

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Shoreline Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5225 South J St Oxnard, CA 93033	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>45849</p> <p>Based on record review, interview, and facility policy review, the facility failed to protect the residents' right to be free from physical abuse by a resident during 4 (10/28/2024, 12/15/2024, 12/19/2024, and 01/12/2025) of 4 incidents of resident-to-resident abuse involving Resident #118.</p> <p>Findings included:</p> <p>A facility policy titled, Alleged or Suspected Abuse and Crime Reporting, revised 10/2022, indicated, Each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy further indicated, The facility will monitor the adequacy of assessment, care planning and monitoring of residents with needs or behaviors that may likely lead to conflict, altercation, abuse, neglect, exploitation and misappropriation and mistreatment such as, which included, Physically aggressive or self-injurious behaviors.</p> <p>Resident #118's Admission Record indicated the facility admitted the resident on 08/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, psychosis, and anxiety disorder.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/22/2024, revealed Resident #118 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #118 did not exhibit any physical or verbal behavioral symptoms directed toward others during the assessment period.</p> <p>Resident #118's care plan included a focus area initiated 10/28/2024, that indicated the resident had struck another resident using an empty coffee cup. Interventions included instructions to keep the residents away from each other when in a common area (initiated 10/18/2024). The resident's care plan revealed a focus area revised 12/19/2024, that indicated the resident had episodes of physical aggression related to dementia and poor impulse control. The care plan indicated the resident had hit another resident on 12/19/2024. Interventions directed staff to analyze the time of day, place, circumstances, triggers, and what de-escalated the resident's behavior (initiated 12/15/2024); monitor the resident for behaviors of aggressiveness and document the behavior (initiated 12/15/2024); intervene when the resident becomes agitated (initiated 12/15/2024); and indicated the resident was to receive one-to-one staff supervision, pending an interdisciplinary team (IDT) review (initiated 12/19/2024).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Resident #118's Progress Notes revealed a Social Services note, dated 10/28/2024 at 4:26 PM, that revealed a police department was contacted regarding an altercation between Resident #118 and another resident.</p> <p>2. Resident #118's Progress Notes revealed a Nursing note, dated 12/15/2024 at 9:52 AM, that revealed a police officer interviewed Resident #118 regarding Resident #118 smacking another resident.</p> <p>3. Resident #118's Progress Notes revealed a Nursing note, dated 12/19/2024 at 7:00 PM, that indicated a police officer arrived at the facility to make a report. The Progress Notes revealed a note, dated 12/20/2024 at 12:24 AM, that indicated the resident was placed on one-to-one staff supervision. A note, dated 12/20/2024 at 10:15 AM, indicated a psychiatrist had been notified that the resident had punched a resident on the left cheek, and indicated that it was the same resident that Resident #118 smacked on 12/15/2024.</p> <p>4. Resident #118's Progress Notes revealed an IDT note, dated 01/14/2025 at 10:28 PM, that revealed the IDT met following an incident involving the resident grabbing another resident by their jacket and pushing them against a wall. The note indicated that staff intervened promptly. Per the note, the resident was interviewed and said the incident occurred when the other resident attempted to take Resident #118's chair. The note indicated that the resident stated they (Resident #118) tried to throw a punch at the other resident, but backed off. The note indicated that the resident's statement was not corroborated by staff witnesses. The note indicated that staff observed the resident sitting alone at a table when another resident approached them, and without a verbal exchange between the residents, Resident #118 grabbed the resident and pushed them against the wall.</p> <p>During an interview on 01/13/2025 at 11:21 AM, Resident #28's responsible party (RP), RP #19, stated they had been notified by the facility the prior evening at around 7:00 PM that Resident #28 had been pushed against a wall by another resident at around 6:30 PM.</p> <p>Resident #28's Admission Record indicated the facility admitted the resident on 09/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, post-traumatic stress disorder, psychosis, depression, and repeated falls.</p> <p>A quarterly MDS, with an ARD of 11/12/2024, revealed Resident #28 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #28 did not exhibit any physical or verbal behavioral symptoms directed toward others during the assessment period.</p> <p>Resident #28's care plan included a focus area revised 11/19/2024, that indicated the resident had impaired cognitive function related to dementia, and indicated the resident was at risk for cognitive and behavior changes. Interventions directed staff to administer the resident's medications as ordered and to monitor the effectiveness (initiated 09/05/2024), and to cue, reorient and supervise the resident as needed (initiated 09/05/2024).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #28's SBAR [Situation, Background, Assessment, and Recommendation] Alleged Abuse Report of Incident, dated 01/12/2025, revealed an incident of physical abuse had occurred between Resident #118 and Resident #28 on 01/12/2025 at 6:10 PM. The report indicated Resident #118 was sitting in the dining room when Resident #28 approached Resident #118 and told the resident to get out of their (Resident's #28's) chair. The report indicated Resident #118 stood up, grabbed Resident #28 by their jacket, pushed Resident #28 against the wall, and said, What did you say? The report indicated that staff immediately separated the residents.</p> <p>During a telephone interview on 01/15/2025 at 3:01 PM, Certified Nurse Aide (CNA) #10 stated she was the aide assigned to Resident #118 on the day of the altercation. CNA #10 stated she had walked with Resident #118 to the dining room. She stated Resident #118 had sat down at the dining room table, and she had turned to get the resident's food from the food cart in the dining room. She stated she was walking toward the table with the tray when Resident #28 approached Resident #118 and tried to remove Resident #118 from the chair. CNA #10 stated Resident #118 pushed Resident #28 back and asked Resident #28 why they did that to them. CNA #10 stated she set the tray down and separated the residents. She stated Resident #118 returned to their room and she followed the resident to their room with their food tray, and the resident ate in their room.</p> <p>During an interview on 01/15/2025 at 3:10 PM, CNA #13 stated she was in the dining room when the altercation between Resident #28 and Resident #118 occurred. She stated Resident #28 approached Resident #118 and asked why Resident #118 was in their seat. She stated Resident #118 then shoved Resident #28. CNA #13 stated CNA #10 intervened immediately. She said CNA #10 was getting Resident #118's food tray when the incident occurred. She stated she assisted with redirecting Resident #28 after the incident. CNA #13 stated she had never witnessed Resident #118 react like that before but knew the resident had. She stated that Resident #118 received one-to-one staff supervision so staff could monitor them.</p> <p>During a telephone interview on 01/16/2025 at 8:35 AM, Licensed Vocational Nurse (LVN) #17 stated she did not witness the entire incident between Resident #118 and Resident #28, by the time she saw it, Resident #118 had already pushed Resident #28 against the wall. LVN #17 stated she assisted with separating the residents. She stated Resident #118 and Resident #28 were kept separate after the incident. LVN #17 stated she notified the supervisor of the incident.</p> <p>During an interview on 01/15/2025 at 3:39 PM, LVN #16 stated she was the supervisor on the day of the altercation between Resident #28 and Resident #118. LVN #16 stated staff had called her to the unit after the incident. She stated that she was told Resident #118 was sitting in a chair and Resident #28 approached the resident and was leaning over them telling them to get out of their (Resident #28's) chair. LVN #16 stated that Resident #118 stood up and pushed Resident #28 and said, What did you say to me? She stated staff intervened and separated the residents at that point. She stated Resident #118 was receiving one-to-one staff supervision at the time, but the aide had turned to get the resident's tray when Resident #28 approached Resident #118. LVN #16 stated that both residents were assessed with no injuries noted. LVN #16 stated she had notified the Executive Director (ED), law enforcement, and the responsible parties. LVN #16 stated Resident #118 had been receiving one-to-one staff supervision since a previous altercation in December.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/16/2025 at 9:58 AM, the Director of Nursing (DON) stated if there was a resident altercation, she expected staff to separate the residents, and when the residents were safe, the nurse or supervisor notified her. The DON stated she notified the California Department of Public Health within two hours of any allegation of abuse. The DON stated she also notified the police, Ombudsman, responsible parties, and the physicians. The DON stated an SBAR was completed, and the resident was evaluated for any skin injuries. She stated social services staff followed up to monitor the resident for any mood or behavior changes or emotional distress. She stated if there were any changes, the resident was referred for psychiatric services. She stated the facility staff completed a root cause analysis. She stated medication changes were discussed, and laboratory tests were completed and discussed with the physician. The DON stated they discussed possible interventions, including room changes and keeping residents separate from each other. The DON stated the investigation included locating witnesses, including staff and alert residents. The DON stated staff received training and were reminded of who needed to be kept away from each other. The DON stated Resident #118 had received one-to-one staff supervision since a previous incident in December. The DON stated they had looked at alternative placement for Resident #118 but had not been successful, so Resident #118 would remain on one-on-one supervision.