioning vents, or air from an uncontrolled atmosphere such as may be encountered when preparing food in a building that is not constructed according to Food Code requirements. 8. During the initial kitchen tour on [DATE] at 10:44 a.m., with the CDM, an air gap (a backflow prevention device that prevents contaminated water from re-entering the sink) was not observed under the fruit/vegetable preparation sink. The CDM confirmed that there was not an air gap on the food preparation sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled Accident Prevention-Safety Precautions, dated 2023, indicated .an air gap is the most reliable backflow prevention device .discharge liquid waste shall drain through into an open floor sink.

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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. 46242 Based on observation, interview, and record review, the facility failed to maintain infection prevention and control practices designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections when: 1. The Treatment Nurse (TN) did not perform hand hygiene (handwash with soap and water or alcohol-based hand rub) in between glove change during the wound dressing change to Resident 70; and, 2. A blood glucose machine was not sanitized after use. These failures had the potential to result in infection and spread of infection among census of 80. Findings: 1. A review of Resident 70's Admission Record dated 10/4/24 (print date), indicated resident 70 was admitted to the facility in Summer of 2024 with diagnoses including orthopedic aftercare following surgical amputation, osteomyelitis (bone infection) and diabetes (inability to properly process blood sugar). A review of Resident 70's Order Summary Report (OSR) dated 10/4/2024 indicated, [order start date 8/6/24] right 2nd side MASD [Moisture Associated Skin Damage]: clean with normal saline pat dry apply silver alginate dressing [a type of wound dressing material] on the site and cover with gauze wrap. every day shift . Another order with start date of 10/4/24, right big toe surgical amputation : clean with wound cleanser pat dry apply iodosorb (iodine gel) cover with gauze wrap and tape to secure. During wound care observation on 10/3/24 at 9:05 a.m., TN reviewed wound care orders for Resident 70 near Resident 70's room. TN gathered wound care supplies and used alcohol hand rub for hand hygiene and applied gown and gloves prior to entering room to provide wound care. TN brought in wound care supplies which included paper tape and saline solution cartridges to the Resident 70's bedside table. She provided treatments to the left and right toe sites per order and after removal of old dressing she removed gloves and without performing hand hygiene applied new gloves and applied new dressing. Upon completion of the dressing change, TN brought the remaining supplies (paper tape and a saline cartridge) out of Resident 70's room and placed them on the treatment cart. During an interview on 10/3/24 at 9:33 a.m., TN admitted that she did not use hand hygiene after removal of Resident 70's old dressing and removing gloves and before applying new gloves. She confirmed that hand hygiene needs to be done between glove changes. She also acknowledged that wound care supplies that are taken to resident's room should not be brought back to the wound card and should be either discarded or left in resident's room. She agreed that paper tape and saline cartridge due to their surface nature can't be sanitized using sanitizing wipes, and the act of wiping them after bringing them back from resident's room indicated intent to use it again on a different resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/3/24 at 12:01 p.m. Infection Preventionist (IP) stated that hand hygiene should be performed between glove changes, and agreed that wound supply items like paper tape and saline cartridge cannot be sanitized with sanitizing wipes and should not be brought back to the supply cart from the resident's room. A review of facility's Policy and Procedure (P&P) titled, Hand Washing/Hand Hygiene, revised October 2023, indicated, Indications for Hand Hygiene . immediately after glove removal . A review of facility's P&P titled, Wound Care, revised October 2010, indicated, Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart. 34328 2. During a medication pass observation with Licensed Nurse 1 (LN 1) on 10/3/24 at 4:15 p.m., The LN 1 was observed to have performed a capillary blood sugar check to the resident in their room. Upon completion of the blood sugar testing, the LN 1 was observed to remove her disposable gloves and held the blood sugar machine in her hand. The blood sugar machine was not sanitized after use by the LN 1. During an interview with the LN 1 on 10/3/24 at 4:30 p.m., she was asked if she had performed any cleaning or sanitation of the blood sugar testing machine. The LN 1 confirmed and stated she did not sanitized the blood glucose machine. The LN 1 stated the blood glucose machine should have been sanitized by wiping it down with an alcohol prep pad or equipment sanitizer after every use to prevent the spread of infection. Review of a facility policy Obtaining a Fingerstick Glucose Level revised 10/2011 indicated: .3. Always ensure that the blood glucose meters intended for reuse are cleaned and disinfected between resident uses . 