STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555200	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond View Care Center	1224 E Street Williams, CA 95987

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to provide two out of eight sampled residents (Residents 80 and 92) with dignity and respect when: 1. Resident 80's bed was not made every day. 2. Resident 92 stated, facility staff spoke in a manner, that led her to believe, facility staff did not want to provide care to Resident 92 and had overheard staff talking disrespectfully about her just outside of the door. This failure had the potential to impact resident well-being and cause psychosocial harm. Findings: A review of the facility's policy and procedure (P&P) titled, Promoting/Maintaining Resident Dignity, dated 11/1/23, indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. The P&P indicated, staff would speak with respect and would have conversations regarding residents in an area that residents could not overhear. A review of the undated Admission Record, indicated, Resident 80 was admitted to the facility on [DATE] with the diagnoses of hypertensive heart disease without heart failure (heart problems that were caused by high blood pressure), anxiety (feelings of fear), and a history of falling. Resident 80 was her own responsible party (RP, made own decisions). A review of the quarterly Minimum Data Set (MDS, an assessment tool), dated 10/17/24, Section C, indicated, Resident 80 had a Brief Interview for Mental Status (BIMS, an assessment that tested a resident's ability to recall information and memory. The test was scored from 0-15 where 0 meant the resident was not able to remember and 15 meant the resident had intact memory) and scored a 14. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 3:44 p.m., Resident 80 stated, not every day, but often, Resident 80 had to ask facility staff to make the bed. Resident 80 stated, inability to make own bed anymore due to being [AGE] years old, a fear of falling again, and stated feeling upset because Resident 80 was not able to perform activities of daily living for herself like she used to. Resident 80 stated, when the bed was left unmade, it bothered her. During an interview on 11/19/24 at 4:03 p.m., Certified Nurse Assistant (CNA) B stated, it was the responsibility of the CNA on the morning shift to make resident's beds. CNA B confirmed Resident 80's allegations that the bed was left unmade and stated, CNA B would come to work in the afternoon and find Resident 80's bed unmade all the time. During an observation on 11/22/24 at 8:57 a.m., Resident 80's room was observed. Resident 80 was not in the room, and the bed had been stripped of all the linen (bed did not have sheets, blanket, or pillowcase). During a concurrent observation and interview on 11/22/24 at 9:18 a.m., Resident 80 was observed standing next to the stripped bed holding on to a walker (metal frame on wheels used by residents that had difficulty walking or were at risk for falls). Resident 80 stated, she had just had a shower. During a concurrent observation and interview, on 11/22/24 at 9:40 a.m., Resident 80's room was observed. Resident 80's bed was stripped of linen. The Director of Staff Development (DSD) was observed walking past Resident 80's room. DSD confirmed Resident 80's bed was stripped of linen and stated, after the CNA provided Resident 80 with a shower, the CNA was expected to make the bed. DSD stated earlier in the week, it was brought to DSD's attention that Resident 80's bed had been left unmade and had planned to re-educate the CNA assigned to Resident 80. During the concurrent observation and interview with the DSD, a request was made to interview Resident 80's CNA. The CNA agreed to an interview after providing resident care. The CNA completed resident care, walked out of the room, and quickly walked down the hall into another resident room and closed the door. 2. A review of the undated Admissions Record, indicated, Resident 92 was admitted to the facility on [DATE] with the diagnoses of hypertension (high blood pressure), anxiety, and need for assistance with personal care (bathing, using bathroom, and rolling in bed). Resident 92 was her own RP. A review of the admission MDS, dated [DATE], Section C, indicated, Resident 92 had a BIMS assessment score of 13 (able to recall and remember information). A review of the undated Admission Record, indicated, Resident 6 was admitted to the facility with the diagnoses of muscle weakness and major depressive disorder (a sad mood). Resident 6 was her own RP. A review of Resident 6's quarterly MDS, dated [DATE], Section C, indicated, Resident 6 had a BIMS assessment score of 14. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/20/24 at 10:17 a.m., Resident 92 was observed lying in bed and maintained good eye contact during the interview. Resident 92 stated, I hear staff talking about me in the hallways all the time. Resident 92's roommate, Resident 6, joined the interview and stated, Resident 6 was treated differently than Resident 92. Resident 6 stated, facility staff treated her with dignity and respect and when facility staff spoke to Resident 92, they were short and sharp. Resident 6 and 92 described short and sharp as not having time and not wanting to care for Resident 92. Resident 92 began to cry and stated being afraid to say anything for fear staff would treat her worse. During an interview on 11/21/24 at 3:05 p.m., the Director of Staff Development (DSD) stated, it had been brought to the DSD's attention, at the end of last week, that two staff members had talked badly and mean to Resident 92. DSD stated one staff member had been identified and one staff member was unknown. DSD stated, DSD had not had an opportunity to follow up with facility staff regarding Resident 92's statements and DSD had previously counseled the identified staff in the past regarding how they spoke to residents.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 23083 Based on interview and review of Resident Council Minutes the facility failed to act promptly to resolve resident grievances in a timely manner and demonstrate their response and rationale for their response. This action had the potential to violate residents' rights. Findings: A review of a facility policy titled, Resident and Family Grievances dated 1/24/24, indicated grievances may be voiced verbally during resident or family council meetings. Under procedure, the policy included the following directions: The staff person receiving the grievance would record the nature and the specifics of the grievance. Steps would be taken to resolve the grievance, and record information about the grievance and actions taken on the grievance form. All staff involved in the grievance investigation should make prompt efforts to resolve the grievance. The Social Service Designee (SSD) would keep residents appropriately appraised of the progress and the resolution of the grievance. The SSD would issue a written decision on the grievance and a conclusion of the investigation. The facility would make prompt efforts to resolve grievances. During an interview with the Activities Director (AD) on 11/20/24 at 4:35 pm she stated there was one missing follow up from a resident council meeting grievance. She provided six months of Resident Council Minutes minutes from June to November 2024. A review of the six months of Resident Council minutes from June to November 2024 indicated during a Resident Council meeting on September 17, 2024, there was one complaint about noise in the facility. There was no follow up documentation of who made the complaint, or a documented effort to resolve the grievance or a conclusion of the investigation. The Resident Council minutes from June to November 2024 did not have any documented food complaints. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator (Admin) on 11/20/24 at 4:45 pm she stated the facility is supposed to have follow up on all concerns brought up by Residents Council members. She stated the concerns are to be brought up to the Department Managers. She also stated this was part of their grievance process which included being discussed with their Interdisciplinary Team (IDT, a group of professionals that meet and plan care and services for the residents). During a confidential interview on 11/21/24 at 10:30 am, five residents stated the food in the facility was not good. Residents stated, the hot food was not hot, the cold food was not cold, and the meat was tough and hard to chew. One resident stated the meat was hard to swallow due to how tough it was. The residents stated this had been an ongoing problem and had been brought up at previous council meetings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43031 Based on observation, interview and record review, the facility failed to ensure residents environment was clean, safe, comfortable, and homelike when: A drain in the kitchen was observed to have missing tile with exposed wood. Two tub and shower rooms used by residents were observed to contain excessive brown stains resembling rust on a handrail and on metal baskets used to hold soap and wash cloths. Doors in residents' rooms bathrooms were observed with scrapes, and gouges of exposed wood. One resident's wall next to his bed had multiple scrapes with exposed drywall. These findings had the potential for injuries to residents and an un home like environment. Findings: A review of a Safe and Homelike Environment policy dated 1/24/24 indicated the facility would provide a safe, clean and homelike environment to ensure residents can receive care and services safely. The policy additionally instructed that the facility maintenance and housekeeping would provide services as needed to maintain a safe, orderly, and comfortable environment. 