</p> <p>During an interview on 01/16/2025 at 10:49 AM, the ED stated if there was a resident altercation, the residents were immediately separated and staff ensured residents were safe, then notified all required parties. He stated they started an investigation, had an IDT meeting to review the cause, and implemented interventions to prevent a recurrence. The ED stated Resident #118 was on one-to-one staff supervision. He stated that he knew Resident #118 had behaviors, so they tried to monitor the resident with one-to-one staff supervision, but the resident could react spontaneously, and things could happen quickly.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>46194</p> <p>Based on interview, record review, facility policy review, and review of the California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level I Assessment Guide, the facility failed to ensure Level I PASRR screenings were accurate and also failed to submit a new Level I PASRR screening after a resident remained in the facility longer than 30 days, during which they were exempt from the requirement. The deficiencies affected 3 (Residents #26, #103, and #129) of 4 residents reviewed for PASRR requirements.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Assessment-Coordination with PASARR [Preadmission Screening and Resident Review; PASRR] Program, reviewed/revised 05/2024, revealed, This facility coordinates assessments with the preadmission screening and Resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The policy revealed, 1. Applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I- Initial pre-screening that is completed prior to admission [sic] i. Negative Level I Screen- permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen- necessitates a PASARR Level II evaluation prior to admission. The policy revealed, 2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. 3. A record of the pre-screening shall be maintained in the Resident's medical record. 4. Exemptions to the preadmission screening program include those individuals who: a. Are readmitted directly from a hospital. b. Are admitted directly from a hospital, requires nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services. 5. If a Resident who was not screened due to an exception above and the Resident remains in the facility longer than 30 days: a. The facility should screen the individual using the State's Level I screening process and refer any Resident who has or may have MD [mental disorder], ID [intellectual disability] or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination.</p> <p>The California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level I Assessment Guide, dated 01/12/2023, revealed, Section III-Serious Mental Illness Questions 10-12 This section helps determine if the individual may have a serious mental illness and benefit from specialized services. Question 10. diagnosed Mental Illness "Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? "If 'yes', there will be a text box question [to] provide the type of mental illness.</p> <p>1. An Admission Record indicated the facility admitted Resident #129 on 08/15/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified psychosis (onset date 08/15/2023) and depression (onset date 08/15/2023).</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/22/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had active diagnoses of depression and psychotic disorder.</p> <p>Resident #129's care plan revealed a focus area initiated 08/17/2023, that indicated the resident had potential behavior disturbance related to psychosis. Interventions directed staff to monitor the resident for aggressive behaviors, redirect the resident, and document the behaviors (initiated 08/17/2023).</p> <p>Resident #129's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 08/08/2023, completed by a hospital, revealed Section III- Serious Mental Illness Screen, question #10 was answered No and did not reflect the resident's diagnoses of psychosis or depression. The screening revealed the results were Negative and did not require a Level II evaluation.</p> <p>On 01/15/2025 at 1:41 PM, the Director of Nursing (DON) reviewed Resident #129's diagnoses and stated that the resident had a diagnosis of psychosis and stated question #10 of the resident's Level I PASRR screening and was not answered correctly. She stated diagnoses of depression or psychosis should trigger as serious mental illness. She stated Resident #129's Level I PASRR screening was considered inaccurate. She stated they had no additional Level I PASRR screenings for Resident #129.