18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 46242 Based on observation, interview, and record review, the facility failed to maintain an antibiotics stewardship program for one (1) of 20 sampled residents (Resident 25) when infection screening evaluation was not conducted for Resident 25's two newly prescribed antibiotics to treat osteomyelitis (bone infection). This failure had the potential for antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria. Findings: The following documents were reviewed in Resident 25's medical record: - Admission Record, dated 10/1/24 (print date), indicated Resident 25 was admitted to the facility in August of 2024 with diagnoses including pneumonia (a lung infection) and type 2 diabetes (inability to properly process blood sugar). - Order Summary Report (OSR) dated 10/4/24, indicated that on 9/30/24 Resident 25 was started on two different antibiotic prescriptions for right foot osteomyelitis: Trimethoprim/Sulfamethoxazole and Cefalexin. - Review of assessments history indicated latest infection screening evaluation was completed on 8/13/24 [admission assessment and no assessments for the current infection]. In an interview on 10/1/24 at 10:47 a.m. Resident 25 stated that he had a right foot infection and facility took an x-ray of his foot and gave him some pills for it. During a concurrent interview and record review on 10/4/24 at 9:18 a.m. Infection Preventionist (IP) reviewed Resident 25's orders and assessments and confirmed that there were no antibiotic use assessments done for resident's two antibiotics that were prescribed for osteomyelitis on 9/30/24. IP confirmed that this assessment should have been done promptly when antibiotics were started. IP confirmed that facility was using McGeer's criteria (an antibiotic use surveillance tool) for antibiotic surveillance. IP was not able to state within what timeframes assessment must be completed. A review of facility's policy and procedure (P&P) titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised December 2016, indicated, As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee . The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics . At the conclusion of the review, the provider will be notified of the review findings . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of California Department of Public Health publication titled, Skilled Nursing Facility Antibiotic Stewardship Program Implementation Toolkit, updated 8/12/2019, indicated, Implement an antibiotic review process or antibiotic time out at 48-72 hours after initiation of antibiotics to reevaluate treatment based on clinical response and culture results.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 46242 Based on interview and record review, the facility failed to ensure one of five residents reviewed for immunizations (Resident 25) received the pneumococcal vaccine (a medical treatment that helps to prevent or reduce severity of pneumonia, a lung infection). This failure had the potential for the Resident 25 to be at higher risk for pneumonia and related complications. Findings: The following documents were reviewed in Resident 25's medical record: - Admission Record, dated 10/1/24 (print date), indicated Resident 25 was admitted to the facility in August of 2024 with diagnoses including pneumonia (a lung infection) and type 2 diabetes (inability to properly process blood sugar). - Informed consent form signed by resident on 8/13/24 indicated that resident consented to receive pneumococcal vaccination. - Order Summary Report (OSR) dated 10/4/24, contained no orders for pneumococcal vaccine administration. - No records of prior pneumococcal vaccination history were found or provided by the facility. In an interview on 10/3/24 at 12:01 p.m. Infection Preventionist stated that Resident 25 provided consent for pneumococcal vaccine administration on 8/13/24, but it was not entered correctly in the system and the order for immunization was not placed. IP confirmed that this vaccine is normally provided within a couple of days of receiving consent and waiting for it over a month was not acceptable. A review of facility's policy and procedure titled Pneumococcal Vaccine, revised October 2023, indicated, All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections . Assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission. Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol.