STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555281	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oroville Hospital Post-Acute Center	1000 Executive Parkway Oroville, CA 95966

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview, and record review, the facility to address resident's grievance of staff going through resident's personal belongings without resident's permission for one of eight sampled residents (Resident 183). This deficient practice had the potential for Resident 183's grievance to go unnoticed, causing anger and distress to the resident; and had the potential to result in a delay of care and services. Findings: During a review of the facility's policy titled, Grievance Procedure, no revised date provided, indicated: a. Residents have the right to voice grievances without discrimination or reprisal and without fear of discrimination or reprisal. b. At admission, the patient or patient Responsible Party (RP) informs the Resident/Resident's Authorized Representative about their right to voice grievances orally, in writing, and anonymously regarding the care and treatment/lack of treatment, behavior of staff and of other residents, and other concerns during their stay. c. The Executive Director (ED), designee oversees the grievance procedure and coordinates the Facility system for collecting, tracking, and responding to grievances. d. Staff are trained at orientation and periodically on the Facility's grievance procedure, including: - How to listen without becoming defensive. - How to diffuse an emotionally charged resident or family member. - The need to take grievances seriously. - What to do with grievances. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- When to put a grievance in writing. - When to report to their supervisor and to the state according to mandated reporting requirement (where applicable). e. If the grievance involves abuse, neglect, exploitation, or misappropriation of resident property, the ED is notified immediately, and an investigation begins. During a review of Resident 183's clinical record, indicated that Resident 183 was admitted to the facility on [DATE] with diagnoses which included severe sepsis (a life-threatening blood infection), urinary tract infection (UTI- an infection in the bladder/urinary tract), and metabolic encephalopathy (ME- a brain dysfunction caused by a chemical imbalance in the blood that impacts brain function). Resident 183 was her own healthcare decision maker. During a concurrent observation and interview on 12/11/24 at 9:24 am, in Resident 183's room, Resident 183 appeared to be upset and stated that she felt well, and she wanted to go home, Resident 183 said, I have the right to go home . Observed the Social Service Director (SSD) walked into Resident 183's room and discussed Resident 183's concern about discharging. Resident 183 appeared to be upset and stating the night staff going through her personal belongings while she was asleep, Resident 183 said, It's against my right! They should not go through my stuff, going through like tornado while I was asleep . Observed the SSD continued with the discussion of discharging, did not offer Resident 183 for filing a grievance report. During an interview on 12/17/24 at 10:57 am, with SSD, in SSD office, the SSD stated, Whoever identify the grievance would file the grievance report and give it to us, we would investigate it, complete it and put it into the grievance binder. The SSD stated that the Activities Director (AD) managed the grievance binder. During a concurrent interview and record review on 12/17/24 at 11:01 am, with AD, the facility's grievance binder was reviewed. The AD stated that there's no grievance report filed for 12/2024. The AD stated, If there's something could not be resolved immediately, the staff/residents would drop of the grievance form to me. We have the forms at each station The AD stated, If a resident said to a staff, 'Someone going through my staff, invaded my privacy', whoever was there, heard this from the resident, she or he should have filed the grievance report and started the investigation. During an interview on 12/17/24 at 1:20 pm with Assistant Director of Nursing (ADON), in ADON's office, the ADON stated that the expectation from the staff was to file a grievance report on behalf of Resident 183. The ADON stated the grievance procedure was educated to the resident at the time of admission, the staff were also educated with how to file a grievance report. The SSD was the one providing the education on filing grievance. During an interview on 12/17/24 at 2:36 pm, with SSD, the SSD acknowledged that she heard Resident 183 saying that someone was going through her belongings, the SSD stated, I asked her who the staff was, and Resident 183 said she did not recall . I could ask Resident 183 and file the grievance report.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to ensure a written notice of transfer or discharge for one of three residents (Resident 292) (or resident representee, RP) was provided to Resident 292 and to the office of the State Long-Term Care (LTC) Ombudsman (a person who investigates and helps resolve complaints for residents) when they were sent to the hospital for emergency care. This failure had the potential to result in the lack of coordination of support for Resident 292 during discharge planning. Findings: A review of the facility's policy titled Attachment F: Resident [NAME] of Rights (undated) indicated on page 26 -27 that before a facility transfers or discharges a resident, the facility must-notify the resident and, if known a, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The written notice must include the following: a. The reason for the transfer or discharge, b. The effective date of transfer or discharged , c. The location to which the resident is transferred or discharged , d. A statement that the resident has the right to appeal the action to the State, e. The name, address, and telephone number of the State LTC ombudsman. A review of Resident 292's Admission Record (undated) indicated Resident 292 was admitted to the facility on [DATE] with diagnoses that included anemia (low red blood cells), depression, anxiety, chronic (ongoing) pain, heart disease, and lung disease and post-operative right leg mass removal. Resident 292 was her own RP (she made her own decisions). During an interview with the Assistant Director of Nursing (ADON) and record review on 12/12/24 at 1:46 am, the ADON indicated that Resident 292 was only in the facility for a less than a day, and she did not return to the facility after discharging to the hospital. Resident 292's records were reviewed and were as follows: a. A nurse's progress note dated 10/21/24 indicated Resident 292 arrived to the facility on [DATE] at 12:30 pm a discharge summary, by Family Nurse Practitioner (FNP), dated 10/21/24 at 16:58 pm indicated Resident 292 was in the facility for less than 24 hours. FNP indicated Resident 292 became quite agitated, and she is [was] reporting chest pain 10/10. She was sent to the acute hospital for further evaluation. During an interview on 12/12/24 at 2:40 pm, the ADON indicated she was unable to find a written notice of discharge with all the requirements, as per their policy, for Resident 292, that would have been provided to the Ombudsman and Resident 292. During an interview on 12/18/24 at 2:15 pm, ADON indicated there was no written transfer or discharge notice given to the Ombudsman or to Resident 292 with all the requirements and there should have been.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview, and record review, the facility failed to provide five residents (Residents 2, 14, 73, 130, 292) out of a sample of 32 with the bed hold agreement in writing when residents were transferred out of the facility to a hospital or for therapeutic leave. This failure had the potential for residents to be unaware that, for a period of up to seven days after the transfer, the facility must readmit them when the resident is ready to return, and that the resident has only a 24-hour window in which to inform the facility that they intend to return. Findings: A facility document titled, California Standard Admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities, undated, was reviewed. The document is a collection of information provided to residents when they are admitted to the facility. Contained in the document is the facility's bed hold policy which outlines that they will hold a resident's bed for seven days upon transfer to a hospital, and that the resident has 24 hours after receiving the notice to inform the facility whether or not the resident wants the bed held for them. Resident 2 was admitted to the facility with dementia (a general term for a progressive decline in thinking, behavioral and social skills that affects a person's ability to function,) Parkinson's disease (a progressively worsening disorder caused by degeneration of nerve cells in the part of the brain,) severe intellectual disability (a developmental disability that starts in infancy or childhood and which limits a person's ability to learn, function, and adapt to their environment,) and schizophrenia (a serious mental illness that affects how a person thinks, perceives reality, expresses emotion, acts, and relates to others) among other diagnoses. Resident 2 does not have capacity to make his own healthcare decisions. A review was made of a nursing progress note dated 12/13/24 at 2:32 pm, by Registered Nurse (RN) G who documented that Resident 2 was transferred to an acute care emergency department after an incident where he became unconscious while sitting in his wheelchair. An interview was conducted on 12/15/24 at 4:30 pm, with RN G who confirmed the events outlined in her nursing progress note of 12/13/24. A review of Resident 2's medical record failed to find evidence that the resident or his representative had been given notification of the bed hold requirement. An interview was conducted on 12/17/23 at 3:15 pm, with the Assistant Director of Nurses (ADON) who confirmed that notice of bed hold was not given to patients or representatives upon transfer to a hospital, and that they were working on a plan of correction. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy and procedure (P&P) titled, Bed Hold, indicated, at the time of transfer, the resident or their responsible party (RP, decision maker) would receive a copy of the bed hold policy. The P&P indicated, depending upon the medical insurance or if the resident was private pay, they would be required to use their own income, and pay the facility for the bed hold. A review of the facility's policy titled Attachment F: Resident [NAME] of Rights (undated) indicated on page 28; (2) Bed-hold notice upon transfer. At the time of transfer of a resident or hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration for the bed-hold policy . A review of Resident 292's Admission Record (undated) indicated Resident 292 was admitted to the facility on [DATE] with diagnoses that included anemia (low red blood cells), depression, anxiety, chronic (ongoing) pain, heart disease, and lung disease and post-operative right leg mass removal. Resident 292 was her own RP (she made her own decisions). During an interview with the Assistant Director of Nursing (ADON) and record review on 12/12/24 at 1:46 am, the ADON indicated that Resident 292 was only in the facility for a less than a day, and she did not return to the facility after discharging to the hospital. Resident 292's records were reviewed and were as follows: (a) A nurse's progress note dated 10/21/24 indicated Resident 292 arrived to the facility on [DATE] at 12:30 pm. (b) A discharge summary, by Family Nurse Practitioner (FNP), dated 10/21/24 at 16:58 pm indicated Resident 292 was in the facility for less than 24 hours. FNP indicated Resident 292 became quite agitated, and she is [was] reporting chest pain 10/10. She was sent to the acute hospital for further evaluation. During an interview on 12/16/24 at 3:53 pm, ADON indicated she was unable to provide the surveyor with bed hold document provided to Resident 292 at discharge. During an interview on 12/18/24 at 2:15 pm, the ADON indicated there was no bed hold policy given to Resident 292 for her transfer/ discharge and there should have been. 45315 A review of Resident 14's undated Admission Record, indicated, Resident 14 was admitted to the facility on [DATE] with the diagnosis of chronic kidney disease (a long-term disease where the kidneys did not work well). Resident 14 was her own RP. A review of the Transfer/Discharge letter, dated 6/5/24, indicated, the facility notified the Long-Term Care Ombudsman (a representative that assisted residents with protecting their rights) that Resident 14 was transferred to the hospital for treatment on 6/5/24. A review of Resident 73's undated Admission Record, indicated, Resident 73 was admitted to the facility on [DATE] with the diagnosis of cerebral infarction (a stroke). Resident 73 was not her own RP. A review of the Transfer/Discharge letter, dated 11/18/24, indicated, the facility notified the Long-Term Care Ombudsman that Resident 73 was transferred to the hospital for treatment on 11/17/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 130's undated Admission Record, indicated, Resident 130 was admitted to the facility on [DATE] with the diagnosis of presence of right artificial knee joint (knee replacement surgery). Resident 130 was her own RP. A review of the Transfer/Discharge letter, dated 9/16/24, indicated, the facility notified the Long-Term Care Ombudsman that Resident 130 was transferred to the hospital for treatment on 9/15/24. During an interview on 12/16/24 at 3:27 pm, the Assistant Director of Nursing (ADON) stated, the bed hold agreement was reviewed with residents upon admission to the facility. ADON stated, when a resident was transferred out of the facility to the hospital, the Ombudsman was provided with a written notice of transfer and stated the resident or the resident's RP was not provided with a written bed hold policy.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to complete the Comprehensive Minimum Data Set (MDS, a standardized resident assessment) for 12 of 29 sampled residents (Residents 41, 44, 7, 87, 73, 27, 55, 96, 100, 291, 293, and 294) when MDS assessments were not completed within 14 days. These failures had the potential to delay the development of a comprehensive care plan necessary to provide the appropriate individualized care and services for Resident 44 and 41 related to the care areas identified on the Comprehensive MDS. Findings: The Resident Assessment Instrument (RAI) Manual gives clear guidance about how to complete the MDS. According to the RAI, Chapter 2 page 9, Assessment completion refers to the date that all information has been collected and recorded for the particular assessment type and staff have signed and dated that the assessment is complete. Page 10 indicated that Comprehensive MDS assessments include Annual Assessments. Page 17 indicated that the Annual assessment completion date (Item Z0500B) must be no later than 366 days from the previous Comprehensive Assessment (Previous comprehensive assessment date +366 calendar days). A review of Resident 44's Admission Record (undated) indicated that Resident 44 was admitted to the facility on [DATE] with diagnoses that included sepsis, urinary tract infection, Parkinson's disease, and diabetes. The most recent completed Annual Assessment was dated 11/24/23. On 12/16/24 at 10:48 am, a review of Resident 44's MDS's showed there was a completed annual assessment MDS with assessment date of 11/24/23. There was another annual MDS labeled in progress with assessment date of 11/8/24 with sections A (Identification Information, B (Hearing, Speech, and Vision), E (Behavior), GG (Functional Abilities), H (Bladder and Bowel), I (Active Diagnosis), J (Health Conditions), K (Swallowing/Nutritional Status), L (Oral, Dental Status), M (Skin Conditions), N (Medications), O (Special Treatment, Procedures, and Programs), P (Restraints and Alarms), S (California State Specific) and V (Care Area) assessments labeled as In Progress. The in progress MDS with assessment date of 11/8/24 was to be completed by 11/24/24 and was identified as 8 days overdue. During a concurrent interview and record review, with Minimum Data Set Licensed Nurse (MDS LN) on 12/16/24 at 10:54 am, Resident 44's MDS was reviewed. MDS LN indicated that Resident 44's annual MDS with assessment date of 11/8/24 was not completed and it should have been. MDS LN indicated that the facility was a very busy building, and that they were behind with completing resident's MDS's. A review of Resident 41's Admission Record (undated) indicated that Resident 41 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, seizures, diabetes, and depression. On 12/16/24 at 10:45 am, a review of Resident 41's MDS's showed there was an annual MDS labeled in progress with assessment date of 11/3/24. Sections A, B, E, GG, H, I, J, K, L, M, N, O, P, S, and V were labeled as in progress. The annual MDS with assessment date of 11/3/24 was due on 11/10/24 and was identified as being 24 days overdue. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41567 Resident 7 was admitted to the facility with sepsis (systemic reaction to what started as a localized infection,) chronic obstructive pulmonary disease (COPD, a group of inflammatory lung conditions that obstruct airflow and make it hard to breathe,) diabetes mellitus (a chronic disorder that affects how the body converts food into energy,) heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs for nutrients and oxygen,) and renal disease (decreased functionality of the kidneys, the organs that clean the blood of toxins and waste,) among other diagnoses. During a record review conducted on 12/13/24 it was noted that Resident 7 was discharged from the facility on 9/20/24, as documented in a discharge summary note dated 9/20/24 at 10:27 am by Licensed Nurse H. A review of Resident 7's resident assessments found the discharge MDS was incomplete. An interview was conducted on 12/13/24 1:39 pm, with MDS RN who stated, We're behind on our discharges, going back to the end of August 2024. 45315 A review of MDS section (the area of the electronic medical record that contained resident information and the dates that the MDS was completed, due, or late), dated, 6/12/24 through 12/11/24, indicated, Resident 14 was admitted to the facility on [DATE] with the diagnosis of cellulitis of left lower limb (infection of left lower left). The MDS section indicated, the Discharge MDS, dated [DATE], was three days overdue, and labeled In Progress. The MDS section, indicated, the next Medicare ARD, dated 12/12/24, was five days overdue, and labeled in Progress. A review of the MDS section, dated 10/25/23 through 11/20/24, indicated, Resident 73 was admitted to the facility on [DATE] with the diagnosis of cerebral infarction, unspecified (stroke). The MDS section indicated, the Discharge ARD, dated 11/17/24, was 12 days overdue, and labeled In Progress. The MDS section indicated, the ARD, dated 10/31/24, was 29 days overdue, and labeled In Progress. A review of the MDS section, dated, 8/5/23 through 11/11/24, indicated Resident 87 was admitted to the facility on [DATE] with the diagnosis of unspecified sequelae of cerebral infarction (long term issues related to a stroke). The MDS section indicated, the ARD, dated 11/11/24, was 22 days overdue, and labeled In Progress. 43739 During a review of Resident 27's clinical record, indicated that Resident 27 was admitted to the facility on [DATE] with diagnoses which included right arm fracture, heart failure, and diabetes (high blood sugar). Resident 27 was his own healthcare decision maker. Resident 27 was discharged on [DATE]. During a review of Resident 27's discharge MDS (a MDS assessment that is completed when a resident is leaving a nursing facility), the status indicated that it's In Progress, and the record indicated that Resident 27's Discharge Assessment Reference Date (ARD) was 10/8/24 and it's 52 days overdue. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 55's clinical record, indicated that Resident 55 was admitted to the facility on [DATE] with diagnoses which included sepsis (a life-threatening blood infection), pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and muscle weakness. Resident 55 was not his healthcare decision maker. Resident 55 was discharged on [DATE]. During a review of Resident 55's discharge MDS, the status indicated that it's In Progress, and the record indicated that Resident 55's ARD was 9/5/24 and it's 85 days overdue. During a review of Resident 96's clinical record, indicated that Resident 96 was admitted to the facility on [DATE] with diagnoses which included infection of the intervertebral disc in the cervical region (a bacterial infection within the disc space of the neck vertebrae), sepsis, and muscle weakness. Resident 96 was his own healthcare decision maker. Resident 96 was discharged on [DATE]. During a review of Resident 96's discharge MDS, the status indicated that it's In Progress, and the record indicated that Resident 96's ARD was 11/20/24 and it's 9 days overdue. During a review of Resident 100's clinical record, indicated that Resident 100 was admitted to the facility on [DATE] with diagnoses which included sepsis, shigellosis (a bacterial infection of the intestines that causes diarrhea, stomach pain, fever, and a strong urge to have a bowel movement), and severe protein-calorie malnutrition. Resident 100 was her own healthcare decision maker. Resident 100 was discharged on [DATE]. During a review of Resident 100's discharge MDS, the status indicated that it's In Progress, and the record indicated that Resident 100's ARD was 11/22/24 and it's 7 days overdue. During a review of Resident 291's clinical record, indicated that Resident 291 was admitted to the facility on [DATE] with diagnoses which included right hip fracture, urinary tract infection (UTI- an infection in the bladder/urinary tract). Resident 291 was her own healthcare decision maker. During a review of Resident 291's entry MDS (the initial MDS assessment completed when a resident is admitted to a Medicare or Medicaid certified nursing home), the status indicated that it's In Progress, and the record indicated that Resident 291's Entry- ARD was 12/1/24, and it's 5 days overdue. Resident 291's Admission/Medicare MDS (the initial comprehensive assessment, that is completed on every resident admitted to a Medicare-certified nursing home, providing a standardized evaluation of their health needs and functional capabilities upon entering the facility) ARD was dated 12/8/24, and it's 5 days overdue. During a review of Resident 293's clinical record, indicated that Resident 293 was admitted to the facility on [DATE] with diagnoses which included sepsis, cellulitis (a skin infection that causes swelling and redness) of face, and pneumonia (an infection/inflammation in the lungs). Resident 293 was her own healthcare decision maker. Resident 293 was discharged on [DATE]. During a review of Resident 293's entry MDS, the status indicated that it's In Progress, and the record indicated that Resident 293's Entry- ARD was 12/4/24, and it's 2 days overdue. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 294's clinical record, indicated that Resident 294 was admitted to the facility on [DATE] with diagnoses which included acute osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of right ankle and foot, sepsis, diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing). Resident 294 was her own healthcare decision maker. Resident 294 was discharged on [DATE]. During a review of Resident 294's entry MDS, the status indicated that it's In Progress, and the record indicated that Resident 294's Entry-ARD was 11/14/24, and it's 22 days overdue. During an interview on 12/16/24 at 11:23 am, Minimum Data Set Registered Nurse (MDS RN) stated unfortunately we are that far behind. It's just me and two other nurses. MDS RN indicated that there was a lot of MDS's not completed and that she had discussed the issue with her Administrator a few weeks ago and asked for more nursing hours in this department. MDS RN indicated that her main concern with the MDS's not being complete was that the residents care plans may not reflect the up-to-date interventions for their care. MDS RN stated It is a terrible feeling because I want to be sure things are good for our residents. During an interview on 12/17/24 at 2:43 pm with the Administrator, the Administrator stated, I knew we were behind, but not that much. I would expect the MDS RN reported to me, so I could do root cause analysis to find out what happened, and from there, we could go find the cause and fix it.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to complete the Quarterly Minimum Data Set (MDS, a standardized resident assessment) withing 92 days of the previous assessment for two of nine sampled residents (Resident 57 and 8). This failure had the potential to delay the development of a comprehensive care plan necessary to provide the appropriate individualized care and services for Resident 57 and Resident 8 related to the care areas identified on the MDS. Findings: The Resident Assessment Instrument (RAI) Manual dated October 2024, gives clear guidance about how to complete the MDS. According to the RAI, Chapter 2 page 9, Assessment completion refers to the date that all information has been collected and recorded for the particular assessment type and staff have signed and dated that the assessment is complete. Page 35 indicated that Quarterly MDS assessments completion date (item Z0500B) must be no later than 92 days from the previous assessment (previous assessment date +92 calendar days). The MDS completion date (Item Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (ARD + 14 calendar days). 1. A review of Resident 57's Admission Record (undated), indicated Resident 57 was readmitted to the facility on [DATE] with diagnoses that included stroke, hemiplegia and hemiparesis to the right dominant side (unable to move the right arm and right leg), neuropathy (nerve damage that causes pain or numbness), dementia, post-traumatic stress disorder (PTSD), bipolar disorder (a mental health condition that causes extreme mood swings), chronic obstructive pulmonary disease (COPD, lung disease), anxiety, and chronic pain. Resident 57 was unable to make her own decisions. On 12/16/24 at 10:07 am, a review of Resident 57's MDS's showed there was a completed quarterly assessment MDS with assessment date of 7/28/24. There was another quarterly MDS labeled in progress with assessment date of 10/28/24 with sections A (Identification Information, B (Hearing, Speech, and Vision), E (Behavior), GG (Functional Abilities), H (Bladder and Bowel), I (Active Diagnosis), J (Health Conditions), K (Swallowing/Nutritional Status), L (Oral, Dental Status), M (Skin Conditions), N (Medications), O (Special Treatment, Procedures, and Programs), P (Restraints and Alarms), S (California State Specific) assessments labeled as In Progress. The in progress MDS with assessment date of 10/28/24 was to be completed by 11/12/24 and was identified as 35 days overdue. During a concurrent interview and record review, with Minimum Data Set Licensed Nurse (MDS LN) on 12/16/24 at 10:09 am, Resident 57's MDS was reviewed. MDS LN indicated that Resident 57's quarterly MDS with assessment date of 10/28/24 was not completed and it should have been. MDS LN indicated that the facility was a very busy building, and that they were behind with completing resident's MDS's. 2. A review of Resident 8's Admission Record (undated), indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included sepsis (a serious infection), urinary tract infection, muscle weakness, heart failure, respiratory failure, and bipolar disorder. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 10:45 am, a review of Resident 8's MDS's showed there was a completed quarterly assessment MDS with assessment date of 8/16/24. There was another quarterly MDS labeled in progress with assessment date of 11/16/24 with sections A (Identification Information, B (Hearing, Speech, and Vision), E (Behavior), GG (Functional Abilities), H (Bladder and Bowel), I (Active Diagnosis), J (Health Conditions), K (Swallowing/Nutritional Status), L (Oral, Dental Status), M (Skin Conditions), N (Medications), O (Special Treatment, Procedures, and Programs), P (Restraints and Alarms), S (California State Specific) assessments labeled as In Progress. The in progress MDS with assessment date of 11/16/24 was to be completed by 11/30/24 and was identified as 18 days overdue. During an interview on 12/16/24 at 11:23 am, Minimum Data Set Registered Nurse (MDS RN) stated unfortunately we are that far behind. It's just me and two other nurses. MDS RN indicated that there was a lot of MDS's not completed and that she had discussed the issue with her Administrator a few weeks ago and asked for more nursing hours in this department. MDS RN indicated that her main concern with the MDS's not being complete was that the residents care plans may not reflect the up-to-date interventions for their care. MDS RN stated It is a terrible feeling because I want to be sure things are good for our residents. 45315 A review of MDS section (the area of the electronic medical record that contained resident information and the dates that the MDS was completed, due, or late), dated, 10/25/23 through 11/20/24, indicated, Resident 73 was admitted to the facility on [DATE] with the diagnosis of cerebral infarction, unspecified (stroke). The MDS section indicated, the ARD Q4 (Q4, fourth quarter, quarterly assessment), dated 11/2/24, was 27 days overdue, and labeled In Progress.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review, the facility failed to ensure the Level 1 Preadmission Screening and Resident Interview (PASARR, an assessment that screened individuals with a mental disorder or intellectual disability to determine if admission to the facility was appropriate) was inaccurate for one out of three sampled residents (Resident 87) when: 1. The Level 1 PASARR was missing the diagnosis of bipolar (extreme mood swings). 2. The Level 1 PASARR included the diagnosis of dementia (memory loss). This failure had the potential for newly admitted residents to be admitted to the facility without knowing if they had a mental disorder or if the facility could provide services that met their needs. Findings: 1. A policy and procedure that outlined the admission PASARR process was requested and not provided. A review of the State Operations Manual, dated 8/8/24, indicated, the PASARR screening process was To ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs. A review of the undated Admission Record, indicated, Resident 87 was admitted to the facility on [DATE] with the diagnosis of bipolar disorder. The Admissions Record indicated, on 1/11/24, Resident 87 was diagnosed with unspecified dementia, unspecified severity, with other behavioral disturbance (memory loss that did not include a specific diagnosis with a behavioral disturbance that could place themselves or others in danger). Resident 87 was not her own responsible party (did not make own decisions). During an interview on 12/17/24 at 8:35 am, the Assistant Director of Nursing (ADON) described the PASARR process. ADON stated, the hospital performed the PASARR, prior to resident admission, and the facility's medical records department was responsible to ensure the PASARR was accurate. During a concurrent interview and record review on 12/17/24 at 8:54 am, with the Health Information Assistant (HIA), resident 87's Level 1 PASARR, dated 8/2/23, was reviewed. HIA confirmed, the hospital performed the Level 1 PASARR and HIA was responsible to review it for accuracy. HIA stated, Resident 87's Level 1 PASARR did not include a diagnosis of bipolar. HIA reviewed Resident 87's Admission Record, and confirmed, Resident 87 was admitted to the facility with a diagnosis of bipolar, it was not listed on the Level 1 PASARR, and should have been. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent interview and record review on 12/17/24 at 8:54 am, with HIA, resident 87's Level 1 PASARR, dated 8/2/23, was reviewed. HIA confirmed, the Level 1 PASARR included a diagnosis of dementia. HIA reviewed the Department of Health Care Services letter, dated 8/2/23, and confirmed, Resident 87 did not receive a Level II PASARR assessment due to the Level 1 PASARR indicating, Resident 87 had dementia. HIA reviewed Resident 87's Admissions Record and confirmed, the date of Resident 87's dementia diagnosis was 1/11/24. A review of Resident 87's Level 1 PASARR, dated 8/2/23, indicated, the hospital employee that completed the Level 1 PASARR, documented Resident 87 had a diagnosis of dementia in section 15 a. During a concurrent interview and record review on 12/17/24 at 10:02 am, with Minimum Data Set (MDS) nurse, Resident 87's Discharge Summary, dated, 8/3/23, was reviewed. MDS nurse stated, there was no diagnosis of dementia listed on Resident 87's Discharge Summary. MDS nurse reviewed Resident 87's Psychiatry Note, dated 1/11/24, and stated, that was the first document, to MDS nurse's knowledge, that included a diagnosis of dementia. During an interview on 12/17/24 at 10:21 pm, the facility's ADON acknowledged there were discrepancies with the Level 1 PASARR.

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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** 43739 Based on observation, interview, and record review, the facility failed to develop and implement an individualized patient-centered care plan for one of twenty-nine sampled residents (Resident 288) when: a care plan was not developed for significant weight loss for Resident 288. As a result, Resident 288, who was identified as malnourished at admission, had a weight loss of 11 pounds or 6.24 % in 2 weeks. This failure had the potential to contribute to the risk of further weight loss and decline for Resident 288. Findings: During a review of Resident 288's clinical record, indicated she was originally admitted to the facility on [DATE]. Resident 288 had been in and out of the acute hospital and readmitted back to the facility from times to times in between 8/5/23 to 11/9/24. The most recent re-admitted to the facility was 11/9/24, the admission diagnoses included disruption of external operation (surgical) wound, difficulty in walking, and severe protein-calorie malnutrition (diagnosed on [DATE]). Resident 288 was her own responsible party, and she was capable of making her own healthcare decision. During a review of Resident 288's Minimum Data Set (MDS - an assessment and care screening tool), dated 11/27/24, the MDS indicated that Resident 288 had a brief interview for mental status (BIMS) score of 15, at section C Cognitive Patterns indicating that her cognition was intact. During a review of Resident 288' medical record titled, Initial Nutrition Evaluation Form, dated 11/15/24, in the section of Registered Dietitian (RD) evaluation, indicated that Resident 288 was at risk for weight loss due to inadequate intake, altered GI function, increased needs, pain The goals of interventions included, Weight maintenance 175 pounds +/- 3 pounds, and the staff would monitor Resident 288's oral intake, weight, skin, and all other nutritional parameters. During a review of Resident 288's weight summary, indicated Resident weighted 179.6 pounds on 11/19/24, 168.4 pounds on 12/3/24. During a concurrent observation and interview on 12/10/24 at 11:30 am, observed Resident 288 lied in bed with her eyes closed, when called by her name, Resident 288 opened her eyes but closed it shortly, appeared to be pale and tired, when asked, Resident 288 nodded her head indicating that she was tired and could not keep her eyes open. During a concurrent observation and interview on 12/11/24 at 4:13 pm, observed Resident 288 lied in bed with her eyes closed, when asked, Resident 288 opened her eyes and stated she noticed that she had lost weight, someone came and talk to her, but she did not know what the plan was for her weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/17/24 at 11:18 am, with the Restorative Nursing Aid (RNA), the RNA was checking a resident's weight in the dining room. The RNA acknowledged that she checked Resident 288 weight, and stated, We got her weight every week. When we go and put it into PointClickCare ([PCC] is a cloud-based software platform that helps long-term care providers manage patient care, clinical documentation, medication, and finance), it would show the previous weight, and it would pop up if there's significant weight loss. If the record showed weight loss, I wouldn't put the weight in, I would reweight the resident again to make sure the number was the same or close. Then I would enter the weight and tell the RD . The RNA confirmed that she reported Resident 288's weight loss to the RD by saying, I didn't make note, I just went face to face. I remembered that I reported to the RD about Resident 288's weight loss on the day I weighted her, which was 12/3/24 During a concurrent interview and record review on 12/17/24 at 12:09 pm with RD, Resident 288's progress note, weight summary, and care plan were reviewed. The RD stated that she monitored weight loss by running a weekly report and identifying who had weight loss, she said, If you see a trend, a large weight loss trend, such as five pounds weight loss, it will trigger weight loss The RD acknowledged that Resident 288 had a weight of 177 pounds on 11/13/24, 179 pounds on 11/1/24, and 168 pounds on 12/3/24. The RD did not answer whether she received the weight loss report from the RNA on 12/3/24 or not, the RD stated, Resident 288 went to the acute hospital on 11/20/24, and came back on 11/25/24, I would put a note about her weight loss, and indicated that she went to the hospital, and came back . I would put a note to indicate that I had discussed with the resident about her weight loss and the plan to help her to gain her weight The RD couldn't find the note in Resident 288's clinical record, the RD said, I thought I did. The RD admitted that the facility had weight loss Interdisciplinary Team ([IDT] - a group of people from different disciplines who work together to achieve common goals, such as providing care for a patient), and Resident 288 would have been brought into weight IDT, but the RD could not find the weight loss IDT note in Resident 288's record. Resident 288's care plan was also reviewed, and the RD confirmed that weight loss care plan was not initiated/implemented for Resident 288 as it should have. During a concurrent interview and record review on 12/17/24 at 1:06 pm with the Assistant Director of Nursing (ADON) in the ADON's office, Resident 288's weight summary, and care plan was reviewed. The ADON stated the facility had, Nutrition, hydration, and skin meeting every Wednesday, weight loss issues would be discussed in this meeting, if a resident had weight loss of nine pounds, it would be discussed in the weight loss IDT meeting. The ADON confirmed that Resident 288 had a weight loss of 11 pounds from 11/14/24 to 12/3/24, and there's no weight loss IDT meeting held for Resident 288. The ADON also confirmed that there's no weight loss care plan initiated and implemented for Resident 288. The ADON stated, I would expect the RD to identify Resident 288's weight loss issues.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to provide one out of 32 sampled residents (Resident 73) with professional standards of care when Licensed Nurses (LN) utilized a DeClogger (a long, thin, flexible, piece of plastic with a jagged end that was used to de-clog peg-tubes) on Resident 73's peg-tube (a tube that was inserted into the abdomen and delivered liquid nutrition directly into the stomach). There was no Physician's order, no monitor in place that tracked how often LN utilized the DeClogger, and there was no care plan (a document that described the care a resident needed and how that care would be provided). This failure had the potential for peg-tube malfunctions to go unnoticed and could lead to a decline in resident health status. Findings: A policy and procedure (P&P) regarding peg-tube care was requested and not provided. The P&Ps that were provided related to administering medications and feeding via the feeding tube. A review of the Job Description for LVN, dated 11/1/16, indicated, LNs would .provide prescribed nursing care and would maintain .standards of professional nursing practice. A review of the undated Admissions Record indicated, Resident 73 was admitted to the facility on [DATE] with the diagnoses of dysphagia, oropharyngeal stage (swallowing difficulty that occurred in the mouth or throat), dementia (memory loss), and gastrostomy status (surgical opening into the stomach, peg-tube). Resident 73 was not her own responsible party (did not make own decisions). A review of the DeClogger package instructions indicated, 4. Insert the DeClogger to reach the blockage and slowly rotate two times in a clockwise direction then reverse and rotate two times in a counterclockwise direction. 6. Flush tube with 30-60 cc's (unit of measure, cubic centimeter) of water. The DeClogger package included the words: Rx ONLY (for use with a physician's prescription [order]). During a concurrent observation and interview on 12/13/24 at 9:04 am, LN A was observed administering Resident 73's medication via the peg-tube. LN A was observed pouring an unmeasured amount of water that was mixed with a medication, into Resident 73's peg-tube. The water/medication mixture drained slowly. LN A opened a package that contained a yellow DeClogger, placed the DeClogger inside the peg-tube, and moved the DeClogger up and down inside the peg-tube until the water/medication mixture freely drained into Resident 73's stomach. LN A repeated that process four times while administering one medication administer through the peg-tube. After LN A de-clogged the peg-tube, LN A continued to administer medication without providing a water flush after use of the DeClogger. (continued on next page)

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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 12/13/24 at 4:01 pm, with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), Resident 73's active orders dated 11/20/24 through 12/13/24 was reviewed. DON confirmed there was no order in place for use of the DeClogger on Resident 73's peg-tube. DON and ADON stated, use of a DeClogger was a nursing intervention that did not require a Physician's order. DON reviewed Resident 73's Feeding Tube care plan, dated 2/25/24, and confirmed, the feeding Tube care plan did not include a nursing intervention for use of the DeClogger and should have. DON reviewed the Medication Administration Record, dated 12/1/24 through 12/13/24 and confirmed there was no treatment monitor in place that tracked how often LN utilized the DeClogger.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43755 Based on observation, interview, and record review, the facility failed to ensure seven of twenty-nine sampled residents (Resident 5, 334, 23, 29, 73, 291, and 46) received the necessary treatment and services to maintain ADL's (activities of daily living). when: 1. Resident 5's lunch tray was not set up by staff and therefore she was unable to eat. 2. Resident 334's fingernails were long with black matter underneath them. 3. Resident 23 stated, staff did not assist with oral care or hair brushing unless Resident 23 asked for help. 4. Resident 29's hair was tangled. 5. Resident 73's mucus membranes (the moist, inner lining if the mouth) were dried and contained a thick, white, debris that was attached to the roof of the mouth and the tongue. 6. Resident 291 didn't receive consistent oral care. 7, Resident 46 didn't receive consistent oral care. This deficient practice had the potential for the residents to decline in their abilities to achieve the resident's highest practicable well-being and quality of life. Findings: 1. A review of Resident 5's Admission Record (undated), indicated she was admitted to the facility on [DATE] with the diagnoses that included anoxic brain damage (when the brain is deprived of oxygen, which can lead to brain cell death and serious or permanent brain damage), dementia, and anxiety disorder. A review of Resident 5's quarterly Minimum Data Set (MDS, a standardized resident assessment) dated 12/2/24, indicated her Brief Interview of Mental Status (BIMS, evaluates a person's cognition, [ability to think, learn, remember, use judgement, and make decisions] with scores from 00 to 15) was 8 indicating Resident 5's cognition was severely impaired. Section GG indicated Resident 5 required supervision or touching assistance for eating. A review of Resident 5's Activity of Daily Living (ADL) Care Plan revised on 4/28/24 indicated Resident 5 had an ADL self-care performance deficit related to anoxic brain damage and advanced dementia. Resident 5's ADL care plan goal was that all her needs would continue to be anticipated and met daily. Interventions included The resident requires (Set up assistance) by (1) staff to eat. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/10/24 at 1:42 pm, Resident 5 was observed lying in bed. Resident 5's lunch tray was sitting on her over bed table next to her bed and out of Resident 5's reach. The food on the plate was uncovered and had not been touched. The milk, boost (a high protein drink), dessert, salad, dressing, and juice were covered and unopened. Resident 5 was looking around and asking for help. Resident 5 indicated that she could not reach her food and wanted to be pulled up. Resident 5 also indicated she was unable to open her milk and boost by herself and needed help. During an observation on 12/10/24 at 1:43 pm, Certified Nursing Assistant U (CNA U) was observed sitting at the bed of Resident 5's roommate and assisting with lunch. CNA U stated, whoever left the (Resident 5's) tray must not have known she needed help. CNA U indicated that Resident 5 needed help because she can only use her right arm. CNA U indicate they should have helped Resident 5 with her lunch tray, and they did not. During an interview on 12/18/24 at 2:24 pm, the Assistant Director of Nursing (ADON) indicated that when staff brought the food tray into Resident 5' room they should have reposition her and set up her tray so she could have eaten. 2. A review of Resident 334's Admission Record (undated) indicated Resident 334 was admitted to the facility on [DATE] with diagnoses that included stroke, respiratory failure, left sided paralysis, and seizures. He was unable to make his own decisions. A review of Resident 334's Admission MDS dated [DATE], indicated his BIMS score was 12 indicating Resident 334's cognition was moderately impaired. Section GG indicated Resident 334 had upper and lower impairment on one side of his body and was dependent on staff for bed mobility (moving self in bed), personal hygiene, dressing, toileting, and transfers. During an observation on 12/10/24 at 12:58 pm, Resident 334 was observed being assisted with his lunch. Resident 334's fingernails were long, chipped and had black matter underneath the nails on all fingers. During a concurrent observation and interview on 12/10/24 at 2:26 pm, with Nursing Assistant Student V (NA V), Resident 334's fingernails were observed. NA V stated, yes they are dirty and needed cutting. NA V indicated she had not noticed Resident 334's nails earlier. NA V indicated that resident fingernails should be cleaned and trimmed, if needed, when they are given a shower but if the resident is a diabetic, then we tell the nurse, and they will trim the nails. Resident 334 was not diabetic. During an interview and document review on 12/13/24 at 3:50 pm, with Licensed Nurse B (LN B), the shower sheets were reviewed. LN B indicated that nowhere on the shower sheets was there a place to document the state of resident's nails or if they were trimmed or needed trimming. LN B stated, I could see them (the nails) getting missed. LN B indicated that there was no place to document that nails needed cleaning or trimmed and there should be. During an interview on 12/18/24 at 2:17 pm, Assistant Director of Nursing indicated that it was her expectations that the nails should be cleaned and cut during showers if needed. 45315 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 291's clinical record, indicated she was originally admitted to the facility on [DATE] with diagnoses which included right hip fracture, urinary tract infection (UTI- an infection in the bladder/urinary tract). Resident 291 was her own responsible party, and she was capable of making her own healthcare decision. During a review of Resident 291's Minimum Data Set (MDS - an assessment and care screening tool), dated 12/5/24, the MDS indicated that Resident 291 had a brief interview for mental status (BIMS) score of 9, at section C Cognitive Patterns indicating that her cognition was mildly impaired. During a review of Resident 291's MDS at section GG - Functional Abilities and Goals, the MDS indicated it was incomplete, and was in progress. (see F 636). During a review of Resident 291's Admission Summary progress note, dated 12/1/24 at 3:17 pm, indicated Resident 291 was admitted to the facility for Physical Therapy, Occupational Therapy, and ADL assistance. During a review of Resident 291's Interdisciplinary team note (IDT-a group of people from different disciplines who work together to achieve common goals, such as providing care for a patient), dated 12/6/24, at 11:21 am, indicated, Resident 291 was here for Physical Therapy, Occupational Therapy with goals working towards safe transfers and ADL assistance. During a concurrent observation and interview on 12/11/24 at 8:24 am, in Resident 291's room, when asked about staff offering oral hygiene care, Resident 291 stated, They don't do that, I wish they did, it felt awful On Resident 291's bedside table, and in the bathroom, oral hygiene items, such as a toothbrush, and toothpaste, were not located. During a concurrent observation and interview on 12/12/24 at 11:59 am, in Resident 291's room. CNA U stated that she did Resident 291's ADLs in the shower room when Resident 291 had shower day, if not her shower day, CNA U would provide the care at the bedside. CNA U stated that Resident 291's toothbrush, comb, and toothpaste should be kept inside the drawer of Resident 291's bedside table. Observed CNA U checking Resident 291's bedside table, and the bathroom, CNA U confirmed that she could not locate those items. CNA U stated that CNAs documented what ADLs care were provided for the residents in the residents' record. CNA U said, Everything is there. During a concurrent observation and interview on 12/12/14 at 1:52 pm, with LN W, the LN W stated CNAs provided oral care in the morning for the residents. LN W stated, Every resident had their nightstand, we kept their brushes inside a bag, and the bag was kept inside the nightstand drawer. Observed LN W went to Resident 281' room, opened the nightstand drawer, and located a bag with toothbrush, toothpaste, and comb. Resident 281 stated the staff provided oral care for him in the morning. During a concurrent interview and record review on 12/16/24 at 9:30 am, with LN X, Resident 291's record titled, ADL-Personal Hygiene, dated 12/1/24 to 12/12/24 was reviewed. The record indicated Personal hygiene including coming hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and Resident 219 was provided with such care on: - 12/1/24, at 1:48 pm. - 12/2/24, at 12:18 am, 1:58 pm, and 10:17 pm. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 12/3/24, at 12:25 pm. - 12/4/24, at 11:18 am, and 10:57 pm. - 12/5/24, at 10:24 pm. - 12/6/24, at 3:26 pm, and 9:35 pm. - 12/7/24, at 8:53 am. - 12/8/24, 1:34 am, and 1:38 pm. - 12/9/24, at 1:30 am, and 9:33 am. - 12/10/24, at 12:26 am, and 6:03 pm. - 12/11/24, at 10:03 pm. - 12/12/24, at 6:48 am, and 9:59 am. The ADL record indicated nine out of twelve days, Resident 291 did not receive personal hygiene care in the morning, before/ and or after breakfast. LN X stated breakfast time was around 8 am, and the record was correct, LN X said, That's the correct record to look at the resident's ADL service, we look at that too. 7. Resident 46 During a review of Resident 46's clinical record, indicated he was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses which included protein-calorie malnutrition, pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of right hip and left hip, stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). Resident 46 was not his own responsible party, but he had the capacity to understand & make health care decision and/or participate in treatment plan. During a review of Resident 46's MDS, dated [DATE], the MDS indicated that Resident 46 had a BIMS score of 14, at section C Cognitive Patterns indicating that his cognition was intact. During a review of Resident 46's MDS at section GG - Functional Abilities and Goals, dated 11/12/24, indicated Resident 46 need partial/moderate assistance (helper lifts, held, or supports trunk of limbs) for Oral hygiene. During an interview on 12/11/24 at 8:34 am, with Resident 46, in Resident 46' room, when asked about staff offering oral hygiene care, Resident 46 stated that the staff had never offered him oral care or washing his face. Resident 46 said, I would like to have On Resident 46's bedside table, and in the bathroom, oral hygiene items, such as a toothbrush, and toothpaste, were not located. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/13/24 at 9:54 am, with CNA Z, in Resident 46's room, the CNA Z stated, Night shift provided oral care in the morning, I didn't do oral care before breakfast. We did oral care after each meal, and before bedtime. At 10:37 am, observed CNA Z checking Resident 46's the drawer of the bedside table, and the bathroom, CNA Z confirmed that she could not locate Resident 46's oral hygiene items. CNA Z stated, It should be there. For me, after I was done with the oral care, I would leave the toothbrush inside the drawer. During a review Resident 46's record titled, ADL-Personal Hygiene, dated 12/1/24 to 12/12/24, The record indicated Resident 46 was provided with inconsistent care on: - 12/1/24, at 10:34 am. - 12/2/24, at 6:45 am, and 10:29 am. - 12/3/24, at 12:14 am, and 9:41 am. - 12/4/24, at 2:54 am, 11:05 am, and 10:49 pm. - 12/5/24, at 3:39 pm, and 10:05 pm. - 12/6/24, at 2:44 pm, and 9:52 pm. - 12/7/24, at 9:16 am, and 10:13 pm. - 12/8/24, at 9:04 am. - 12/9/24, at 1:03 am, 2:02 pm, and 9:03 pm. - 12/10/24, at 6:22 pm. - 12/11/24, at 4:59 am, 5:38 pm, and 10:52 pm. - 12/12/24, at 6:59 am, 6:59 pm, and 9:42 pm. During an interview on 12/13/24 at 10:27 am, with the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) in the Administrator's office, the ADON stated, Oral hygiene care is indicated in each resident's care plan. It's provided before and after each mean, and before bedtime. The DON stated, It depends. Some residents wanted to have it done before they ate, some preferred after. So, it's personal preference. The ADON stated the personal preference would also indicate in the residents' care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for two out of 29 sampled residents (Residents 44 and 5) when: 1. Coccyx (the skin over the tailbone) treatments were not provided for Resident 44 who had Moisture Associated Skin Damage (MASD, skin breakdown caused by prolonged expsure to moisture). This failure had the potential for Resident 44's health and wellbeing to decline and her skin redness to worsen. 2. The facility failed to ensure consistent assessments of a skin condition for Resident 5. This failure had the potential for a change in condition to go unattended, with possible negative health outcomes for Resident 5. Findings: During a review of the facility's policy and procedure (P&P) titled Skin Integrity (undated), the P&P indicated, In an effort to maintain the resident's optimal level of skin integrity and promote healing of skin . wounds, the Center has a systematic approach and monitoring process for evaluating and documenting skin integrity. In the even that a resident is admitted with or develops a skin . wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds. During a review of the facilities policy titled Medication Administration, reviewed 9/18, the policy indicated The resident's MAR/TAR (Medication Administration Record/ Treatment Administration Record) is initialed by the person administering the medication, in space provided under the date, and on the line for that specific medication dose administration and time. A review of Resident 44's Admission Record (undated) indicated Resident 44 was admitted to the facility on [DATE] with diagnoses that included Sepsis (serious infection) due to Escherichia Coli (a bacteria [germ] found in fecal matter), urinary tract infection, chest pain, Parkinson's (a progressive disorder that affects the nervous system and causes tremors, stiffness and slowing of movement), diabetes (high sugar in the blood) , lung disease, anxiety disorder, heart failure, and chronic kidney disease. She made her own decisions about her health care. A review of Resident 44' Annual Minimum Data Set (MDS, a standardized resident assessment) dated 11/8/24 indicated her cognition was intact. Resident 44 was dependent fully on staff for toileting, perineal hygiene (cleaning her bottom after going to the bathroom), showering, and bathing. Resident 44 was incontinent of bowel and bladder and used disposable briefs. During an interview on 12/11/24 at 2:34 pm, Resident 44 indicated she had sores to her bottom and the inside of her thighs because she sat in her urine and poop. Resident 44 stated I just get them cleared up and then I sit in my urine again and they open up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/16/24 at 2:29 pm, Certified Nursing Assistant AA (CNA) indicated that Resident 44 had redness on her bottom and in-between her thighs. CNA AA indicated Resident 44 was incontinent of urine and bowel and had a lot of moisture to her skin. CNA AA indicated she assisted Resident 44 with brief changes every one-and-a-half to two hours during her shift. During an interview and record review on 12/16/24 at 2:39 pm, Treatment Nurse (TN) indicated that Resident 44 had recurring redness on her buttocks. TN stated, It tends to get better than breakdown again. A review of Resident 44's December TAR showed an order dated 12/5/24 for coccyx MASD (moisture associated skin damage): cleanse with NS (normal saline) pat dry, apply Medi-honey (a treatment cream) and foam sacral (coccyx) dressing every day and evening shift . Out of 22 opportunities for treatments 13 opportunities were not documented as being done. TN indicated that according to Resident 44's TAR the treatments had not been done as ordered and they should have been. During an interview with the Assistant Director of Nursing (ADON) and record review on 12/18/24 10:31 am, Resident 44's December TAR was reviewed. The ADON confirmed there was missing documentation for the coccyx treatments, so she could not confirm that the treatments were done. The ADON indicated she expected her staff to render the treatments and sign the TAR when done. 41567 2. Resident 5 was admitted to the facility with anoxic brain damage (in which the brain was deprived of oxygen for sufficient time to cause permanent damage,) dementia (a general term for a progressive decline in thinking, behavioral and social skills that affects a person's ability to function,) and lymphedema (a chronic condition in which lymph fluid does not drain properly and builds up in the tissues, causing them to swell), among other diagnoses. Resident 5 did not have capacity to make her own healthcare decisions. A review of Resident 5's orders was made. On 12/2/24, an order was created, to take effect on 12/3/24: LLE (left lower extremity, or leg) venous ulcers (sores that develop on the skin due to problems with blood flow through the veins) scabs - monitor for s/s (signs/symptoms) of worsening/infection every shift. A review was made on 12/18/24 of a treatment administration record for the month of December 2024. From 12/3/24 through 12/17/24 there were 30 shifts when Resident 5's LLE should have been monitored for worsening of her skin condition. There were 7 shifts in which it appeared the order was not followed. A concurrent interview and record review was conducted on12/18/24 2:10 pm, with the Assistant Director of Nurses (ADON). Resident 5's medical record was reviewed to determine if nursing staff had documented monitoring the ulcerations elsewhere; four records were found that confirmed nurses had followed the order and charted in nursing notes or health notes. ADON confirmed that there were three shifts (12/3/24 day shift; 12/10/24 day shift, 12/11/24 day shift) in which the assessments were not performed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to ensure appropriate care was provided to prevent urinary tract infections (UTI's, a clinically detectable condition associated with invasion by disease causing microorganisms [germ] of some part of the urinary tract) for one of 29 sampled residents (Resident 44) when Certified Nursing Assistances did not do complete and proper peri-care (the process of washing the genital and anal areas) after incontinent episodes. This deficient practice had the potential to cause UTI's for incontinent residents and a decline in health status. A review of Resident 44's Admission Record (undated) indicated Resident 44 was admitted to the facility on [DATE] with diagnoses that included Sepsis (serious infection) due to Escherichia Coli (E-Coli, a microorganism [germ] found in the bowel[stool] and commonly causes UTI's), urinary tract infection, chest pain, Parkinson's (a progressive disorder that affects the nervous system and causes tremors, stiffness and slowing of movement), diabetes (high sugar in the blood) , lung disease, anxiety disorder, heart failure, and chronic kidney disease. She made her own decisions about her health care. A review of Resident 44' Annual Minimum Data Set (MDS, a standardized resident assessment) dated 11/8/24 indicated her cognition was intact. Resident 44 was dependent fully on staff for toileting, perineal hygiene (washing of the bottom after going to the bathroom), showering, and bathing. Resident 44 was incontinent (involuntary loss) of bowel and bladder and used disposable briefs. During an interview on 12/11/24 at 2:42 pm, Resident 44 stated They do not clean me (after an incontinent episode of urine and bowel) well enough, and I have to ask them to clean me better because I can feel stuff down there. I have been in and out of the hospital for UTI's (urinary tract infections) During an interview on 12/16/24 at 2:25 pm, Certified Nursing Assistant AA (CNA AA) indicated that Resident 44 had complained to her that some CNA's did not clean her bottom very well after an incontinent episode. CNA AA indicated that she had found dried bowel inside Resident 44's vagina when she came on shift which indicated Resident 44 had not been cleaned completely after her last incontinent episode of bowel. A review of Resident 44's lab results for urine analysis in July 2024 and November 2024 showed E-coli grew in her urine. Resident 44 was put on antibiotics for the infections. During an interview on 12/17/24 at 2:41 pm, Infection Preventionist (IP) indicated that he had not done peri-care training with cna's. The IP indicated that Resident 44 had told him about her concerns that cna's were not doing proper peri-care The IP indicated Resident 44 had frequent UTI's. The IP indicated that his expectations with peri-care was that they should do a thorough job with cleaning. Staff should wash from front of the peri area to the back and ensure that there is no bowel left. IP indicated that it could cause a UTI if there was bowel left there. During an interview on 12/18/24 at 2:42 pm, the Assistant Director of Nursing indicated it was her expectation for residents to be cleaned completely. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Centers for Disease Control (CDC) Urinary Tract Infection Basics indicated UTI's are common infections that happen when bacteria (E-Coli), often from the skin or rectum, enter the urethra and infect the urinary tract. Risk factors include poor hygiene.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observations, interview, and record review, the facility failed to maintain the nutritional status for one of three sampled residents (Resident 288), when Resident 288 had insidious weight loss within a month timeframe (from 11/19/24 to 12/3/24). The weight loss was not identified, and intervention was not implemented. As a result, Resident 288, who was identified as malnourished at admission, had a weight loss of 11 pounds or 6.24 % in 2 weeks. This failure had the potential to contribute to the risk of further weight loss and decline for Resident 288. Findings: During a review of the facility's policy titled, Weight Policy, no revised date provided, indicated, The nursing center utilizes weights as one component of data collection needed to evaluate resident's nutritional status, fluid retention or diuresis. The process, included: a. Weight criteria - New Admission: weight resident within 24 hours of admission then weekly for one month; hospital weights are not used as nursing center weights. b. Weekly weights - for residents who may need to be weighted weekly (not all inclusive): - Food intake has declined and persisted. - Slow trending of weight loss/gain; significant weight loss/gain - 5 % in 30 days - Significant change of condition. c. Re-weight: - Any weight with a 5-lb variance is re-weighted within 72 hours. - Only after a re-weight has been completed will a weight be recorded on the permanent weight record. - If a significant variance is actual after re-weigh, the Restorative Nursing Aid (RNA) or designee will complete an electronic notification. The nurse will notify resident/resident's authorized representative and the physician. There notifications are recorded in the progress notes of the medical record. - Registered Dietitian (RD) or designee reviews the weights and determines which residents are evaluated. RD or designee makes recommendations as needed. d. Process for Obtaining and Recording Weights: - Weights are obtained by RNA or designee. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Notification to physician, resident/responsible party of significant changes in weight and document notification in progress notes. Progress notes to include responses as applicable. During a review of Resident 288's clinical record, indicated she was originally admitted to the facility on [DATE]. Resident 288 had been in and out of the acute hospital and readmitted back to the facility from times to times in between 8/5/23 to 11/9/24. The most recent re-admitted to the facility was 11/9/24, the admission diagnoses included disruption of external operation (surgical) wound, difficulty in walking, and severe protein-calorie malnutrition (diagnosed on [DATE]). Resident 288 was her own responsible party, and she was capable of making her own healthcare decision. During a review of Resident 288's Minimum Data Set (MDS - an assessment and care screening tool), dated 11/27/24, the MDS indicated that Resident 288 had a brief interview for mental status (BIMS) score of 15, at section C Cognitive Patterns indicating that her cognition was intact. During a review of Resident 288' medical record titled, Initial Nutrition Evaluation Form, dated 11/15/24, in the section of Registered Dietitian (RD) evaluation, indicated that Resident 288 was at risk for weight loss due to inadequate intake, altered Gastrointestinal (the organs and system involved in digestion) function, increased needs, pain The goals of interventions included, Weight maintenance 175 pounds +/- 3 pounds, and the staff would monitor Resident 288's oral intake, weight, skin, and all other nutritional parameters. During a review of Resident 288's weight summary, indicated Resident weighed 179.6 pounds on 11/19/24, 168.4 pounds on 12/3/24. During a concurrent observation and interview on 12/10/24 at 11:30 am, observed Resident 288 lied in bed with her eyes closed, when called by her name, Resident 288 opened her eyes but closed it shortly, appeared to be pale and tired, when asked, Resident 288 nodded her head indicating that she was tired and could not keep her eyes open. During a concurrent observation and interview on 12/11/24 at 4:13 pm, observed Resident 288 lied in bed with her eyes closed, when asked, Resident 288 opened her eyes and stated she noticed that she had lost weight, someone came and talk to her, but she did not know what the plan was for her weight loss. During a concurrent observation and interview on 12/17/24 at 11:18 am, with the Restorative Nursing Aid (RNA), the RNA was checking a resident's weight in the dining room. The RNA acknowledged that she checked Resident 288 weight, and stated, We got her weight every week. When we go and put it into a cloud-based software platform that helps long-term care providers manage patient care, it would show the previous weight, and it would pop up if there's significant weight loss. If the record showed weight loss, I wouldn't put the weight in, I would reweight the resident again to make sure the number was the same or close. Then I would enter the weight and tell the RD . The RNA confirmed that she reported Resident 288's weight loss to the RD by saying, I didn't make note, I just went face to face. I remembered that I reported to the RD about Resident 288's weight loss on the day I weighted her, which was 12/3/24 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/17/24 at 12:09 pm with RD, Resident 288's progress note, weight summary, and care plan were reviewed. The RD stated that she monitored weight loss by running a weekly report and identifying who had weight loss, she said, If you see a trend, a large weight loss trend, such as five pounds weight loss, it will trigger weight loss The RD acknowledged that Resident 288 had a weight of 177 pounds on 11/13/24, 179 pounds on 11/1/24, and 168 pounds on 12/3/24. The RD did not answer whether she received the weight loss report from the RNA on 12/3/24 or not, the RD stated, Resident 288 went to the acute hospital on 11/20/24, and came back on 11/25/24, I would put a note about her weight loss, and indicated that she went to the hospital, and came back . I would put a note to indicate that I had discussed with the resident about her weight loss and the plan to help her to gain her weight The RD couldn't find the note in Resident 288's clinical record, the RD said, I thought I did. The RD admitted that the facility had weight loss Interdisciplinary Team ([IDT] - a group of people from different disciplines who work together to achieve common goals, such as providing care for a patient), and Resident 288 would have been brought into weight IDT, but the RD could not find the weight loss IDT note in Resident 288's record. Resident 288's care plan was also reviewed, and the RD confirmed that weight loss care plan was not initiated/implemented for Resident 288 as it should have. During a concurrent interview and record review on 12/17/24 at 1:06 pm with the Assistant Director of Nursing (ADON) in the ADON's office, Resident 288's weight summary, and care plan was reviewed. The ADON stated the facility had, Nutrition, hydration, and skin meeting every Wednesday, weight loss issues would be discussed in this meeting, if a resident had weight loss of nine pounds, it would be discussed in the weight loss IDT meeting. The ADON confirmed that Resident 288 had a weight loss of 11 pounds from 11/14/24 to 12/3/24, and there's no weight loss IDT meeting held for Resident 288. The ADON also confirmed that there's no weight loss care plan initiated and implemented for Resident 288. The ADON stated, I would expect the RD to identify Resident 288's weight loss issues.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45315 Based on observation, interview, and record review, the facility failed to implement downtime policies and procedures (P&P) when there was an internet outage on 12/13/24. This failure caused an inability for facility staff to access the residents electronic medical record (EMR) and could cause a delay in resident care needs. Findings: A review of the undated P&P titled, Downtime Access to Patient Records, indicated, Each day HER Support will run and save a copy of the 24 Hr. Summary. The P&P indicated, Staff members will have access to the downtime folder and will be able to pull up the 24 Hr. Summary for review or print out hard copy. The P&P indicated, In the event of a network outage or scheduled network maintenance, staff will be able to access the EMR system (Point Click Care) by using a jetpack device to connect to wireless network. We will then activate emergency access protocol to allow staff to access the EMR remotely. During a concurrent observation, located at the East Wing nurses' station, and interview on 12/13/24 at 7:11 am, unidentified staff members were observed talking to each other about the facility's internet. An unidentified staff member stated, the internet had been down since midnight. Licensed Nurse (LN) A confirmed the internet had been down since midnight and stated unawareness of the downtime plan. LN A stated, the facility provided a cell phone that could be utilized for accessing the Medication Administration Record (MAR, document that indicated what medications were due, at what time, and LN utilized to sign that the medication was provided), however, there was no way to document the medication was provided until the internet came back on. LN A stated, LN A was not able to log into the computer system utilizing the cell phone and had no access to resident records. During an observation, located at the East Wing nurses' station, on 12/13/24 at 7:20 am, LN A and LN B were observed stating they could not log into the facility's computer system using the cell phones that had been provided. LN A was observed looking at a desktop computer with an unidentified staff member. The unidentified staff member stated, there was one desktop computer at every nurse's station that worked and could be utilized to access the EMR. The CCM was observed at the nurse's station on the phone with the facility's Information Technology (I.T.) department discussing the current situation. During a concurrent observation, located at the East Wing nurses' station, and interview on 12/13/24 at 7:25 am, LN B stated, LN B was required to call the facility's I.T. department to unblock LN B's access so that LN B could utilize the cell phone and access the resident's MAR. The facility's Assistant Director of Nursing (ADON) was observed talking to the LN's and informing them that the paper MARS were currently being printed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/13/24 at 7:50 am, LN A and LN B were observed at the East Wing nurses' station, attempting to log into the computer system utilizing the computers and cell phones. LN A and LN B both stated, the desk top computer could be utilized to access the EMR, but they could not print from it. During an observation, located at the East Wing nurses' station, on 12/13/24 at 8:22 am, LN A and LN B were both observed stating they still had no access to the facility EMR. During an observation, located at the East Wing nurses' station, on 12/13/24 at 8:26 am, Nurse Practitioner (NP) was observed stating there was a jetpack device that could be used to access the internet and was observed assisting LN A with the jetpack device. NP was observed stating, I don't know why we have a jet pack at all these nurses' stations, if they aren't working. During a concurrent observation, located at the East Wing nurses' station, and interview on 12/13/24 at 8:29 am, LN A was observed on the phone with the I.T. department attempting to gain access to the EMR utilizing the facility's cell phone. LN A stated, the I.T. department stated, the internet was down and the I.T. department was not able to assist LN A. During an observation, located at the East Wing nurses' station, on 12/13/24 at 8:32 am, NP was overheard on the phone stating, the I.T. department was not being helpful, was unable to access resident records, and stated the jet pack devices were not working. During an observation on 12/13/24 at 8:42 am, an unidentified male arrived at the East Wing nurses' station with paper MARS. During an observation, located at the East Wing nurses' station, on 12/13/24 at 8:54 am, the ADON was observed stating that the facility's internet was back on. During an observation, located at the East Wing nurses' station, on 12/13/24 at 9:04 am, LN A was observed logged into the facility's computer system and preparing to administer morning medications to the residents. During an interview on 12/16/24 at 8:34 am, the ADON confirmed, the facility's internet had been down since midnight on 12/13/24 and the jet pack devices did not work.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review the facility failed to provide necessary monitoring for one out of two sampled residents (Resident 87) while on an antipsychotic (a medication that altered the brain, caused a change in mood, awareness, thought, feelings, or behaviors) medication when: 1. Resident 87 was prescribed Asenapine (an antipsychotic medication that can be used to treat bipolar [a serious mental illness that caused mood swings] disorder) Transdermal Patch (a patched that was placed on the skin) and there was no monitor in place that tracked specific behaviors for the use of Asenapine. 2. Resident 87 was prescribed Haloperidol (Haldol, an antipsychotic medication that can be used to treat bipolar disorder) and there were no monitors in place that assessed for adverse reactions (side effects that could be serious or dangerous). These failures had the potential for serious or dangerous medication side effects to go unnoticed and could cause a decline in Resident 87's physical, mental, and psychosocial well-being. Findings: 1. A review of the facility's undated policy and procedure (P&P) titled, Psychoactive and Behavior Management Policies and Procedures, indicated, the Medication Administration Record (MAR) would include tracked and documented behaviors that were exhibited. A review of the undated Admissions Record, indicated, Resident 87 was admitted to the facility on [DATE] with the diagnoses of dementia (memory loss), bipolar disorder, and unspecified psychosis not due to a substance or known physiological condition (symptoms could include hallucinations [seeing or hearing things not there], delusions [having false/untrue beliefs], disorganized thinking and or behavior). Resident 87 was not her own responsible party (not able to make own decisions). A review of the Active Orders, dated 12/13/23, indicated the physician ordered Asenapine Transdermal Patch 24-hour 3.8 milligram (mg, unit of measure) every 24 hours. Apply one patch on the skin one time a day for bipolar disorder as evidenced by (AEB, specific behaviors) mood swings and outburst. During a concurrent interview and record review on 12/18/24 at 10:36 am, with Registered Nurse/ Neuropsychiatric Assistant (RN/NA), Resident 87's MAR, dated 12/1/24 through 12/18/24 was reviewed. RN/NA confirmed, the MAR indicated, there was no monitor in place that tracked specific behaviors regarding the use of Asenapine and there should be. 2. A review of the facility's undated P&P titled, Psychoactive and Behavior Management Policies and Procedures, indicated, facility staff would monitor residents that were prescribed antipsychotics for complications or side effects. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Active Orders, dated 2/25/24, indicated the physician ordered Haloperidol cream 5 mg/milliliter (ml). Apply 1 ml to the wrists and forearms every eight hours for mood swings AEB emotional outburst and aggression. During a concurrent interview and record review on 12/18/24 at 10:36 am, with RN/NA, Resident 87's MAR, dated 12/1/24 through 12/18/24 was reviewed. RN/NA confirmed, there was no monitor in place that indicated, facility staff would monitor Resident 87 for complications or side effects from the use of Haldol and there should be.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility had a 27.59% medication error rate when eight medication errors out of 29 total opportunities were observed during medication passes for two out of six sampled residents (Residents 73 and 184). These failures had the potential to compromise the resident's health status. Findings: A review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 1/1/07, indicated, medication would be administered utilizing good nursing principles and in accordance with physician orders. A review of the undated Admissions Record indicated, Resident 73 was admitted to the facility on [DATE] with the diagnoses of dysphagia, oropharyngeal stage (swallowing difficulty that occurred in the mouth or throat), dementia (memory loss), and gastrostomy status (surgical opening into the stomach, [peg-tube also called g-tube, that delivered liquid nutrition and medication]). Resident 73 was not her own responsible party (did not make own decisions). A review of the Medication Administration Record, dated 12/1/24 through 12/13/24, indicated, Resident 73 received the following morning medications: Amlodipine Besylate (treated high blood pressure) 5 milligrams (mg, unit of measure), give one tablet via g-tube daily, Lansoprazole (treated heart burn caused by excessive stomach acid) give one capsule via g-tube one time a day, mix with 10 ml of water, docusate sodium (treated constipation) 100 mg, give one tablet via g-tube, two times a day, levetiracetam (treated seizure disorders) oral solution (liquid) 100 mg/ml, give 7.5 ml via g-tube every 12 hours, multivitamin with minerals (a supplement), give one tablet via g-tube once a day, Juven packet (a nutritional supplement) give one packet via g-tube one time a day, mix with 6-8 ounces of water, and Biotene Spray (treated dry mouth) give two sprays by mouth four times a day (the manufacture recommendations written on the box indicated, once the medication was sprayed in the mouth, it was to be spread thoroughly inside the mouth. The MAR indicated, the g-tube would be flushed with 15-30 ml of water before and after each medication pass and there were no instructions that indicated how much water would be used to flush the g-tube in-between each medication that was administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview, and record review on 12/13/24 from 9:16 am to 9:47 am, Licensed Nurse (LN) A was observed preparing Resident 73's morning medication that was to be administered via Resident 73's peg tube. LN A was observed opening the Juven packet and mixing it with an unmeasured amount of water. LN A prepared two additional cups of unmeasured water to be utilized as water flushes (used to flush the g-tube in between each individual medication that was administered). LN A opened the Lansoprazole capsule and added the medication beads into a medication cup and added 10 ml of cold water. LN A stated, the beads from inside the capsule did not dissolve easily and confirmed, LN A was unaware that the medication label indicated, that warm water was to be used to dissolve the Lansoprazole. LN A was observed providing an unmeasured water flush prior to medication administration and an unmeasured water flush in between each medication that was administered via the g-tube. LN A attempted to administer the Lansoprazole five times; each time LN A added more water to the medication cup to get the entirety of the medication. LN A was observed setting the medication cup down, looked at the remaining Lansoprazole in the medication cup and stated, Well, I got a majority of it. LN A was asked how LN A was able to measure the water flushes or the water used to mix the Juven packet when the cups did not have measurements on them. LN A confirmed, the cups that were utilized to flush the g-tube with water and mix the contents of the Juven packet did not contain measurements and stated, LN A was unsure how much water was being used. LN A was observed spraying Biotene Spray into Resident 73's mouth and did not spread the spray around inside Resident 73's mouth. A review of the Minimum Data Set (MDS, a comprehensive assessment), dated 5/16/24, indicated, Resident 173 was admitted to the facility on [DATE] with the diagnosis of malnutrition (not enough food or vitamins that the body needed). During a concurrent observation and interview on 12/13/24 at 10:06 am, LN T was observed preparing morning medication for Resident 184. LN T was observed looking through the medication cart for vitamin D3 125 mg and stated, there was none, and LN T needed to go to the medication storage room to obtain a new bottle. LN T was observed looking through three different medication storage rooms and stated an inability to find vitamin D3 150 mg. LN T stated, LN T would notify Resident 173's physician that vitamin D3 was not provided per the order and would contact the pharmacy to have it delivered to the facility. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/13/24 at 4:01pm, with Director of Nursing (DON), Resident 73's current physician orders dated 11/20/24 through 12/13/24 was reviewed. DON stated, there should be an order that indicated, LN would flush the g-tube with 5-10 ml of water in between each medication and confirmed there was no order present. DON stated the reason for flushing the g-tube in between each individual medication was due to not knowing how the medication would react if mixed in the g-tube. DON confirmed, the physician order dated, 11/20/24 indicated, LN would perform a 15-30 ml water flush before and after each medication administration pass. DON stated, this order indicated, 15-30 ml of water would be used to flush the g-tube prior to and after the medication administration and was in addition to the 5-10 ml of water flush that was provided in between each individual medication that was provided. DON stated the expectation for mixing the Juven packet with water was for LN to use six ounces of water. The photo of the Juven packet was reviewed, DON confirmed the manufacture recommendation was to use 8-10 ml of water, not 6-8 ml of water per the order. DON observed the cup that was used to flush Resident 73's g-tube with water and used for the Juven packet. DON confirmed, the bottom of the cup indicated, it held 5 ounces of water (5 ounces of water is equal to 147 ml of water) and did not meet the manufacture recommendations of using 8-10 ounces of water to mix the Juven packet. DON reviewed the Biotene Spray package and acknowledged the manufacture recommendation for use indicated, Biotene Spray was to be spread around the mouth. DON acknowledged, LN T did not provide vitamin D3 to Resident 184 and stated, that the facility should not have run out of medication. DON acknowledged the medication errors and stated they should not have happened.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to store and label drugs in accordance with professional standards when: 1. The label attached to a medication container did not match the Physician's order. 2a. The freezer section, located in the medication refrigerator, of the [NAME] Wing medication storage room, contained ice build up and had icicles hanging from the freezer. 2b. An e-kit, (emergency medication) that was in the medication refrigerator of the [NAME] Wing medication storage room, was placed inside a tray like container that contained ice and clear liquid. 3. The medication cart, located on the [NAME] Wing, contained 2 unlabeled medication cups, each containing resident medication, and a pill cutter (a device that was used to cut pills in half) that was covered in residual pill powder. 4. The e-kit, located in the East Wing medication room contained two vials of liquid Ativan (a controlled substance that was used to treat anxiety disorders) was expired (not to be used). 5. The East 3 medication cart contained a loose pill. 6. The East 2 medication cart contained a pill cutter that was covered in residual pill powder and had medication and cleaning supplies stored together. 7. There was an unlabeled bag with the brand name Kangaroo (a bag that was used to administer water through a peg-tube) hanging from a pole in Resident 73's room. These failures resulted in unsafe medication storage and had the potential for medications to cross contaminate (mix) with residual pill powder. Findings: 1. A review of the facility's policy and procedure (P&P) titled, Medications and Medication Labels, dated [DATE], indicated, Improperly or inaccurately labeled medications are refused and returned to the dispensing pharmacy. The P&P indicated, when the medication directions changed, the Licensed Nurse (LN) would place a direction change sticker on the label, notify the pharmacy so a new label could be made, and LN would compare the medication to the Physician's order prior to administering the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 11:55 am, LN M was observed preparing medication for Resident 60. The label indicated, the Nurse Practitioner prescribed modafinil (a medication that treated excessive sleepiness) 100 milligram (unit of measure), one tablet by mouth as needed. LN M reviewed Resident 60's order and stated, the medication was to be taken once daily, not as needed, and the label was incorrect. LN M was asked if LNs were expected to compare medication labels to the orders and LN M stated, we probably should be looking at that. During a concurrent interview and record review, on [DATE] at 4:01 pm, the Director of Nursing (DON) reviewed the photo of Resident 60's modafinil and compared the label to the order. DON confirmed the label, and the order did not match and should have. DON stated, comparing the medication label to the order was a part of the residents five rights to medication administration. 2a. During a concurrent observation and interview, on [DATE] at 2:34 pm, located the [NAME] Wing medication room, with the DON, the freezer section of the medication refrigerator was observed. The freezer contained a build up of ice and had icicles hanging from the outside, bottom of the freezer. 2b. A review of the facility's P&P titled, Medication Storage dated [DATE], indicated, the refrigerator would be kept clean and frost free. The P&P indicated, To protect refrigerated medication from freezing, store them away from the freezer section. During a concurrent observation and interview, on [DATE] at 2:34 pm, located the [NAME] Wing medication room, with the DON, the medication refrigerator was observed. A plastic tray like container was stored on the top shelf in the medication refrigerator and partially underneath the icicles hanging from the freezer. There was ice and clear liquid inside the tray like container where the e-kit was stored. DON confirmed the observations of the ice buildup, the icicles hanging from the freezer, and the water and ice in the plastic tray like container. DON stated, there was a potential for medication contamination due to the water and ice. 3. A review of the facility's P&P titled, Medication Storage dated [DATE], indicated, all medication storage areas would be kept clean. During a concurrent observation and interview, on [DATE] at 2:39 pm, with DON, the [NAME] 4 medication cart was observed. Inside the top drawer on the left side were two unlabeled medication cups stacked on top of each other. The bottom cup contained two pills, and the top cup contained one pill. Registered Nurse (RN) G stated, RN G placed the medication cups with medication in the drawer due to the resident being asleep and unable to administer at the time they were prepared. RN G confirmed, both medication cups were not labeled and stated, RN G knew who the medications belonged to and stated, they should not have been stored in the medication cart. There was a pill cutter, that was blue in color, covered in residual pill powder. DON confirmed the observations and stated, RN G should not have stored prepared medication in the medication cart and the pill cutter should be wiped clean after each use. 4. A review of the facility's P&P titled, Medication Storage dated [DATE], indicated, expired medication would be removed and not available for use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 3:55 pm, located in the East medication room, with the DON. A white sticker with an expiration date of [DATE] was attached to the e-kit. Inside the e-kit were two vials of liquid Ativan with the expiration date of ,d+[DATE] and were available for use. DON confirmed the observation and stated, the expired Ativan should not be in the e-kit. 5. During a concurrent observation and interview on [DATE] at 3:57 pm, with the DON, a loose pill was found inside the East 3 medication cart. DON confirmed the observation and stated, there should not be loose medication in the medication cart. 6. A review of the facility's P&P titled, Medication Storage dated [DATE], indicated, chemicals and germicidal cleaning agents (a cleaner that killed germs) would not be stored with medication. During a concurrent observation and interview on [DATE] at 3:59 pm, with the DON, the East 2 medication cart was observed. There was a pill cutter that was covered in residual pill powder located in the top drawer. In the bottom drawer was a box of Juven packets (a powdered nutrition drink that supported wound healing). The Juven packets were stored next to germicidal cleaning agents, and bottles that contained chemicals and discarded medication. DON confirmed, the pill cutter should be cleansed after every use and medication should not be stored with any cleaning agents or chemicals. 7. During a concurrent interview and record review on [DATE] at 4:01 pm, with the DON, a photograph of a Kangaroo bag was reviewed. DON confirmed the Kangaroo bag did not have a label that identified what was in it, and stated it should have.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42448 Based on observation, interview, and record review the facility failed to ensure the Registered Dietitian (RD) and Dietary Services Manager (DSM) provided adequate oversight of the Food and Nutrition Services (FNS) when 1. The RD did not provide evidence of regularly scheduled consultation and audits of the kitchen. 2. Effective systems and monitoring were not in place to ensure sanitation of the kitchen, food cooling, the consistency of pureed foods on tray line, and management of dented cans. 3. The facility accepted residents with requirements for Vegetarian diet, the RD and DSM reported the four-week vegetarian menu cycle and cook's spreadsheets had been in place for a while, but kitchen staff were not aware of a pre-planned vegetarian menu and did not follow it. These failures had the potential to result in foodborne illness and decline for residents consuming food from the facility. 1. RD Oversight of the Kitchen During an interview with the RD on 12/16/24 at 1:05 pm, she stated she had worked at the facility full time, 40 hours per week, for [AGE] years. Recently their part-time RD had left, and they were looking for a new person. She stated she provided oversight of FNS and worked closely with the DSM, and that she popped into the kitchen every day or two and conducted monthly audits. She stated staff knew how to communicate with her and did, and that she or the DSM conducted monthly in-services about things from the audits or residents with unusual diets. During the survey from 12/10/24 at 8:15 am through 12/16/24 at 5:15 pm, sanitation and food safety concerns were identified in the kitchen including soiled equipment and floors, potential cross contamination through staff behaviors with hair covering, apron storage, and glove use. Concerns were also identified regarding the provision of food with appropriate textures/consistencies to residents on texture-modified diets, cold food, and staff practice in provision of vegetarian meals to meet resident nutrient needs (Cross Reference F802, F803, F804, F805, F812). On 10/12/24 at 10:15 am, the Registered Dietitian was asked to provide copies of her past three kitchen inspections/audits to demonstrate her required provision of oversight of the facility's Food and Nutrition Services (FNS). During an interview with the RD on 12/16/24 at 1:05 pm, she provided a blank copy (not filled out) of a document titled Food and Nutrition Services Comprehensive Summary used for inspection of food and nutrition services areas. When asked again for her completed FNS audits, the RD responded they were internal audits, she didn't have to give them to surveyors, and the audit summary she provided was all that was needed. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a second document also titled Food & Nutrition Services Comprehensive Summary provided by the Registered Dietitian on 12/16/24 at 1:05 pm showed: September 2024 - Overall Score 82%, with scores underneath for Meal Service 88%, Food Handling 86%, Clinical 75%, Equipment 80%, Dining Service 80%. No further information. October 2024 - Overall Score 81%, with scores underneath for Meal Service 84%, Food Handling 85%, Clinical 75%, Equipment 76%, Dining Service 79%. No further information. November 2024 - Overall Score 71% with scores underneath for Meal Service 88%, Food Handling 70%, Clinical 69%, Equipment 74%, Dining Service 54%. No further information. This document of cumulative scores did not provide important information that demonstrated the RD's oversight of food and nutrition services. It did not provide insight as to why food handling scores fell from 86% in September to 70% in November, Clinical scores fell from 75% in September to 69% in November, Equipment scores fell from 80% in September to 74% in November, and Dining Service scores related to resident meals fell from 80% in September to 54% in November. Without the additional data detail and comments determined through regular FNS audits, there was no way to know if any of the regulatory compliance problems such as soiled equipment, glove use, ambient food cooling and hair restraints identified during survey had previously been identified by the RD and were being addressed. There was no way to know if in-services provided to staff were selected randomly or if they were part of a plan of correction to resolve identified problems. There was no way to connect if QAPI efforts were in place to effectively solve problems and improve care for the facility's residents. During continued interview the RD on 12/16/24 at 1:30 pm she stated current FNS QAPI (quality assurance/ performance improvement) activities for the FNS department included a committee to transition the facility to the International Dysphagia [difficulty swallowing] Diet Standardization Initiative (IDDSI) standards and terminology. She stated that a previously solved project to address weight loss may need to be re-examined. The RD did not report any FNS kitchen QAPI activities. 2. Effective systems and monitoring were not in place to ensure sanitation of the kitchen, food cooling, the consistency of pureed foods on tray line, and management of dented cans (Cross Reference F802, F805, F812). Sanitation (Cross Reference F812): During the survey spanning 12/10/24 at 8:15 am through 12/26/24 at 5:15 pm, the kitchen was not sanitary. Observations in the walk-in refrigerator included thick dust on the ceiling and walls around the condenser fan, and grime accumulation on the floor. The cook's area had a box fan thickly covered with dust located next to food preparation equipment. There was an accumulation of soil, grime, and food particles and/or tape/tape residue on food storage containers/ lids. Pots, pans and bake pans had burned on grease. The cook's prep sink was regularly used in a manner that could promote cross contamination through temporary storage of trash and rinsing/temporary storage of soiled equipment in the sink and on counters, in addition to food production activities such as preparing fresh produce, draining food, draining meat, and thawing meat and other frozen foods. There were no observations of the cooks cleaning the sink area, and on 12/11/24 at 2:26 pm when the sink and counters were piled with rinsed, soiled equipment and trash, there were no wash or sanitizer buckets set up in that area. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DSM on 12/16/24 at 11:40 am he stated he was aware staff used the cooks prep sink to defrost meat, rinse out equipment, and perform minimal fresh vegetable prep, but cooks cleaned it. Review of undated documents titled Daily Cleaning List A.M., and Daily Cleaning List P.M. together listed 57 staff assignments for daily cleaning, and showed the AM and PM cooks were responsible to clean the cook prep sink and the Robo Coops food processors. The PM cook was to Clean Prep Station without further description provided. Cleaning the walk-in refrigerator or other deep cleaning assignments were not found on any of the documents provided. During an interview with Kitchen Staff J (KS J) on 12/10/24 at 9:30 am he stated the DSM scheduled a dietary aide weekly to do cleaning. During an interview with the DSM on 12/10/24 at 9:46 am he stated, Someone deep cleans the pots and pans weekly. Review of the FNS Dietary Schedule for November 2024 and December 2024 showed position C, defined as Deep clean/ help assist tray line was scheduled twice monthly for a four-and-a-half-hour shift. Food Cooling: (Cross Reference F812) A review of the FDA (Food and Drug Administration) Food Code 2022, Section 3-501.14 showed Time/Temperature control for Safety Food shall be cooled within 4 hours to 5oC (41oF) or less if prepared from ingredients at ambient temperature, such as .canned tuna. (B) Time/temperature control for safety food shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature such as reconstituted foods and canned tuna. 3-501.14 indicated, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 41 degrees F to 135 degrees F for too long. Observations and interviews and record reviews of the menus and food cooling logs during the survey showed the facility prepared products such as egg salad, tuna salad and turkey salad for resident meals and snacks. Review of the December 2024 Cool Down Log showed no cool down log was completed for Turkey Salad on 12/2/24. Further review of the November 2024 Cool Down Log showed the Flan (like baked custard) cool down log process had not been documented through to completion. During an observation and concurrent interview on 12/10/24 at 11:20 am, KS I stated mayonnaise was stored in the reach-in refrigerator, but when he looked for it, there was none there. He stated they did not store a backup container there in addition to the opened container. During an interview with KS L, on 12/11/24 at 3:40 pm, she stated she made the sandwiches offered on the dinner menu. She stated she assembled and combined pre-chilled ingredients and then checked the temperature. The temperature goal was 41 F or lower. If it was higher than 41 F she would do the cooling process, check and record temps every two hours until it was 41 F or lower, within four hours total. KS L stated she would not write anything down in the cooling log if the first temperature was 41 F or lower. When asked how anyone would know if a staff checked the food temperature if it wasn't written down, KS L agreed they wouldn't know. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DSM, on 12/12/24 at 12:05 pm, he stated they rarely used cooling logs because they didn't use leftovers. They didn't do a cooling log for ambient foods because the ingredients come out of the refrigerator and were already cold. Pureed Diets (Cross Reference F805). During an observation and concurrent interview with KS J on 12/11/24 at 10:00 am, he explained and demonstrated his process for preparation of pureed fish for lunch tray line (Cross Reference F805). During an observation and concurrent interview with KS J on 12/11/24 at 10:00, he demonstrated and explained his process for pureeing fish (Cross Reference F 805). Review of a recipe titled Recipe: Pureed (IDDSI Level 4) Meats dated 2024, and the Thick and Easy manufacturer's instructions for use of the thickener showed it did not match the process used by KS J to prepare the pureed fish (Cross Reference F805). During evaluation of a pureed test tray on 12/11/24 at 12:50 pm, the RD, DSM and two surveyors agreed the pureed fish had a gummy consistency. The DSM stated KS J was following the recipe to a T (Cross Reference F805). Dented Cans: Review of a 2023 policy titled Food Storage - Dented Cans showed Food in unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents, or swells shall not be retained or used by the facility . All dented cans (defined as side seam or rim dents) .are to be separated from remaining stock and placed in a specified labeled area for return to purveyor for refund. During an observation in the kitchen's dry storage room on 12/10/24 at 8:55 am, five cans of beef stew with dents in their sides or rims were comingled with other food products stacked in the middle of the room. In a concurrent interview with KS J, he stated the cans were there to be used. When pointed out the cans were dented, he stated they did not use dented cans. He was unable to locate an identified place for dented can collection, stated this place is constantly changing. During an interview with the DSM on 12/10/24 at 9:46 am he was asked about the 5 cans of beef stew in the storeroom. He stated they would use the cans. He didn't notice the cans were dented until attention was drawn to that. He stated staff probably put the cans in the middle of the room so he would see them. He stated the dented can sign fell and had not been replaced. The process was for staff to put dented cans on his desk for his inspection, and he would take photos of the cans to get reimbursement from the vendor. 3. A pre-planned vegetarian menu (provides mostly plant foods, no meat/fish/poultry) cycle was not followed (Cross Reference F803). (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Facility Assessment (explains what types of patients/residents a facility will accept and services it will provide) dated 1/31/24 and signed by the Executive Director (Administrator), Director of Nursing (DON), Medical Director, and Governing Body Representative showed We as a facility, make sure we have the staff to meet the unique needs of the individuals at all times. Part 2 Services and Care We Offer Based on our Residents' Needs showed they provided nutrition - Individualized dietary requirements, liberal diets, specialized diets . cultural or ethnic dietary needs. A review of the California Health and Safety Code Section S1265.10 showed Availability of plant-based meals: (a) A licensed health facility, as defined in subdivision (a), (b), (c), (d), (f), or (k) of Section 1250, shall make available wholesome, plant-based meals of such variety as to meet the needs of patients in accordance with their physicians' orders. (b) Notwithstanding any other law, including, but not limited to, Section 1290, a violation of this section shall not constitute a crime. (c) For the purposes of this section, plant-based meals shall mean entire meals that contain no animal products or byproducts, including meat, poultry, fish, dairy, or eggs. Review of lunch tray tickets dated 12/11/24, provided by the DSM, showed Resident 291 had a lacto-ovo vegetarian food preference (ate plant foods, dairy foods, eggs, but no beef/chicken/fish/pork products). Review of the facility diet manual on 12/11/24 showed the diet manual was approved/signed by the facility RD provided rationale, guidelines, and a 1-day sample menu for a vegetarian diet, however there was no evidence the facility had a vegetarian menu cycle or cook's spreadsheets to direct cooks what to prepare. Other diets in the facility had a four-week menu cycle. During interviews with KS J on 12/12/24 at 1:35 pm, and with KS L on 12/16/24 at 11:10 am, they stated that menus and spreadsheets for vegetarian meals were not available to follow, that the cooks just made vegetarian meals that tasted good, and they tried to provide variety. The cooks normally had a vegetarian recipe binder, but it was not currently in the kitchen. On 12/12/24, surveyors requested the facility's vegetarian menu, cook's spreadsheets and nutrient analysis from the DSM and RD. A four-week menu cycle titled Good for Your Health Menus, Vegetarian Menu, dated 12/2/24 through 12/29/24 was provided to surveyors on 12/13/24. The menus showed the regular diet menu, with a separate box listing the vegetarian option for the lunch and dinner meals each day. A concurrent review of an undated document titled Cooks spreadsheet, Spreadsheet for Vegetarian, showed Vegetarian Entree with variations for portion size, texture modification, and low sodium, consistent carbohydrate, and renal diets. It directed Follow daily Vegetarian Alternatives. Replace the entree of the day with the vegetarian entree. Follow the vegetarian recipe. During an observation in the kitchen, on 12/16/24 at 9:25 am, there continued to be no vegetarian recipes or cookbooks in the cooks' area. During an interview with KS L on 12/16/24 at 11:10 am she stated she most often prepared food such as cheesy potatoes with two vegetables for Resident 291, or foods like cheesy rice or tacos. A review of the 4-week vegetarian menu cycle provided by the RD and dated 12/2/24 through 12/29/24 did not show cheesy potatoes or cheesy rice or tacos anywhere on the vegetarian menu 4-week cycle. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with DSM, on 12/16/24 at 11:40 am, he stated the vegetarian menu had been in place for a while and that the cooks followed it every day. Some residents wrote what food they wanted on the menus, and the cooks accommodated that as much as possible. During an interview with RD, on 12/16/24 at 1:30 pm, she did not respond when told kitchen staff reported they didn't follow a vegetarian menu or spreadsheet.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 42448 Based on observations, interviews and record reviews, the facility failed to ensure staff were trained, competent and following their training when: *1. The kitchen was not sanitary. *2. Staff did not consistently perform standards of professional practice to prevent cross contamination. *3. Staff did not consistently complete or document ambient food cooling temperature checks. *4. Pureed fish did not have a palatable consistency. Findings: Review of an undated document titled New Hire - OHPAC Dietary Employee Orientation Checklist showed that upon hire new employees are trained in 24 different topics, including dress code (jewelry, hair covering, aprons), proper use of aprons, equipment cleaning. Review of employee training files showed these staff completed the training: Kitchen Staff I (KS I) on 4/4/24, and KS K on 4/4/24. Review of a document titled Annual - OHPAC Dietary Employee Orientation Checklist showed 24 topics assessed, such as handwashing and glove use, dress code, apron use, cleaning equipment, cleaning and pest prevention, and monitoring tray line temperatures was discussed with staff annually. Food cooling was not included. A review of completed employee training documents showed this training was completed by KS J on 11/27/24, KS L on 9/19/24, KS Q on 8/15/24. Review of a 2018 document titled Verification of Job Competency Demonstration - Cooks included 31 topics of competency assessed initially upon hire and annually. It included use of recipes, spreadsheets and substitutions; portion sizes, food danger zones, apron use and storage, hair covering use including facial hair, glove use in food preparation and service, proper use of the cool down log, how to clean and sanitize equipment and counter tops, food storage procedures, and storage of personal items. A review of completed employee training documents showed this training was completed by: KS I in 2024; KS J in 2024; KS L in 2024. This training was discussed with Kitchen Staff Q (KS Q) in 2024 but there was no Verified By (signature) or completion date on the form. Review of a 2018 undated document titled Verification of Job Competency Demonstration - Diet Aide listed 31 topics of competency assessed initially upon hire and annually. It included apron use and storage, hair coverings use including facial hair, glove use in food preparation and service, how to clean and sanitize equipment and counter tops, food storage procedures, and storage of personal items. A review of completed employee training documents showed this training was completed by KS K in 2024, KS L in 2024, and KS Q on 4/15/24. *1. During the survey starting on 12/10/24 at 8:15 am and continuing through 12/16/24 at 5:15 pm, the kitchen was not sanitary (Cross Reference F812). (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 2022 FDA Food Code 4-601.11 showed A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. During the initial tour on 12/10/24 beginning at 8:15 am, thick dust coated the ceiling and walls near the condenser fan in the walk-in refrigerator, and the refrigerator floor had a buildup of grime. The food processor, blender, multiple storage containers and lids, and other equipment were not clean, had accumulated grime, or tape/tape residue. Pots, pans and bake pans had burned on grease. A box fan positioned near food production equipment had thick dust and grime on blades and wire frame cover (Cross Reference F812). During an interview with the Dietary Services Manager (DSM) on 12/10/24 at 9:46 am, he stated Someone deep cleans the pots and pans weekly. Review of undated documents titled Daily Cleaning List A.M., and Daily Cleaning List P.M. together listed 57 staff assignments for daily cleaning, and showed the AM and PM cooks were responsible to clean the cook prep sink and the Robo Coops food processors. The PM cook was to Clean Prep Station without further description provided. Cleaning the walk-in refrigerator or other deep cleaning assignments were not found on any of the documents provided. *2. Staff did not consistently perform standards of professional practice to prevent cross contamination (Cross Reference F812). Hair Restraints In multiple observations in the kitchen during the survey from 12/10/24 through 12/16/24, KS J wore a black cloth face mask that covered his mouth but dipped below his nose leaving his mustache exposed (Cross Reference F812). During an interview with the DSM on 12/16/24 at 11:40 am he stated hair must be covered. A hair net must be worn under a hat. Facial hair must be covered, and he had purchased multiple types of covers to help staff be comfortable. Review of an undated document provided by the facility titled Dress Code showed Hair net - all employees must wear one, even under hat, etc. [NAME] restraint if any facial hair (mustache or beard). FDA Food Code (2022) 2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from FDA Food Code 2022 Chapter 2. Management and Personnel Chapter 2 - 22 contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. Glove Use: (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility document titled, Glove Use Policy, 2023, stated, appropriate glove use is essential in preventing foodborne illness. Gloved hands are considered a food contact surface that can get contaminated. A section titled When Gloves Need To Ge Changed, showed gloves are to be changed before beginning a different task, and before handling all food. During an observation on 12/10/24 at 11:20 am, Kitchen Staff I (KS I) wore the same gloves to prepare food, touched the refrigerator door and inside contents, and then return to food preparation activities wearing the same gloves. During an observation of lunch tray line (meal assembly process) on 12/11/24 at 12:05 pm, Kitchen Staff K (KS K) wore the same gloves to placed food items on resident trays, touch the reach-in refrigerator handle and door as she obtained a sandwich for a resident, and returned to tray line without changing gloves or washing hands. Apron Use: During multiple observations in the survey, staff stored aprons in a manner that put them at risk for cross contamination. On 12/10/24 at 8:47 am an apron hung near the main entrance adjacent to staff coats. On 12/13/24 beginning at 8:05 am, new green aprons were left rolled up on an employee cart, comingled with employee food, beverages, purses and other belongings, instead of being put away in the normal clean apron storage area. During an interview with the DSM on 12/16/24 at 11:40 am he stated staff should put on an apron when starting their shift, should replace it when soiled, and should remove it when leaving the kitchen on break or to take out trash. He stated he didn't have much wall space available for a separate apron hanging area. Review of an undated document provided by the facility titled Dress Code showed proper dress included clean apron. 3. Staff did not consistently complete food cooling processes when indicated (Cross Reference F812). A review of the FDA Food Code 2022, Section 3-501.14 showed Time/Temperature control for Safety Food shall be cooled within 4 hours to 5oC (41oF) or less if prepared from ingredients at ambient temperature, such as .canned tuna. (B) Time/temperature control for safety food shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature such as reconstituted foods and canned tuna. 3-501.14 indicated, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 41 degrees F to 135 degrees F for too long. Review of the November 2024, Cool Down Log, showed five cool down entries for the month. The cooling log for Flan (a dessert similar to baked custard) on 11/16/24, indicated the flan began its cooling process at an unknown time, at 140 degrees( ) Fahrenheit (F). The next temperature check at 3:00 pm was 105 F, and the last entry was done at 5:00 pm at 48 F. Since there was no start time recorded, and the end temperature was above 41 F, it is unknown if the flan cooling process met food safety requirements for time and temperature in accord with the FDA Food Code described above. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with KS J on 12/10/24 at 9:20 am, he stated they mostly used the cooling log process when making tuna salad, egg salad, etc. for sandwiches (ambient food cooling). During an interview with KS J on 12/11/24 at 9:10 am he stated the PM cooks made the entree sandwiches that are mostly offered on the dinner menu, and Dietary Aides made sandwiches daily for snacks. A review of the posted four-week menu cycle on 12/11/24 at 9:10 am showed Turkey Salad Sandwich was offered on Week 1 Monday (12/2/24), Deviled Egg Sandwich on Week 2 Saturday (12/14/24), Tuna Salad on Week 3 Friday (12/20/24). A concurrent review of the food cooling log dated December 2024 showed no cooling temperatures documented for the Turkey Salad on 12/2/24. During an interview with KS L, on 12/11/24 at 3:40 pm, she stated she made the sandwiches (egg salad, tuna salad, turkey salad, etc.) offered on the dinner menu. She assembled and combined chilled ingredients, checked the temperature. If it was higher than 41 F she would do the cool down log, but if it was 41 F or lower she would not write anything down in the cool down log. She agreed that if staff did not record a product, date/time and temperature in the cooling log, no one would know if a product not logged was because the temperature was less than 41 F or because the staff failed to do a needed cooling log. 4. Pureed Fish had a thick, gummy consistency During an observation and concurrent interview with KS J on 12/11/24 at 10:00, he demonstrated and explained his process for pureeing fish (Cross Reference F 805). Review of a recipe titled Recipe: Pureed (IDDSI Level 4) Meats dated 2024, and the manufacturer's instructions for use of the thickener showed it did not match the process used by KS J to prepare the pureed fish (Cross Reference F805). During evaluation of a pureed test tray on 12/11/24 at 12:50 pm, the RD, DSM and two surveyors agreed the pureed fish had a gummy consistency (Cross Reference F805). Review of the facility diet manual approved by the RD on 8/24/23 showed pureed protein foods should be moist and should have added sauces, gravies and broth as needed. A review of FNS staff in-services in the past year showed these topics: 1/23/24 - Leftover foods, Pureed foods - given by DSM. Pureed diet, use of pureed recipes, pureed techniques, correct liquids and stabilizers for various foods, proper consistencies. Demonstration and post-test. Attendees included KS J, KS L, KS P. 1/31/24 - Quat Sanitizer and Chlorine, given by a Nutritionist. Appropriate uses for dish machine vs sanitizer buckets. Testing chlorine and quat sanitizer concentration. Post-test. Attendees included KS J and KS L. 3/29/24 - Logs, Labeling and Dating, POC Annual Survey presented by RD/DSM. Review of past survey plan of correction efforts regarding complaints of cold food, completion of daily logs, labeling and dating. Attendees included KS I, KS J, KS K, KS BB. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/29/24 - Kitchen sanitation, given by (no name/title provided). Staff role in kitchen sanitation and organization, how to clean kitchen equipment, how to use the cleaning schedule, focus on weak sanitation areas in the kitchen and discuss solutions, location of policies and procedures for cleaning specific equipment. A sanitation inspection and checklist will be completed by the Registered Dietitian monthly to ensure that kitchen operations continue to comply with federal and state regulations. Attendees included KS I, KS J, KS L, KS P. June 2024 - Pureed Foods, given by DSM/RD. No curriculum or post-tests were provided. Attendees included RD, KS J, KS L, KS P, KS BB. 8/16/24 Dry food storage and supplies - Procedures for dry storage including temperature, cleaning, food storage containers, pest control procedures, dry food storage guidelines for labeling and dating, do not use cans with dents in side seams or rims. The post-test stated 5. Dented cans need to be stored in a separate labeled area - True. - Attended by KS L, KS BB. 9/24/24 Dress code - required clean apron, hair restraints, Beards and mustaches (any facial hair) must wear beard restraint. Attendees included KS I, KS J, KS L, KS Q, KS BB. 12/5/24 - Review Safety, Sanitation, Logs, Residents provided by DSM. Hair net, beard net, apron. Document temperatures, complete logs. Attendees included KS I, KS J, KS K, KS L, KS P, KS BB. On 12/12/24 at 10:15 am, the Registered Dietitian was asked to provide copies of her past three kitchen inspections/audits to demonstrate her oversight of the facility's Food and Nutrition Services (FNS). During an interview with the Registered Dietitian (RD) on 12/16/24 at 1:05 pm, she provided a blank copy (not filled out) of a document titled Food and Nutrition Services Comprehensive Summary used for inspection of food and nutrition services areas. When asked again for her completed FNS audits, the RD responded she didn't have to give them to surveyors, and an audit summary was all that was needed. Review of a second document also titled Food & Nutrition Services Comprehensive Summary showed: September 2024 - Overall Score 82%, with scores underneath for Meal Service 88%, Food Handling 86%, Clinical 75%, Equipment 80%, Dining Service 80%. No further information. October 2024 - Overall Score 81%, with scores underneath for Meal Service 84%, Food Handling 85%, Clinical 75%, Equipment 76%, Dining Service 79%. No further information. November 2024 - Overall Score 71% with scores underneath for Meal Service 88%, Food Handling 70%, Clinical 69%, Equipment 74%, Dining Service 54%. No further information. These cumulative/ summarized scores did not demonstrate the RD's oversight of food and nutrition services or provide insight as to why scores consistently declined in the past three months. Staff had received ongoing education and training, yet the above problems have persisted, prompting questions about the effectiveness of education and training provided, the adequacy of staff mentoring, monitoring and corrective action, the adequacy of QAPI processes to fix problems for good, and the adequacy of FNS staffing to ensure enough time is available to not only prepare the food, but to also perform the cleaning required to ensure food safety and sanitation for residents safety.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49934 Based on observation, interview and record review the facility did not follow a preplanned standardized menu cycle or cooks spreadsheets for vegetarian meals, and had the potential to not meet the nutritional needs of vegetarian residents. Findings: A review of the Facility Assessment (explains what types of patients/residents a facility will accept and services it will provide) dated 1/31/24 and signed by the Executive Director (Administrator), Director of Nursing (DON), Medical Director, and Governing Body Representative showed We as a facility, make sure we have the staff to meet the unique needs of the individuals at all times. Part 2 Services and Care We Offer Based on our Residents' Needs showed Nutrition - Individualized dietary requirements, liberal diets, specialized diets, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions. A review of the California Health and Safety Code Section S1265.10 showed Availability of plant-based meals: (a) A licensed health facility, as defined in subdivision (a), (b), (c), (d), (f), or (k) of Section 1250, shall make available wholesome, plant-based meals of such variety as to meet the needs of patients in accordance with their physicians' orders. (b) Notwithstanding any other law, including, but not limited to, Section 1290, a violation of this section shall not constitute a crime. (c) For the purposes of this section, plant-based meals shall mean entire meals that contain no animal products or byproducts, including meat, poultry, fish, dairy, or eggs. A review of lunch tray tickets dated 12/11/24, provided by the DSM, showed Resident 291 had a lacto-ovo vegetarian food preference (eats plant foods, dairy foods, eggs, but no beef/chicken/fish/pork products). A review of the facility diet manual on 12/11/24 showed the diet manual was approved/signed by the facility Registered Dietitian (RD) and the Medical Director on 8/24/23, and provided rationale, guidelines, and a 1-day sample menu for a vegetarian diet, however there was no evidence the facility had a vegetarian menu cycle or cook's spreadsheets to direct cooks what to prepare. Other diets in the facility had a four-week menu cycle. During an interview with KS J on 12/12/24 at 1:35 pm, he stated they did not have vegetarian residents very often, and that menus and spreadsheets for vegetarian meals were not available to follow. He stated there was a consistent supply of tofu and vegetarian meat, and the cooks just made vegetarian meals that tasted good and they tried to provide variety. He stated the cooks had a vegetarian recipe binder, but it wasn't currently in the kitchen because the Registered Dietitian (RD) had it. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/24, surveyors requested the facility's vegetarian menu, cook's spreadsheets and nutrient analysis from the DSM and RD. Review of the four-week Good For Your Health Menus, Vegetarian Menu, dated 12/2/24 through 12/29/24 were provided to the surveyors on 12/13/24. They showed the regular diet menu, with a separate box that listed the vegetarian option for the lunch and dinner meals each day. A concurrent review of an undated document titled Cooks spreadsheet, Spreadsheet for Vegetarian, showed Vegetarian Entree with variations for portion size, texture modification, and low sodium, consistent carbohydrate and renal diets. It directed Follow daily Vegetarian Alternatives. Replace the entree of the day with the vegetarian entree. Follow the vegetarian recipe. In a concurrent review of the nutrient analysis titled Nutritional Breakdown, Winter 2024-25, showed the diet provided 2168 kilocalories, 99 grams protein, 97 grams total fat, and 23 grams fiber, but did not indicate if it was for the vegetarian menu or for the facility's regular menu. During an observation in the kitchen, on 12/16/24 at 9:25 am, there were no vegetarian recipes or cookbooks in the cooks' area. During an interview with KS L on 12/16/24 at 11:10 am she stated she most often prepared food such as cheesy potatoes with two vegetables for Resident 291, or foods like cheesy rice or tacos. A review of the 4-week vegetarian menu cycle dated 12/2/24 through 12/29/24 did not show cheesy potatoes or cheesy rice or tacos anywhere on the vegetarian menu 4-week cycle. During an interview with DSM, on 12/16/24 at 11:40 am, he stated the vegetarian menu had been in place for a while and that the cooks followed it every day. Some residents wrote what food they wanted on the menus, and the cooks accommodated that as much as possible. When a vegetarian resident arrived, they would learn what the resident wanted, and then meet with the cooks about how to provide resident's food preferences. During an interview with RD, on 12/16/24 at 1:30 pm, she did not respond when told kitchen staff reported they didn't follow a vegetarian menu or spreadsheet. She stated she did not know if the Nutrient Analysis provided to surveyors was for the vegetarian alternatives or for the standard meals.

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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. 42448 Based on observation, interview, and record review the facility failed to ensure food was served at an appetizing temperature when four out of twenty nine residents interviewed (Resident 29, 44, 54, 284) stated the food was cold. This failure had the potential to result in decreased resident meal intakes, weight loss, and decline in health status. Findings: During an observation and concurrent interview with KS J on 12/11/24 at 10:00 am he stated he checked his steam table temperatures daily to ensure they were 150 F to 160 F. In a later review of a recipe titled Recipe: Pureed (IDDSI Level 4) Meats dated 2024, it showed Serve on trayline at the recommended temperature of 160 F to 180 F. During an interview conducted on 12/10/24 at 10:16 am, Resident 29 stated the food was terrible. A review of Resident 29's diet orders showed a 4/15/2024 order for regular fortified (extra nutrients added) mechanical soft texture (soft and easy to chew) diet. On 11/27/2024, a calorie dense nutritional supplement 120ml two times a day between meals was added to improve nutrition intake. During an additional interview with Resident #29 on 12/13/24 at 9:25 am, she stated her meals did not taste good, and were barely warm. During an interview with Resident #284 on 12/10/24 at 9:43 am he stated food was cold at times, then clarified the food was pretty much cold all the time. During an interview conducted on 12/11/24 at 08:47 am, Resident #54 stated, the food was always cold, because this was the last hall. Resident 54 was admitted to the facility with a diagnosis of protein calorie malnutrition (a nutritional deficiency due to insufficient intake of protein and energy,) among other diagnoses. During an interview with Resident #44 on 12/11/24 at 2:59 pm about the food she received at the facility, she stated When we get it, it is cold. The food does not get (arrive) to me hot. I tell them it is cold. They are not allowed to heat it up. I do not think they offer anything else. Review of an undated document titled Meal Cart Schedule listed the times meal carts should be expected each meal, plus or minus 15 minutes. It showed lunch carts should be delivered at these times: RNA 12:00 pm East Early (trays) 12:10 pm West Dining/Early 12:20 pm North/North Dining 12:35 pm East/East Dining/Late Trays 12:50 pm (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	West/ Late Trays 1:10 pm During an observation of lunch tray line on 12/11/24 at 11:47 am, Kitchen Worker J (KW J) used a thermometer to measure the temperatures of all foods on tray line. Temperatures were comparable to those measured by the surveyor. Review of a document titled Daily Temperature Logs (tray line temperatures), dated 12/9/24 through 12/15/24 showed these lunch temperatures at the beginning of tray line on 12/11/24: Pureed Breaded Fish 180 F, Pureed Carrots 188 F, Mashed Potatoes with Gravy 158 F, Pureed Bread (no temp located). Regular Breaded Fish 165 F, Carrots 180 F, Tater Tots 189 F, Bread at room temperature. Lunch Tray line started at 12:03 pm. Tray line was stopped multiple times as staff went to get needed items that were not readily at hand. The [NAME] Dining cart started at 12:15 pm and the last tray was added at 12:29 pm. Nursing transported the cart and arrived at [NAME] wing at 12:33 pm. Many staff, including the Assistant Director of Nursing (ADON) assisted with passing the meal trays to residents. The first meal was removed from the cart at 12:34 pm, the last tray was removed at 12:47 pm, and the last resident began eating at 12:50 pm. During an observation and concurrent interview on 12/11/24 at 12:50 pm, the Registered Dietitian (RD), Dietary Services Manager (DSM), and two surveyors transported two test trays, one a regular diet and texture, and the second a pureed regular diet, to the North Dining Room for evaluation. The DSM used a thermometer to check the temperatures of the foods which showed: Pureed Tray: Pureed Breaded Fish 116 F, Pureed Carrots 116 F, Mashed Potatoes with Gravy 115 F, Pureed Bread 110 F. Regular Tray: Breaded Fish 110 F, Carrots 95 F, Tater Tots 100 F, Bread at room temperature. The test tray foods were tasted by all present. All present agreed the flavor of the foods was pleasant, but the food temperatures were not warm enough.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 49934 Based on observation, interview, and record review the facility failed to ensure six resident's (Resident #70, #288, #334, #336, #338) individual texture needs were met when the food consistencies provided did not meet facility diet manual standards or resident preferences. This failure had the potential to result in resident's inability to consume their food resulting in decreased intakes and decline, or to potentially result in choking and death. Findings: Parsley Garnish: Review of the cook's spreadsheets titled Winter Menus, Week 2 Wednesday, dated 12/11/24 showed pureed and mechanical soft diets were to receive parsley flakes as garnish rather than whole parsley sprigs (to reduce risk of choking). Review of the facility diet manual, approved by the facility Registered Dietitian (RD) and Medical Director on 8/24/23 provided this description of the regular pureed diet: The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture should be of a smooth and moist consistency and able to hold its shape. Under foods allowed, it listed Pureed garnishes. Parsley flakes in place of parsley. Further review of the diet manual provided this description of the regular mechanical soft diet: The mechanical soft diet is designed for residents who experience chewing or swallowing limitations. The regular diet is modified by mechanically altering, by chopping or grinding, allowable food items and/or cooking raw items to a soft texture. Foods allowed: Parsley flakes. Foods to avoid: Parsley sprigs. During an observation of lunch tray line on 12/11/24 at 12:07 pm, Kitchen Staff J (KS J) placed a whole parsley sprig on pureed and mechanical soft diet trays (Resident #51, #70, #334, #336, #338) and the pureed test tray. Fish Texture: During an observation and concurrent interview in the kitchen on 12/11/24 at 10:00 am, KS J demonstrated how he pureed fish. He stated he baked the breaded fish until it reached a temperature greater than 165 degrees ( ) Fahrenheit (F). The current fish temperature was 190 F. He pureed the fish in a blender in small batches, explaining he estimated the portions with one fish fillet equivalent to about three ounces of protein. He stated the fish breading absorbed more liquid, and he used warm milk for more flavor and nutrition. He pulsed the fish a few times in the blender to break it up. He measured 1/4 cup of warm milk and mixed it in with the fish. Then he added an additional one cup of warm milk. He added an additional 1/4 cup warm milk, then whisked in 4-5 ounces of thickener to get the consistency of mashed potatoes. He stated the pureed fish would smooth out more with the heat on the steam table. He added 4-5 ounces more of thickener. KS J stated he checked his steam table wells daily to ensure they were 150 F to 160 F. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a recipe titled Recipe: Pureed (IDDSI Level 4) Meats dated 2024 directed cooks to use the appropriate servings of meat, warm fluid such as gravy or broth, and stabilizer such as instant potato or food stabilizer/thickener. If the meat is moist, you can start with only a few ounces of liquid. These amounts are only and average and may vary. For six servings, the estimated amounts were six servings of meat, 3/4 to one cup of fluid, and zero to six tablespoons of thickener. The directions stated to complete the regular (fish) recipe and measure out the total number of portions. Puree on low speed to a paste consistency before adding any liquid. Gradually add warm liquid starting with above recommended amounts. Add stabilizer to increase the density of the pureed food if needed. Breaded items or casseroles may not need stabilizer. If using commercial food thickener, check the can for usage, otherwise see above for recommended amount of stabilizer. Taste and adjust seasoning as needed. The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not week. Serve on trayline at the recommended temperature of 160 F to 170 F. Review of the Thick and Easy stabilizer/thickener instructions showed To Thicken Foods: Pureed meats - 3 ounces, add 1 ounce meat broth slurry (meat broth slurry = 4 ounces meat broth thickened with 1 Tablespoon thickener). Review of the facility diet manual approved 8/24/23 showed pureed protein foods should be moist and should have added sauces, gravies and broth as needed. During an evaluation of appearance, texture, flavor and temperature of lunch regular diet and pureed diet test trays on 12/11/24 at 12:50 pm, the Dietary Services Manager (DSM), Registered Dietitian (RD) and two surveyors agreed the pureed fish had a gummy texture. The DSM stated it had a gummy quality but it was not a choking hazard. The RD stated, I see what you mean about the consistency. During an interview with Resident #288 on 12/11/24 at 4:05 pm she stated the food was always dry. Today we had fish, it was dry. I don't like the food too dry. She further stated no one came to ask her about her food preferences or her need for moist foods. A review of facility lunch meal tray tickets dated Review of Resident #288's lunch tray ticket for 12/11/24 showed Resident #288 was on a regular diet, did not show any alerts regarding moist food, but did show she disliked brussels sprouts, salmon, and bread.

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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** 49934 Based on observation, interview, and record review, the facility failed to maintain professional standards of practice to ensure food service safety for the residents of the facility when: 1. The kitchen was not sanitary. 2. Kitchen staff did not follow professional standards of practice to avoid cross contamination in food production processes. 3. Ambient food cool down process was not performed consistently when indicated. 4. There was not an effective process in place for management of dented cans. 5. Three out of three nursing unit nourishment rooms were not sanitary. 6. Chemicals that were not food-safe were used to clean food contact surfaces in nursing unit nourishment rooms. These failures had the potential to spread infection and cause food borne illness for residents consuming food in the facility. An event of food borne illness has the potential to cause a resident' decline or even death. Findings: 1. The kitchen was not sanitary. Review of the 2022 Food and Drug Administration (FDA) Food Code ,d+[DATE].11 showed A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. Soiled Equipment: During the initial tour, beginning on [DATE] at 8:38 am, the kitchen was not sanitary. An observation in the walk-in refrigerator on [DATE] at 9:05 am, showed it contained food items such as dairy products, cheese, produce, meat, and eggs. Dust and grime were accumulated on the ceiling and walls around the condenser fans, and behind the sealed wiring of the light. The floor on both sides of the threshold had an accumulation of unknown particles and grime. Further observation of the walk-in freezer showed an accumulation of dust and grime on the ceiling, walls, and floor. These unsanitary areas had the potential to cross contaminate food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Maintenance Supervisor (Maint. Sup.), on [DATE] at 10:20 am, he stated Maintenance was responsible for the mechanical operations of the walk-in refrigerator and walk-in freezer, and it was the responsibility of the Dietary Department to clean the ceiling, walls, and floors. During an observation and concurrent interview in the cook's and cold prep areas with Kitchen Staff I (KS I), on [DATE] at 9:36 am, a metal pitcher stored on the shelf had white hardened spatter resembling dried batter. A green dating gun, blender base and pitcher, and food processor base had an accumulation of grime. A plastic bin used to store plastic lids was soiled inside and outside with grime, food debris and unknown particles. Several lids had tape or labels stuck to them. KS I stated, It is part of the training to take the tape off. When asked how often the lid storage bin was cleaned or replaced, KS I said, It is changed out every week or so .It probably should be cleaned every day. Tape on plastics should be taken off. During further observation in the cook's area on [DATE] at 9:44 am, nine out of twelve pots and pans hung on the wall had an accumulation of burned on grease on their sides and bottoms, and one pot bottom had exterior pitting. Approximately twenty-five out of thirty-two stacked bake pans showed burned on grease on their interior and exterior surfaces. During an interview with Dietary Service Manager (DSM), on [DATE] at 9:45 am, the burnt material on the pots and pans was discussed. He stated someone deep cleaned the pots and pans weekly. When shown the pot with burned on grease and pitting the DSM stated, That pan is still good on the inside. When asked about the system for replacing pots and pans, the DSM stated they had new pans in the back room and slowly replaced them as needed. He removed the pitted pan from service. Cook's Food Preparation Sink: During an observation of the cook's sink on [DATE] at 3:05 pm a tub of vanilla shake cartons was in the right sink thawing under running water. Soiled food preparation equipment was stacked on the left sink counter, and there was food debris in the sink. There were no detergent or sanitizer buckets in place for ready use. In a concurrent interview with Kitchen Staff P (KS P), she stated the cook used the prep sinks to prep meat, vegetables, and to drain food. She added they also rinsed their dishes there. During an interview with the DSM on [DATE] at 3:08 pm he stated the cook's sink wasn't used much for cleaning fresh produce because he purchased mostly frozen or precleaned and pre-cut produce. Staff would use a colander to rinse fresh broccoli, or other fresh vegetables rarely used. During an observation of the cook's sink on [DATE] at 2:25 pm, it held soiled cooking equipment on the left counter. The right sink and counter held and eleven emptied cans, an empty milk carton, trash and used gloves, and a soiled cook's knife. During an observation of the cook's sink on [DATE] at 3:25 pm, the sinks and counters had been cleared off, but no cleaning process was observed. The left sink contained a substance resembling fresh diced tomatoes in and around the entry to the garbage disposal. In a concurrent interview with Kitchen Staff L (KS L), she stated the cooks sink was used for straining foods. That's it. Then she stated they rinsed dishes there, rinsed produce, and drained canned food items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 2:26 pm soiled food preparation equipment was stacked on the left counter, eleven emptied cans, an empty gallon jug, soiled discarded jugs and plastic wrap trash were piled in the right sink and on the right counter. During an observation of the cook's sink on [DATE] at 2:05 pm, a colander of lentils sat draining in the sink. During further observation on [DATE] at 3:40 pm, KS L drained cooked meat through a colander into the left sink, and then proceeded with rinsing dishes in the left sink. During an observation of the cooks sink on [DATE] at 8:35 am, Kitchen Staff J (KS J) drained thawed spinach in a perforated hotel pan sitting directly on the bottom of the left sink over the garbage disposal. During an interview with the DSM on [DATE] at 11:40 am, he stated cooks sink had a garbage disposal, and cooks cleaned and used the sink for defrosting meat. They also rinsed out equipment and left it there until it was taken to the dish room. He stated they didn't do much fresh vegetable preparation, maybe cucumbers and tomatoes, and they drain foods like pasta there. He stated if they drain meat they have to sanitize the sink. Box Fan: During an observation in the kitchen, on [DATE] at 9:16 am, a large box fan sat on a shelf in the cook's area, next to a stack of bake pans, and above the cook's recipe binders. The fan blades and protective wire covers were coated with thick grimy dust. In a concurrent interview, KS J stated the fan was used to keep the kitchen cooler during the summer months, and maintenance was supposed to remove it. KS J agreed the fan was dirty and needed to be cleaned more often or covered. In a follow-up interview with DSM, on [DATE] at 9:45 am, he stated the fan was cleaned 2 weeks ago. It shouldn't look like that. Maintenance will remove it. 2. Kitchen staff did not follow professional standards of practice to avoid cross contamination in food production processes. Review of an undated document titled Dress Code showed Dirty clothing may carry pathogens, which can be transferred to your hands and the food that is being prepared. Proper dress included Clean apron; Hair net - all employees must wear one, even under hat, etc.; [NAME] restraint if any facial hair (mustache or beard). Aprons: During the initial tour on [DATE] at 8:47 am, a white apron was hung adjacent to staff coats near the door, at risk for cross contamination. In a concurrent interview with the Registered Dietitian (RD), she stated it was not their standard of practice to hang aprons with personal belongings. During observations in the kitchen throughout the survey [DATE] through [DATE], a cart was maintained near the kitchen entry and behind the yellow line (boundary for food prep area) and held employee personal food and drinks, and purses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 8:06 am, the employee cart held three rolled up green aprons, one on the top shelf with employee food and beverages, and two on the bottom shelf next to a plastic tub of unknown contents. The second shelf contained purses, a canvas satchel, and five loaves of bread. During an observation and concurrent interview with KS P on [DATE] at 2:05 pm, two rolled up green aprons continued to be stored on the employee cart. KS P stated the process for apron use was they put on a clean apron at the start of each shift. They removed their aprons if leaving the kitchen, such as to take out the trash, go on breaks, go to the restroom. She stated the green aprons on the employee cart were aprons that staff would wear, and explained they ran out of aprons the previous day and broke out a new package of the green aprons. KS P stated clean aprons were normally stored in the closet with the disposable paper products. During an interview with the DSM on [DATE] at 11:40 am, he stated that upon start of shift, staff were to put on hair net, wash hands, put on aprons. Dish room staff wore a plastic apron over their cloth apron when working the dirty side of the dish machine. Staff were to remove aprons when leaving the kitchen (on breaks, taking out trash, etc.), and to replace them when soiled. Staff could hang aprons behind the door temporarily or get a clean apron upon return. He explained staff could hang their aprons from the coat rack on the wall as long as it was separated from the jackets hanging there, or the aprons could be put on a chair since there wasn't a lot of wall space for a separate rack. That's all I have available for them to use. Glove Use: Review of the FDA Food Code 2022 - ,d+[DATE].15 showed (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. Review of a facility document titled, Glove Use Policy, 2023, stated, appropriate glove use is essential in preventing foodborne illness. Gloved hands are considered a food contact surface that can get contaminated. A section titled When Gloves Need To Ge Changed, showed gloves are to be changed before beginning a different task, and before handling all food. During an observation in the kitchen, on [DATE] at 11:26 am, KS I wore gloves while preparing food. When asked how he made sandwiches, he took us to the refrigerator to show the deli lunch meat they used. KS I continued to wear his food preparation gloves as he touched the refrigerator handle and as he moved boxes of food items around, then returned to his food preparation duties without washing his hands or changing his gloves. During an observation on tray line, on [DATE] at 12:08 pm, Kitchen Staff K (KS K) wore her gloves to a refrigerator and retrieved a sandwich. Upon return to the tray line, KS K did not change her gloves. During an observation on [DATE] at 12:12 pm, KS J wore gloves while dishing food on lunch tray line. He retrieved a utensil from a drawer and went back to tray line to dish food onto Residents' plates and did not change his gloves. Hair Restraints did not effectively cover hair. (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 FDA Food Code 2022 - ,d+[DATE].11(A) showed Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single service and single-use articles. During multiple observations in the kitchen throughout the survey KS J wore a black cloth mask to cover facial hair. On [DATE] at 10:00 am, 11:24 am, 12:02 pm, 2:05 pm, KS J wore the mask below his nose, leaving his mustache hair exposed during food preparation and service activities. 