</p> <p>On 01/16/2025 at 11:17 AM, the Executive Director (ED) stated Resident #129 had a diagnosis of psychosis, and a new Level I PASSRR screening should have been submitted.</p> <p>31524</p> <p>2. Resident #26's Admission Record indicated the facility admitted the resident on 06/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of paranoid schizophrenia (onset date 06/04/2024) and anxiety disorder (onset date 06/04/2024).</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/12/2024, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Per the MDS, Resident #26 had active diagnoses of schizophrenia and anxiety disorder.</p> <p>Resident #26's care plan included a focus area revised initiated 06/07/2024, that indicated the resident had anxiety. Interventions directed staff to administer anti-anxiety medication as ordered (initiated 06/07/2024) and to encourage the resident to identify and express causes of their anxiety (initiated 06/07/2024). Resident #26's care plan included a focus area initiated 06/07/2024, that indicated the resident had a potential behavior disturbance related to paranoid schizophrenia. Interventions directed staff to administer medications as ordered (initiated 06/07/2024) and to monitor for anti-psychotic medication side effects (initiated 06/07/2024).</p> <p>Resident #26's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 06/04/2024, completed by a hospital, revealed Section III- Serious Mental Illness Screen, question #10 was answered No and did not reflect the resident's diagnoses of schizophrenia or anxiety disorder. The screening revealed the results were Negative and did not require a Level II evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/15/2025 at 1:41 PM, the Director of Nursing (DON) stated Resident #26's Level I PASRR screening was completed at the hospital prior to admission. She stated she considered Resident #26's Level I PASRR screening to be inaccurate. She stated diagnoses of schizophrenia or anxiety disorder should trigger as serious mental illness. She stated she was responsible for the PASRR screenings in the facility. The DON stated if a resident was newly admitted, the Level I PASRR screening was sent to the facility from the hospital, and she, as well as medical records staff or the Assistant Director of Nursing (ADON), reviewed the screening for accuracy. The DON stated the facility staff should be looking at the Level I PASRR screenings closer to ensure they were completed correctly. She stated the facility staff needed to make sure the proper referral was made to ensure the resident received the appropriate services. She stated if the Level I PASRR screening from the hospital was not completed correctly, then the facility staff needed to submit a new one.</p> <p>During an interview on 01/15/2025 at 2:54 PM, the DON stated Resident #26 had no other Level I PASRR screenings in their medical record.</p> <p>During an interview on 01/16/2025 at 10:10 AM, the Executive Director (ED) stated the hospital completed the Level I PASRR screenings and sent them to the facility for new admissions. The ED further stated that upon admission, nursing staff or the interdisciplinary team (IDT) reviewed the Level I PASRR screenings to ensure appropriate placement of the resident. The ED stated that he was not a clinician, but he considered schizophrenia to be a serious mental illness.</p> <p>40141</p> <p>3. An Admission Record revealed the facility admitted Resident #103 on 11/16/2024. According to the Admission Record, the resident had a medical history that included diagnoses of psychosis (onset date 11/16/2024) and depression (onset date 11/16/2024).</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2024, revealed Resident #103 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had active diagnoses of depression and psychotic disorder.</p> <p>Resident #103's care plan revealed a focus area that indicated the resident had diagnoses that included depression and psychosis.</p> <p>Resident #103's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 11/16/2024, completed by a hospital, specified that the resident required a stay of less than 15 calendar days. The screening revealed the Level I PASRR screening was Negative and revealed, Exempted Hospital Discharge.</p> <p>A letter from the California Department of Health and Senior Services addressed to Resident #103, dated 11/16/2024, indicated that the Level I PASRR screening's result was Negative, indicating Exempted Hospital Discharge. The letter revealed, If the individual remains in the NF [nursing facility] longer than 30 days, the facility must resubmit a new Level I Screening as a Resident Review on the 31st day.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>31524</p> <p>Based on observation, interview, and facility document and policy review, the facility failed to serve meals according to the recipes for the planned menu for residents prescribed a pureed diet. Specifically, staff pureed plain beef instead of beef stew, mixed breadcrumbs in water in place of sliced bread to make pureed bread and served applesauce in place of pureed baked apple slices to residents on a pureed diet. This deficient practice had the potential to affect 22 residents who received pureed diets.