1.During an observation on 11/19/24 at 11:00 am, in the kitchen during the walk through, the sink drain on the floor was missing tile with bare, water damaged wood exposed. During a concurrent interview and observation on 11/21/24 at 3:00 pm, with Dietary Manager (DM), and Registered Dietician (RD) 2 in the kitchen, DM stated, That drain really needs to be fixed with tiles, maintenance has ordered tiles and is in the process of starting to fix it, and RD 2 concurred in agreement that the drain needed to be fixed. 2. During a concurrent observation and interview on 11/20/24 at 8:55 am, with LN B in the Tub/Shower Room in the hall of the locked unit across from the nurse's station and utility room. Extensive rust was observed on metal baskets with plastic coating used for holding items such as soap and resident's wash cloths, also observed substantial rust on and in a floor drain with capped off spickets entirely coated in corrosion and rust which appears to not be in current use. LVN B concurred that rust and corrosion were evident, and this did not appear to be a satisfactory environment for someone's home. 3. During an observation on 11/20/24 at 9:15 am, in the Tub/Shower Room across from room [ROOM NUMBER] in the locked unit, observed rust on metal plastic coated baskets, rusted washers on shower safety handlebars, and 3 circular spackled areas in the shower exposed to water. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/21/24 at 2:00 pm, with Admin in the Administrator's Office. Pictures recently obtained of the kitchen drain, and Tub/Shower Rooms with apparatus' observed with rust and corrosion issues were reviewed. Admin concurred the items were not in good shape and needed to be fixed. Admin stated we are in the process of fixing them. During a concurrent observation and interview on 11/21/24 at 4:30 pm, with MS, in the hall outside the Theatre Room. Pictures recently obtained of the kitchen drain, and Tub/Shower Rooms with apparatus' observed with rust and corrosion issues were reviewed. MS concurred he has been made aware of the issues and is in the process of fixing them. There is only one person in maintenance with a part time person recently hired. MS concurs many things need to be fixed. 23083 4. On 11/19 24 at 11:30 am, room [ROOM NUMBER]-bathroom door was observed to have a long gouge of exposed wood measuring approximately 9 inches by 1 inch long above the door handle. Concurrently, on the same day room [ROOM NUMBER]c bed wall next to his bed was observed to have scrapes with exposed drywall the length of his bed. At 11:40 am, the bathroom door of room [ROOM NUMBER] was observed to have exposed wood gouges by the doorknob measuring one foot in length by 1 inch in length. The inside door of this room also had wood gouges observed by the door knob measuring approximately 15 inches in length by 1 inch in width. On 11/21/24 at 4:15 pm, the above rooms and disrepair was observed with the Maintenance Supervisor (MS). He acknowledged at this time the findings and the measurements. MS stated these areas needed to be repaired. He stated sometimes the staff tell him about needed repairs. 40425

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH) for one out of eight sampled residents (Resident 92) when Resident 92 notified Licensed Nurse (LN) A that facility staff working the night shift provided rough care (too much force, not careful or gentle). This failure had the potential for allegations of abuse to go unrecognized and placed residents at risk for abuse. Findings: A review of the facility's policy and procedure titled, Abuse-Reporting & Investigating, revised 11/1/16, indicated, when an allegation of abuse was made, the facility would notify CDPH. A review of the undated Admission Record, indicated, Resident 92 was admitted to the facility on [DATE] with the diagnoses of hypertension (high blood pressure), anxiety (feelings of fear), and need for assistance with personal care (bathing, using bathroom, rolling in bed). Resident 92 was her own responsible party (made own decisions). A review of the admission Minimum Data Set (MDS, an assessment tool), dated 10/17/24, Section C, indicated, Resident 92 had a Brief Interview for Mental Status (BIMS, an assessment that tested a resident's ability to recall information and memory. The test was scored from 0-15 where 0 meant the resident had poor memory and 15 meant the resident had good memory) and scored a 13. During a concurrent observation and interview on 11/20/24 at 10:17 a.m., Resident 92 was observed in bed and maintained good eye contact during the interview. Resident 92 stated, One night, the nurses were really rough turning me and changing me. Resident 92 was observed to lower her head, broke eye contact, and began to cry. During an interview on 11/21/24 at 12:26 p.m., LN A stated, Resident 92, came to me with concerns about rough care provided by NOC [nighttime] shift on last Friday and had reported to the Director of Staff Development (DSD). During an interview on 11/21/24 at 2:29 p.m., with the facility's Administrator (ADMIN), Resident 92's allegations of potential abuse were discussed. ADMIN confirmed, there was no report of Resident 92's allegations of potential abuse made to CDPH and stated, ADMIN was not notified of Resident 92's statements. During an interview on 11/21/24 at 3:05 p.m., DSD stated, last Friday, LN A notified DSD that Resident 92 alleged the NOC shift staff was rough while providing care, the Director of Nursing (DON) was aware, and it wasn't abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 3:21 p.m., DON stated, LN A notified DON that Resident 92 alleged something happened a while ago, and the night shift didn't seem nice. DON stated, asking LN A what had happened and if Resident 92 was abused. DON confirmed, Resident 92's allegation of potential abuse was not reported.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 23083 Based on observation, interview, and record review the facility failed to include nail care to one sampled residents comprehensive care plan (Resident 8). Resident 8 was observed to have long dirty fingernails, and was observed eating with his fingers. This deficient practice led to unidentified need for nailcare, and the potential for injury (scratches), and poor hygiene. Findings: On 11/19/24 at 12:38 pm Resident 8 was observed eating his lunch in the Dining Room with his fingers. His nails on his fingers were observed long with black particles in the nails. A review of Resident 8's record indicated he was admitted to the facility on [DATE] with diagnoses that include dementia (a progressive state of decline in mental abilities), diabetes (disorder characterized by difficulty in blood sugar control and poor wound healinge), and the need for assistance with personal care. A review of a Minimum Data Set (MDS, an assessment tool) dated 8/30/24, indicated Resident 8 was severely impaired for decision making and dependent on staff for personal hygiene. On 11/20/24 at 8:45 am, Resident 8 was observed with Licensed Nurse (LN) C. Resident 8's fingernails on all of his nails were approximately one inch in length with brown substance under the nails. LN C confirmed the findings stating nail care is usually done on a weekly basis during their showers and with activities. LN C acknowledged all Resident 8's nails were at least one inch long on all fingers and dirty. On 11/20/24 at 9 am, LN D was interviewed while reviewing Resident 8's record. LN D confirmed a care plan for refusal of ADLS (Activities of Daily Living) was present in the record but nothing about his refusal or need for nail care. On 11/21/24 at 7:35 am the Director of Nurses (DON) stated during an interview that nail care should have been included in Resident 8's ADL care plan. During an interview with the Activity Director (AD) on 11/22/24 at 10 am, she stated she usually does rounds to observe the residents. She stated Resident 8 is usually resistant to care, and she did not know his nails were a concern. A review of a facility policy titled, Care Planning / Interdisciplinary Team Care Planning Conference dated 9/2016, indicated the purpose of resident care plans were to assure resident care needs are identified through continuous assessment with measurable objectives and adequate interventions. The policy additionally indicated care plans would be reviewed, evaluated and updated as necessary by nursing staff.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 23083 Based on observation, interview and record review, the facility failed to maintain personal hygiene to one sampled resident that was unable to carry out his activities of daily living (Resident 8). Resident 8 was observed to have long dirty fingernails. This deficient practice led to unidentified need for nailcare, and the potential for injury (scratches) and poor hygiene. Findings: On 11/19/24 at 12:38 pm, Resident 8 was observed eating his lunch in the Dining Room with his fingers. His nails on his fingers were observed long with black particles in the nails. A review of Resident 8's record indicated he was admitted to the facility on [DATE] with diagnoses that include dementia (a progressive state of decline in mental abilities), diabetes (disorder characterized by difficulty in blood sugar control and poor wound healinge), and the need for assistance with personal care. A review of a Minimum Data Set (MDS, an assessment tool) dated 8/30/24, indicated Resident 8 was severely impaired for decision making, and dependent on staff for personal hygiene. On 11/20/24 at 8:45 am, Resident 8 was observed with Licensed Nurse (LN) C. Resident 8's fingernails on all his fingers were approximately one inch in length with brown substance under the nails. LN C confirmed the findings stating nail care is usually done on a weekly basis during their showers and with activities. LN C acknowledged all Resident 8's nails were at least one inch long on all his fingers and dirty. During an interview with the Activity Director (AD) on 11/22/24 at 10 am, she stated she usually does rounds to observe the residents. She stated Resident 8 is usually resistant to care and she did not know his nails were a concern. A review of a facility policy titled, Activities of Daily Living (ADLs) dated 1/24/24, indicated grooming and personal hygiene would be provided to residents who are unable to carry out activities of daily living. Additionally the policy directed it would identify resident triggers and inform the resident or his representative about the benefit verses benefit of the proposed treatment, and offer an alternative action if the resident refusals continue.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43031 Based on Observation, Interview, and Record Review the facility failed to ensure federal regulations related to the certification qualification requirement of the dietary manager were followed as outlined in the California Code, Health and Safety Code (HSC 1265.4). This failure had the potential to result in inadequate oversight of the food and nutrition services department associated with resident assessment accuracy, meal distribution accuracy, safe food handling, and sanitation guidelines. Findings: According to the HSC 1265.4 (a) Shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. The dietetic services supervisor shall receive frequently scheduled consultation from a qualified dietitian. According to the HSC 1265.4, (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association and maintains this certification. A record review of the facility's job description titled, Dietary Manager, dated 2022, indicated, Minimum requirements include .Certification as a dietary manager .Must also meet State requirements for food service managers or dietary managers. During a concurrent interview and record review on 11/19/2024 at 11:00 am with Dietary Manager (DM) and Registered Dietician (RD) 1 in the office of DM and RD. DM's education certificates were observed hanging on the wall with a passing date of April 12, 2023. The actual Dietary Manager Certificate was not observed, thus requested. DM stated, I am not certified yet. I have not passed the test. I am scheduled to take the test on 1/3/24. I have been performing duties of the position for three (3) years. RD 1 stated, I am here at the facility one (1) time a month, I only started two (2) months ago, so I have only been here twice, and I have four (4) other facilities that I oversee. I am always available for DM if needed. During an interview on 11/21/2024 at 2:00 pm with Administrator (Admin) in the Administrator office, Admin stated, we know the DM does not have the certificate and is working on getting it, the test is scheduled for January. We thought we were covered with our RD in place and the other Certified Dietary Manager (CDM) with a current certificate in the building now serving as the Medical Records Director.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43031 Based on observations and interviews, the facility failed to ensure the facility food was an appetizing temperature and palatable texture when 14 of 21 sampled residents (Residents 17, 9, 51, 70, 16, 36, 85, 72, 80, and five confidential residents), who received food prepared in the facility kitchen were not satisfied with the facility food temperature and texture. This failure had the potential to result in residents not obtaining appropriate nutritive intake, unplanned weight loss, increased health issue complications, and diminished emotional well-being. Findings: A review of the facility's policy and procedure (P&P) titled, Food Preparation Guidelines, dated February 2023, Revision, indicated, Food shall be palatable attractive, and at a safe and appetizing temperature. 1. A review of Resident 17's medical record indicated that Resident 17 was admitted on [DATE] with diagnoses that included Dementia with mood disturbance (loss of memory, language, problem solving, and thinking ability with mood issues such as depression, anxiety, and apathy), Hypertension (HTN, high blood pressure), and Syncope and Collapse (fainting). The Minimum Data Set (MDS, Tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) score dated 9/19/24, indicated Resident 17 rates 14/15, which equates to having cognition intact. During an interview on 11/20/24 at 12:40 pm, with Resident 17 while in the dining room, Resident 17 stated, Food is bland, mostly cold, and veggies are mushy. 2.A review of Resident 9's medical record indicated that Resident 9 was admitted on [DATE] with diagnoses that included Diabetes Mellitus (DM), Chronic Kidney Disease (Progressive damage and loss of function to the kidneys), and Cerebral Infarction (Stroke, blockage of blood flow to the brain). The MDS BIMS, Section C score dated 11/20/24, indicated Resident 9 rates 10/15, which equates to having moderately impaired cognition. During an interview on 11/20/24 at 12:40 pm, with Resident 9 while in the dining room, Resident 9 stated, Food is cold. 3.A review of Resident 51's medical record indicated that Resident 51 was admitted on [DATE] with diagnoses that included Alzheimer's Disease (brain disease which causes brain to shrink and brain cells to die) , Chronic Obstructive Pulmonary Disease (COPD, ongoing lung condition causing damage to the lungs and difficulty to breathe), and Heart Failure. The MDS BIMS, Section C score dated 10/24/24, indicated Resident 51 rates 5/15, which equates to having severely impaired cognition. During an interview on 11/21/24 at 12:35 pm, with Resident 51 while in the dining room, Resident 51 stated, Food is cold. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Almond View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 E Street Williams, CA 95987	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.A review of Resident 70's medical record indicated that Resident 70 was admitted on [DATE] with diagnoses that included Neurocognitive disorder with Lewy Bodies (progressive damage to the brain with build-up of Lewy body cells which are clumps of proteins causing the brain to have symptoms of hallucinations, lack of focus and attention, and movement tremors), Parkinsonism (Neurologic condition that causes movement abnormalities such as tremor and impaired speech), and Generalized Muscle Weakness. The MDS BIMS, Section C score dated 11/7/24, indicated Resident 70 rates 2/15, which equates to having severely impaired cognition. During an interview on 11/19/24 at 1:35 pm, with Resident 70 while in the resident's room, Resident 70 stated, I am picky, the Food isn't to my taste, I get food out from my daughter. 5.A review of Resident 16's medical record indicated that Resident 16 was admitted on [DATE] with diagnoses that included Alzheimer's Disease , DM, and HTN. The MDS BIMS, Section C score dated 10/2/24, indicated Resident 16 rates 14/15, which equates to having intact cognition. During an interview on 11/19/24 at 2:00 pm, with Resident 16 while in the resident's room, Resident 16 stated, Food is cold, not good, I just have to eat it. 6.A review of Resident 36's medical record indicated that Resident 36 was admitted on [DATE] with diagnoses that included Cerebral Vascular Accident (Stroke, Blood flow to the brain is cut off and can lead to brain cell death, and neurologic damage), Monoplegia to Left Lower Limb (paralysis to one leg), and DM. The MDS BIMS, Section C score dated 10/30/24, indicated Resident 36 rates 7/15, which equates to having severely impaired cognition. During an interview on 11/20/24 at 12:40 pm, with Resident 36 while in the resident's room, Resident 36 stated, Food is cold. 7.A review of Resident 85's medical record indicated that Resident 85 was admitted on [DATE] with diagnoses that included Dementia with Behavioral Disturbances, Heart Failure, and Cardiomyopathy (disease of the heart muscle causing the heart to have a difficulty pumping blood to the body). The MDS BIMS, Section C score dated 9/23/24, indicated Resident 85 rates 8/15, which equates to having severely impaired cognition. During an interview on 11/21/24 at 12:35 pm, with Resident 85 while in the dining room, Resident 85 stated, Food does not taste good and is cold. During an interview on 11/21/22 at 3:00 pm, with DM in the DM and RD office, DM stated, I understand the food must meet the resident's tastes. 45315 8. A review of the undated Admission Record, indicated, Resident 72 was admitted to the facility on [DATE] with the diagnosis of Chronic Obstructive Pulmonary Disease (affected the lungs and made breathing difficult). Resident 72 was her own responsible party (RP, could make own decisions). During an interview on 11/19/24 at 11:58 a.m., Resident 72 stated, the hot foods were not always hot, the cold foods were not always cold, and the meat was tough and over cooked. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Almond View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 E Street Williams, CA 95987	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. A review of Resident 80's undated Admission Record, indicated, Resident 80 was admitted to the facility on [DATE] with the diagnosis of type 2 diabetes (body was not able to control blood sugar levels). Resident 80 was her own RP. During an interview on 11/19/24 at 3:44 p.m., Resident 80 stated, the dietary department had served tomato soup the other day. Resident 80 had tears in her eyes and stated, I had my heart set on that hot tomato soup, on a cold evening, and it was stone cold. A review of the facility's weekly meal menu, titled Good for Your Heart Health Menus, dated 11/18/24 through 11/24/24, indicated, on 11/18/24, the residents received tomato soup with dinner. 10 - 14. During a confidential interview on 11/21/24 at 10:30 a.m., five residents stated the food in the facility was not good. Residents stated, the hot food was not hot, the cold food was not cold, and the meat was tough and hard to chew. One resident stated the meat was hard to swallow due to how tough it was.