</p> <p>Findings included:</p> <p>A facility policy titled, Menus, effective February 2009, indicated, 1.0 PURPOSE To ensure food variety, adequate nutrition, and allow for effective planning of food and dining service. The policy indicated the section titled 2.0 FUNDAMENTAL INFORMATION included 3. Therapeutic (Special) diet descriptions/extensions are written for physician-ordered special diets. The policy further indicated the section titled 4.0 PROCEDURE included 6. Recipes are available for use and will be utilized.</p> <p>A facility policy titled, Therapeutic Diets, effective February 2009, indicated, 1.0 PURPOSE Ensure therapeutic diets are written and available as ordered. The policy indicated the section titled 4.0 PROCEDURE included 3. The Food and Dining Services Manager and/or Registered Dietitian writes the therapeutic and mechanically altered menus as an extension of the regular menu, utilizing the same foods when possible. The policy further indicated, 7. The facility prepares and serves all special diets as planned.</p> <p>The facility's Resident Listing Report dated 01/15/2025 indicated 22 residents received a pureed diet.</p> <p>During an interview on 01/14/2025 at 9:30 AM, [NAME] #6 stated she prepared about 45 servings of pureed foods.</p> <p>The facility's menu for Week 5 dated 10/20/2024 revealed the scheduled lunch meal for 01/14/2025 was beef stew, mashed potatoes, mixed green salad, wheat bread, and baked apple slices.</p> <p>The facility's Diet SpreadSheet X-format dated 01/14/2025 revealed the food that residents with pureed diets should have received for lunch included two #8 scoops of beef stew pureed, one #16 scoop of wheat bread pureed, and one #10 scoop of baked apple slices pureed.</p> <p>The BEEF STEW 3OZ [ounces] SCR [scratch] FRSH [fresh] recipe directions for 40 servings included 10 pounds of beef stew meat, one-quarter cup and 2 tablespoons of vegetable oil, 13 oz of diced onions, 1 pound (lb) 9.5 oz of diced celery, 2.25 quarts and 0.5 cup of water, 1 tablespoon and 1 teaspoon of salt, 0.75 teaspoon of black pepper, 3 lbs and 3 oz of diced potatoes, 3 lbs and 3 oz of sliced or diced carrots, additional 1 5/8 teaspoon of salt, additional 0.75 teaspoon of black pepper, 1 cup flour, and 1.5 cup and 2 tablespoons of water.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The BEEF STEW 3OZ SCR FRSH PU [pureed] recipe directions for 40 servings included 40 1 cup servings of the scratch prepared beef stew, 1/2 cup two tablespoons of food thickener bulk, and 1 1/4 quart of water or stock.</p> <p>During a concurrent observation and interview on 01/14/2025 at 9:42 AM, [NAME] #6 pureed 20, 4 oz scoops of plain beef stew meat while adding water. [NAME] #6 said she liked to add the water a little at a time to determine the thickness. [NAME] #6 did not puree the scratch prepared beef stew and was not observed to add food thickener.</p> <p>The WHEAT BREAD CONV [converted] PU recipe directions for 40 servings included 40 slices of bread, 1 1/4 quart of water or juice, and 1/2 cup 2 tablespoons of food thickener bulk.</p> <p>During a concurrent observation and interview on 01/14/2025 at 10:12 AM, [NAME] #6 filled a 1/3 size, 6-inch-deep steam table pan with hot water and added breadcrumbs while continuously mixing until smooth. [NAME] #6 stated she was preparing the pureed bread.</p> <p>During an interview on 01/15/2025 at 9:06 AM, [NAME] #6 stated she pureed plain beef stew meat instead of beef stew because sometimes the vegetables did not puree well. [NAME] #6 stated she knew the recipe indicated to puree the beef stew, but that she did it differently. [NAME] #6 said she used breadcrumbs instead of sliced bread to make the pureed bread because they had sandwiches for dinner the prior night and she did not want to use up all the bread.</p> <p>The BAKED APPLE SLICES recipe directions for 40 servings included 1 1/4 gallon 1 cup apple slices, 2 1/2 cup sugar or brown sugar, 2 3/8 teaspoon ground cinnamon, and 6 1/2 oz margarine.</p> <p>The BAKED APPLE SLICES PU recipe directions for 40 servings included 40 1/2 cup servings of baked apple slices prepared according to the regular recipe, and 2 1/2 cups of food thickener bulk.</p> <p>During an interview on 01/14/2025 at 10:10 AM, [NAME] #8 stated the dessert for lunch that day was baked apple slices, so he just opened a container of applesauce and poured that into small cups for the pureed residents.</p> <p>During a follow-up interview on 01/16/2025 at 8:31 AM, [NAME] #8 stated he used applesauce on 01/14/2025 instead of the baked sliced apples because he knew the applesauce would be the right consistency instead of pureeing the sliced baked apples.</p> <p>During an observation on 01/14/2025 at 11:45 AM revealed [NAME] #6 served the pureed plain beef stew meat, water and breadcrumb mixture, and small cups of applesauce on the tray line for service to the pureed residents.</p> <p>During an interview on 01/15/2025 at 9:49 AM, the Manager of Dietary stated she had been struggling with her staff to follow the menu. She further stated her staff felt overwhelmed to follow the recipes, so they chose the easiest way to get things done. She stated [NAME] #8 did not discuss with her that he used applesauce instead of pureeing the baked sliced apples for dessert. She further stated [NAME] #6 did not puree the beef stew because she felt the celery in the stew would not puree. The Manager of Dietary stated not having the vegetables in the pureed beef stew affected the flavor.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/15/2025 at 11:52 AM, the RD stated the kitchen staff had been trained multiple times to follow the recipes. The RD said staff should check with her if they substitute anything on the menu. The RD stated staff should puree according to the recipe to maintain proper nutrition.</p> <p>During an interview on 01/16/2025 at 10:10 AM, the Executive Director (ED) stated the kitchen staff should follow the diet spreadsheet for the planned menu. The ED further stated staff should follow the menu for pureed diets to ensure the proper nutrition and flavor.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>31524</p> <p>Based on observation, interview, and facility policy review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, the facility's kitchen staff failed to maintain clean food preparation equipment, date and label leftovers, thaw raw meat properly, wear gloves when handling ready-to-eat (RTE) food, and ensure hair restraints were worn in the food preparation areas. This deficient practice had the potential to affect all residents who received food from the kitchen.</p> <p>Findings included:</p> <p>1. A facility policy titled, Kitchen Sanitation & [and] Cleaning Schedules, effective in February 2009, indicated 2.0 POLICY Maintain a clean, sanitary, and safe kitchen. The policy indicated, 3.0 PROCEDURE 1. The Food and Dining Services Manager develops, implements, and monitors a cleaning schedule that assigns specific cleaning responsibilities to specific individuals. The policy further indicated, The Food and Dining Services Manager/designee will check the cleaning schedule at the end of each shift to assure assignments have been completed.</p> <p>During a concurrent observation and interview on 01/13/2025 at 9:03 AM, the walk-in freezer had multiple dried liquid spills, food debris, and trash on the floor. Dietary Aide (DA) #18 stated staff cleaned the floor of the freezer on Tuesdays and Saturdays when they received food deliveries. DA #18 said there should not be any trash or debris on the freezer floor.</p> <p>During a concurrent observation and interview on 01/13/2025 at 9:06 AM, a plastic restaurant silverware holder storing clean scoops and serving utensils next to the food preparation station contained spilled food, crumbs, and built-up grime on the holder with multiple crumbs on the food contact portion of the clean utensils. [NAME] #1 stated the plastic restaurant silverware container was cleaned on Wednesdays per the cleaning schedule and then added he would wash the container and utensils at that time because they were dirty.</p> <p>During a concurrent observation and interview on 01/13/2025 at 9:08 AM, the can opener attached to the food preparation table was covered with built up food debris and grime making the metal of the blade on the opener not visible. It was also sticky to the touch. [NAME] #1 removed the can opener out of its stand and stated that he was going to wash it since it was dirty and should not be.</p> <p>During an interview on 01/15/2025 at 9:49 AM, the Manager of Dietary stated she expected her staff to follow the guidelines and regulations for kitchen sanitation. The Manager of Dietary further stated they deep cleaned the kitchen every Thursday and Sunday. She said the freezer floor, the plastic restaurant silverware container, and the can opener should have been cleaned to where there was no food or built-up grime on any of the items. The Manager of Dietary said the kitchen was short staffed and they were not having time to clean as they should.</p> <p>During an interview on 01/15/2025 at 11:52 AM, the Registered Dietitian (RD) stated she expected the kitchen staff to keep up with the cleaning schedules for cleaning the kitchen and expected them to sweep and mop after meals.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 01/16/2025 at 10:10 AM, the Executive Director (ED) stated he expected the kitchen to be kept clean for food safety to prevent any contamination in the food service areas.</p> <p>2. A facility policy titled, Food Safety in Receiving and Storage, effective in February 2009, indicated, 1.0 PURPOSE Food is received and stored by methods to minimize contamination and bacterial growth. The policy indicated the section titled General food storage guidelines included 3. Food that is repackaged will be placed in a leak-proof, pest proof, non-absorbent, sanitary container with a tight-fitting lid. The container will be labeled with name of the contents and dated with the date it was transferred to the new container.</p> <p>During a concurrent observation and interview on 01/13/2025 at 9:11 AM, undated, unlabeled, plastic containers containing applesauce, canned peaches, canned pineapples, boiled eggs, and diced ham were in the walk-in refrigerator. There was no date or label on the containers. The Manager of Dietary stated the kitchen went through food so fast that her staff probably opened all those items that morning, The Manager of Dietary then asked Dietary Aide (DA) #2 about the unlabeled containers and DA #2 stated she did not know how long the food in the plastic containers had been there.</p> <p>During an interview on 01/15/2025 at 9:49 AM, the Manager of Dietary stated she expected all foods to be dated and labeled so staff knew what items were and how old they were. The Manager of Dietary said it was challenging to get her staff to consistently date and label leftover food items.</p> <p>During an interview on 01/15/2025 at 11:52 AM, the Registered Dietitian (RD) stated she expected all foods to be dated and labeled to maintain food quality and freshness.</p> <p>During an interview on 01/16/2025 at 10:10 AM, the Executive Director (ED) stated he expected leftover food to be dated and discarded within the appropriate time frame for food safety reasons.</p> <p>3. A facility policy titled, Safe Food Handling, effective in February 2009, indicated, 2.0 POLICY Sanitary food handling and practices will be followed. The policy indicated the section titled Preparation included 14. Frozen foods are thawed during the cooking process, under refrigeration (preferred method) or by immersion under running potable water of a temperature of 70 degrees F [Fahrenheit] or lower.</p> <p>An observation on 01/14/2025 at 9:28 AM revealed a pan containing three plastic bags of raw chicken with pooling blood on a preparation table at room temperature with no staff attending to it.</p> <p>During an interview on 01/14/2025 at 10:20 AM, [NAME] #6 stated the raw chicken in the pan on the food preparation table was pulled out about 9:15 AM and it was still a little frozen, so they left it on the food preparation table to thaw.</p> <p>During an interview on 01/15/2025 at 9:49 AM, the Manager of Dietary stated the chicken was thawing in the refrigerator prior to being placed on the food preparation table by another cook who was supposed to marinate it. The Manager of Dietary said she expected her staff to thaw meat in the refrigerator or under running water and not at room temperature to prevent foodborne illness.</p> <p>During an interview on 01/15/2025 at 11:52 AM, the Registered Dietitian (RD) stated she expected staff to thaw raw meat in the refrigerator to maintain food safety. The RD said a cook pulled out the raw chicken to season it and it was left out accidentally, so they discarded it.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 01/16/2025 at 10:10 AM, the Executive Director (ED) stated he expected staff to thaw raw meat in the refrigerator but did not know the expected time frames.</p> <p>4. A facility policy titled, Safe Food Handling, effective in February 2009, indicated, 2.0 POLICY Sanitary food handling and practices will be followed. The policy indicated the section titled Preparation included 2. Use utensils to handle food or wear disposable gloves when it is necessary to handle food directly with your hands.</p> <p>During an observation on 01/14/2025 at 12:32 PM, [NAME] #7 carried two heads of romaine lettuce and 2 heads of iceberg lettuce with his bare hands and set them on a food preparation table. [NAME] #7 then retrieved two more heads of romaine lettuce from the walk-in refrigerator with his bare hands, set them on the food preparation table, then placed the heads of lettuce into a large pan. [NAME] #7 then jokingly tore a leaf of romaine lettuce off and threw it at another cook. Part of the lettuce leaf landed on the other side of the steam table past the food and the other parts landed on the floor by the trash can. [NAME] #7 then picked up the lettuce leaves that fell on the floor and threw them out. [NAME] #7 did not wash his hands or wear gloves during this process.</p> <p>During an interview on 01/14/2025 at 12:34 PM, [NAME] #7 stated the lettuce was for salads that he was about to prepare and that he did not wear gloves when touching RTE food because he washed his hands all the time.</p> <p>During an interview on 01/15/2025 at 9:49 AM, the Manager of Dietary stated staff should wear gloves when handling RTE food and should not handle it with their bare hands to prevent cross contamination. The Manager of Dietary said throwing lettuce was unacceptable behavior.</p> <p>During an interview on 01/15/2025 at 11:52 AM, the Registered Dietitian (RD) stated the kitchen staff should not handle RTE food with their bare hands but should wear gloves. The RD said they had already spoken to [NAME] #7 about how he should not have thrown lettuce and said he was a newer cook but should not be doing that.</p> <p>During an interview on 01/16/2025 at 10:10 AM, the Executive Director (ED) stated he expected the kitchen staff to wear gloves when handling RTE foods and to wash their hands between glove changes.</p> <p>5. A facility policy titled, Personnel Sanitation Standards, effective in February 2009, indicated, 2.0 POLICY Food and dining services personnel follow sanitary standards and practices. The policy indicated the section titled 3.0 PROCEDURE included a. Hair must be restrained or covered (via [by way of] hat or hair net).</p> <p>During a concurrent observation and interview on 01/14/2025 at 9:30 AM, Dietary Aide (DA) #3 was wearing a baseball cap with no hairnet or beard net on in the food preparation area putting away clean dishes. DA #3's hair was approximately three inches long on his neck and DA #3 had a full beard approximately one inch long. DA #3 stated he had never been told to wear a beard net.</p> <p>During a concurrent observation and interview on 01/14/2025 at 9:33 AM, DA #4 had a goatee approximately 0.5 centimeters long with no beard net on in the food preparation area retrieving food from storage. DA #4 stated there was no reason he was not wearing a beard net.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent observation and interview on 01/14/2025 at 9:35 AM, DA #5 had a goatee approximately 0.5 centimeters long with no beard net on in the food preparation area retrieving food from storage. DA #5 stated he had never heard of wearing a beard net when in the food preparation area.</p> <p>During an interview on 01/15/2025 at 9:49 AM, the Manager of Dietary stated she expected her staff to wear hairnets and beard nets when in the kitchen. The Manager of Dietary said she started a year ago and it had been a challenge with this staff to get them to wear beard nets.</p> <p>During an interview on 01/15/2025 at 11:52 AM, the Registered Dietitian (RD) stated she expected the kitchen staff to wear hairnets when in the kitchen. The RD said it was important to wear hair restraints when in the kitchen to prevent any hair from getting in the food.</p> <p>During an interview on 01/16/2025 at 10:10 AM, the Executive Director stated he expected staff to restrain all hair when in the kitchen but did not know that facial hair needed to be restrained using a beard net as well.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>31524</p> <p>Based on observation, interview, and facility policy review, the facility failed to dispose of garbage and refuse properly affecting 3 of 3 dumpsters. Specifically, the trash and recycle dumpster lids were open with overflowing trash piled up over the top of the dumpsters and trash and debris was on the ground surrounding the base of the dumpsters. This had the potential to affect all 171 residents who resided in the facility at the time of the survey.</p> <p>Findings included:</p> <p>A facility policy titled, Garbage & Rubbish Disposal, effective in February 2009, indicated, 1.0 PURPOSE Maintain a sanitary and safe environment through effective disposal of garbage and rubbish. The policy indicated the section titled 3.0 PROCEDURE included 8. Outside dumpsters provided by garbage pickup services must be kept closed and free of litter around the dumpster area.</p> <p>During a concurrent observation and interview on 01/13/2025 at 9:15 AM, one recycle dumpster was observed with both lids open and one trash dumpster with one of two lids open with overflowing trash piled up over the top of the dumpster. An additional trash dumpster was observed with both lids resting on top of overflowing bags of trash. A bag of trash was observed on the ground with multiple pieces of trash and food debris spread out around the base of the three dumpsters. The Manager of Dietary stated she would notify maintenance to come and clean the ground around the dumpsters.</p> <p>An observation on 01/14/2025 at 3:57 PM revealed three of the four lids to the trash dumpsters were open with one of the dumpsters overflowing with bags of trash piled up over the top of the dumpster.</p> <p>An observation on 01/15/2025 at 8:30 AM revealed one of two lids were open on one of the trash dumpsters.</p> <p>During an interview on 01/15/2025 at 9:49 AM, the Manager of Dietary stated she expected the dumpster lids to always be closed. The Manager of Dietary said housekeeping and maintenance picked up trash on the grounds around the dumpsters and that it should be done whenever there was trash on the ground. The Manager of Dietary further stated facility staff were not up to date with keeping the grounds around the dumpsters clean.</p> <p>During an interview on 01/15/2025 at 11:01 AM, the Supervisor of Maintenance stated the city provided dumpster services and swept the street every other Friday but could not remember the last time the street was swept. The Supervisor of Maintenance stated there was trash all over the ground and that he cleaned it up daily.</p> <p>During an interview on 01/15/2025 at 11: 52 AM, the Registered Dietitian (RD) stated the dumpsters should remain closed.</p> <p>During an interview on 01/16/2025 at 8:43 AM, the Director of Nursing (DON) stated she expected the dumpsters to be secured, lids closed, and not overflowing. The DON further stated there should be no trash on the ground around the dumpsters.</p> <p>(continued on next page)</p>		

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