3. Ambient food cool down process was not performed consistently when indicated. A review of the FDA Food Code 2022, Section ,d+[DATE].14 showed Time/Temperature control for Safety Food shall be cooled within 4 hours to 5oC (41oF) or less if prepared from ingredients at ambient temperature, such as .canned tuna. (B) Time/temperature control for safety food shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature such as reconstituted foods and canned tuna. ,d+[DATE].14 indicated, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 41 degrees F to 135 degrees F for too long. Review of the [DATE], Cool Down Log, showed five cool down entries for the month. The cooling log for Flan (a dessert similar to baked custard) on [DATE], indicated the flan began its cooling process at an unknown time, at 140 degrees( ) Fahrenheit (F). The next temperature check at 3:00 pm was 105 F, and the last entry was done at 5:00 pm at 48 F. for this particular item. Since there was no start time recorded, and the end temperature was above 41 F, it is unknown if the flan cooling process met food safety requirements for time and temperature in accord with the FDA Food Code described above. During an interview with KS L, on [DATE] at 3:40 pm, she stated she made the sandwiches offered on the dinner menu. When asked how she made things like eggs salad, tuna salad and turkey salad, she stated she assembled and combined the ingredients and then checked the temperature. The temperature goal was 41 F or lower. If it was higher than 41 F she would do the cooling process, check and record temps every two hours until it was 41 F or lower, within four hours total. She stated she used pre-chilled ingredients. She stated she always pulled the meat (from the freezer) two days in advance, and she always put an extra container of mayonnaise in the reach-in refrigerator so there would be two available. KS L stated she would not write anything down in the cooling log if the first temperature was 41 F or lower. When asked how anyone would know if a staff checked the food temperature if it wasn't written down, KS L agreed they wouldn't know. Review of facility menus titled Good For Your Health Menus, dated Fall, [DATE] - [DATE], showed Classic Egg Salad Sandwich at dinner on [DATE], and Dill Tuna Salad Sandwich at dinner on ,d+[DATE]. Concurrent review of the [DATE] cooling log showed a log for the Egg Salad, but no log for the Tuna Salad. Review of facility menus titled Good For Your Health Menus, dated Winter, [DATE] - [DATE], showed Turkey Salad Sandwich on [DATE], Deviled Egg Sandwich on [DATE], and Tuna Salad Sandwich on [DATE]. Concurrent review of the Cool Down Log dated [DATE] showed no cooling log temperature checks for the [DATE] Turkey Salad. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DSM, on [DATE] at 12:05 pm, he stated they rarely used cooling logs because they didn't use leftovers. They didn't do a cooling log for ambient foods because the ingredients come out of the refrigerator and were already cold. During an interview with KS P on [DATE] at 9:10 am she stated the PM Diet Aide made the resident snack sandwiches, and there was no defined rotation for the types of sandwiches provided. They provided egg salad or tuna salad when there was some leftover from the resident menu, or if a resident asked for it. 4. There was not an effective process in place for management of dented cans. Review of the 2022 FDA Food Code ,d+[DATE].11 showed rusted and pitted or dented cans may also present a serious potential hazard. Review of a 2023 policy titled Food Storage - Dented Cans showed Food in unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents, or swells shall not be retained or used by the facility . All dented cans (defined as side seam or rim dents) .are to be separated from remaining stock and placed in a specified labeled area for return to purveyor for refund. During an observation and concurrent interview with KS J in the dry goods storage room, on [DATE] at 8:58 am, a stack of food boxes was topped with 5 cans of beef stew. Closer observation revealed large dents in the sides or along the lid seams of the cans. KS J stated the cans were from the emergency food area, had nothing to do with denting, and were there to be used. When it was pointed out the cans were dented, he stated dented cans would not be used. When asked where dented cans should be placed to avoid use, he pointed to several areas of the dry storage room where they could possibly be stored and stated, We usually have a place for dented cans, but this place is constantly changing. During an observation and concurrent interview with the DSM, on [DATE] at 9:45 am, he was asked about the cans of beef stew on the boxes in the dry storage room. He replied the cans were there to be used. When informed the cans were dented, DSM stated staff probably put the cans in that location so he would see them. When asked where the dented cans should be stored, he looked toward several areas in the dry storage room, and stated their dented can sign had fallen down and not replaced. DSM stated dented cans should be removed immediately, and employees generally placed them on his desk so he could inspect and take photos of them for reimbursement from the vendor. Then the cans were discarded or donated. 5. Three out of three nursing unit resident nourishment rooms were not sanitary (Cross Reference F880, F813). During an observation of the [NAME] Nourishment Room, on [DATE] at 1:15 pm, three out of six condiment drawers were soiled with food debris, opened and discarded condiment packets, dust and grime. The refrigerator/freezer for resident snacks and personal food showed a buildup of grime, drips, and unknown debris. The refrigerator and freezer held multiple resident food items in manufacturer's packaging that were not labeled with the resident's name and room number. The counter was soiled, its' edges were chipped, missing and uncleanable. The floor was soiled. The room was comingled with a large copier, a soiled coffee cart containing used cups and spoons, a cart with an ice chest on it, and nursing staff coats, purses, and opened beverages. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the East Nourishment Room on [DATE] at 1:45 pm, showed it also had a closet with staff personal belongings, opened staff beverages, and a large copier machine. The counters were not clean, and their edges were chipped, missing, and uncleanable. Soiled paper towel trash was left on the corner of the sink and counter. Two out of six condiment drawers were soiled with drips and unknown debris. The coffee cart was soiled and held soiled cups. The refrigerator and freezer held multiple resident food items in manufacturer's packaging that were not labeled with the resident's name and room number. During an interview with the Maintenance Supervisor (Maint. Sup.) on [DATE] at 10:20 am, he was asked about the ongoing problem with cockroaches in the facility, including the surveyor's observations and sanitation concerns in the three nourishment rooms. In a subsequent nourishment room walk-through and concurrent interview, the Maint. Sup. agreed the counters were damaged and uncleanable and the copier cord was a trip hazard. He stated cockroaches are everywhere (in the world), they could be brought in on staff coats or purses. He stated nursing staff also had storage for their personal items in their break room, and he wished staff belongings weren't in the nourishment rooms. During an interview with the Maintenance Supervisor (Maint. Sup.) on [DATE] at 10:20 am he stated he was also responsible for the housekeeping department. During an observation of the North Nourishment Room, on [DATE] at 8:40 am, there were open staff beverages on the counter. A plastic staff closet had jackets and purses hanging off of it. The light in the refrigerator was burned out. The refrigerator and freezer held multiple resident food items in manufacturer's packaging that were not labeled with the resident's name and room number. The trash can was not covered. 6. Chemicals that were not food-safe were used to clean food contact surfaces in nursing unit nourishment rooms. During an interview with the Housekeeping Assistant Manager (HK AMgr.) on [DATE] at 10:35 am, she stated the housekeeping staff cleaned the nursing unit nourishment rooms twice daily. They wiped the counters, mopped the floor, wiped out the refrigerator if it needed it, or cleaned the refrigerator once weekly. She stated staff used their facility disinfectant Quat-Stat 5 to wipe out the interior of the refrigerator and clean the counters, but Dietary department staff cleaned out any expired food. In a concurrent review of the Quat-Stat 5 label and interview with the Maint. Sup. there was no indication it was a food-safe chemical. The Maint. Sup. stated he would contact his chemical vendor to find out if it was food safe and added We've been using this for years. In a follow-up interview with the Maint. Sup. on [DATE] at 1:25 pm he stated the only thing he could find about the Quat-Stat 5 was the MDS (Material Data Sheet), and it didn't say if the chemical was food safe. During an interview with a Housekeeper R (HK R) on [DATE] at 8:25 am, she stated housekeeping staff were trained to clean the Nourishment Rooms by wiping down the shelving, doors, interior of refrigerators, with the disinfectant Quat-Stat 5, or occasionally she used bleach to remove stains. HK R explained she cleaned the refrigerator and freezer weekly, shelf by shelf. She put the food items on the counter, cleaned the shelves and drawers with a rag and a disinfectant bucket, dried the shelves with a clean dry rag or paper towel, then put everything back. She stated staff always had their beverages on the nourishment room counters. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with HK AMgr. on [DATE] at 8:25 am she stated the process for using Quat-Stat 5 throughout the facility was to wipe down surfaces and provide a five-minute dwell (wet) time. She stated that was how all staff were trained. Sometimes they used bleach to clean handrails and any rooms contaminated with C. Difficile (a bacteria). The HK AMgr. stated she trained her staff to clean the nourishment room refrigerators using Quat-Stat 5 to wipe down the shelving, doors, and seals, and to have a 5-minute wet time. An observation of chemical labels in the kitchen chemical closet on [DATE] at 8:35 am showed the Quat Sanitizer II Disinfectant, Sanitizer used in the kitchen was safe for food contact surfaces. During an interview with Maintenance Supervisor (Maint. Sup.), on [DATE] at 9:10 am, he stated they did not have a policy and procedure for cleaning surfaces or for cleaning the nourishment rooms. They just followed the chemical label instructions. Review of the Betco Quat-Stat 5 website https://www.betco.com/products/quatstat-5-disinfectant/34104?pageNumber=1 showed a use for disinfecting food processing facilities (factories), but not for food service facilities. The food processing facility instructions required a five-minute wet (dwell) time and rinsing all food contact surfaces with potable water prior to reuse, which was not the process being followed at this facility. During an interview with the DSM on [DATE] at 11:40 am he stated he was unaware Housekeeping used chemicals in the nourishment room refrigerators that were not food-safe. During an interview with RD, on [DATE] at 1:05 pm, the RD stated she inspected the nourishment rooms monthly or when getting a resident a snack. She stated that she looked at the counters, and to see if the room was neat, organized, and clean. She also checked for labeling on foods and checked the thermometers. She stated the staff belongings and personal food, and beverages were a consistent problem. She was unaware Housekeeping used chemicals in the nourishment room refrigerators that were not food-safe. Review of documents titled Infection Prevention and Control Manual, Environmental Services/ Housekeeping/ Laundry provided by Administration showed All chemicals should be used as the manufacturer recommends. Only cleaning supplies approved by the Infection Control Committee are to be used in this facility.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42448 Based on observation, interview and record review, the facility failed to ensure sanitary food storage for resident's personal food in three out of three nursing unit nourishment rooms. Resident food stored in the freezer were not labeled with patient identifiers (name, room number and date) to ensure the correct patient received their personal food items. These failures had the potential to cause foodborne illness and decline in residents, and to decrease resident's quality of life if personal foods were discarded or given to someone else due to lack of labeling. Findings: Review of an undated facility policy titled Food for Residents from Outside Sources showed staff were to label residents personal food with their name and the date received. Disposal dates depended on the type of food, storage requirements, opened or unopened, etc. It stated the facility would not heat food from home for residents. Review of the 2022 FDA (Food and Drug Administration) Food Code 4-601.11 showed A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. During observations of the facility's nourishment rooms (nursing unit food storage room for residents) on 12/10/24 at 13:15 PM (West wing) and 13:45 PM (East wing), and on 12/13/24 at 8:40 AM (North wing), the rooms were commingled with large plastic closets full of employee personal belongings. Coats were draped over the open doors, and the top of the closet held more belongings. Opened employee beverages were stored on top of the closets and on nourishment room counters. The trash was not covered in all three nourishment rooms. One floor was soiled and sticky. (Cross Reference F812 and F925). A sign was posted on each refrigerator stating Attention Staff! All food must be labeled and dated with the Residents Name and the Date. Items must not be held longer than 3 days. Any items without Residents name or Date will be Discarded Immediately. No Employee food in this Refrigerator/Freezer. During an observation of the [NAME] Nourishment Room, on 12/10/24 at 1:15 pm, the counter was soiled and stained, and the floor was soiled and sticky. Three out of six condiment drawers were soiled with food debris, opened condiment packet trash, and grime. The coffee cart had spills, dark stains, and held used coffee cups and spoons. The top of the refrigerator was dusty and held two large bowls, an unlabeled undated case and a bottle of Pepsi, and some additional papers. The interior of the refrigerator/freezer for resident snacks and personal food showed a buildup of grime, drips and unknown debris. In the freezer a white plastic bag with unknown, orange-colored contents was labeled 105B/no name/no date. An individual container of ice cream was labeled 115B/no name/no date. A Rebbl pumpkin pie protein shake had no room/name or date. A container of fruit cocktail had a partially opened lid, was drained of its juice, and had no name/room or dates. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the East Nourishment Room on 12/10/24 at 1:45 pm, showed it also had a closet with staff personal belongings, opened staff beverages, and a large copier machine. The counters were soiled and stained. Soiled paper towel trash was left on the corner of the sink and counter. Two out of six condiment drawers were soiled with drips and unknown debris. The coffee cart was soiled and held two soiled cups adjacent to the coffee condiments. The freezer held a manufacturer's package of [NAME] Dean sausage and gravy breakfast bowls with no name/room/date, M&Ms candy with no name/room/date. Freal Chocolate Chill Milkshake showed room [ROOM NUMBER]B but no name. There was a ziplock bag of three specialty ice cream sandwiches labeled 207, Tuesday 9/3/24, no name. In the refrigerator, three containers of Boost Breeze had pink drips across the lids and down the sides of the cartons. During an observation of the North Nourishment Room, on 12/13/24 at 8:40 am, the staff microwave oven was rusted at the top front edge, inside at the top center, and along most inside edges, with a soiled paper towel on the carousel. There were open staff beverages on the counter, and the plastic staff closet had jackets and purses hanging off of it. The trash can was not covered. The top of the refrigerator held a blanket, two rolls of trash bags, a green bunched up plastic bag with unknown contents, and a box of unlabeled, undated Idahoan Triple Cheese Potato Shreds. The light in the refrigerator was burned out. In the refrigerator were two opened Med Pass cartons with opened on 12/9 and opened on 12/12, an opened Boost Breeze without an opened-on date, mayonnaise with room [ROOM NUMBER] B/no resident name or date, two Ensure bottles with 304 B/no name, and one Ensure Plus not labeled. There were also three small bags of Lays Potato Chips not labeled and five Yoplait Yogurts with 304 B/no name. In the freezer was one opened bag of Frozen Berry Medley without a label or opened on date. During an interview with Housekeeper R (HSK R) on 12/13/24 at 9:15 am she stated staff always had their beverages on the counters in the nourishment rooms. During an interview with the Dietary Services Manager (DSM) on 12/16/24 at 11:40 am he stated staffs open beverages on nourishment room counters was an ongoing problem. During an interview with Registered Dietician (RD), on 12/16/24 at 1:05 pm, she stated the staff belongings and personal food, and beverages were a consistent problem in the nourishment rooms. During an interview with the Director of Nursing (DON), on 12/16/24 at 3:20 pm, she stated resident food was to be labeled with the date received, the residents name, and the residents room number. If it is an unopened package, the manufacturer's use-by date may be used. Opened items such as Med Pass should have an opened-on date. During further interview, the DON confirmed the Nourishment Rooms are not staff break rooms. She was aware of staff belongings in the nourishment rooms and explained the rooms were transitioned during COVID for staff use, but that the facility had never gotten around to taking them (the plastic closets) back out. She stated the facility did not have a policy on the storage of employee personal property, food or beverages, but the staff were not supposed to have personal food, drinks, or belongings in the Nourishment Rooms.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview and record review, the facility failed to explain the terms of the arbitration agreement (arbitration: a private process where disputing parties agree that one or several other individuals can make a decision about the dispute after receiving evidence and hearing arguments.) to the resident in a language that the resident understood for one of five sampled residents (Resident 283). This failure resulted in Resident 283 signing a document that she did not understand and had the potential to result in Resident 283 to not be able to make an informed decision and/or her rights to be denied. Findings: During a review of Resident 283's clinical record, indicated that Resident 283 was admitted to the facility on [DATE] with diagnoses which included left knee osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and Artificial left knee joint. Resident 283's primary language is Spanish, and she is her own Responsible party (RP) and capable of making her own healthcare decisions. During a concurrent interview and record review on 12/12/24, at 2:26 pm, with the Admissions Transition Coordinator (ATC), the ACT stated English was the only language on the arbitration agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) that the facility provided for every resident. The ATC said, I just did it with Resident 283 through the tablet. The ACT stated that she provided the arbitration agreement in English to Resident 283, she acknowledged that she knew Resident 283 was her own Responsible Party (RP) and she was aware that Resident 283 only spoke and understood Spanish. The ACT said, the son spoke English, they agreed, and Resident 283 signed it! During a concurrent interview and record review on 12/13/24 at 11:44 am, the interview was conducted with the assistance of the interpreter, ID: xxx641, from California Department of Public Health (CDPH), Office of Compliance, LanguageLine Solutions, Resident 283's signed arbitration agreement was reviewed. Resident 283 acknowledged that she signed that agreement because her son told her to sign, and she did not know what she had signed and agreed to. Resident 283 stated that the ACT did not provide the agreement in Spanish and did not speak to her in Spanish.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 43739 Based on interview and record review, the facility failed to ensure Quality Assessment and Performance Improvement (QAPI - a data driven proactive approach to improvement used to ensure services are meeting quality standards) was utilized effectively for identifying and resolving deficiency related to timely complete residents' assessment for 13of 29 sampled residents (Residents 41, 44, 7, 87, 73, 14, 27, 55, 96, 100, 291, 293, and 294). This failure had the potential to inaccurately reflect the data relative to the residents' health status, and delay the developments of a comprehensive, individualized care plan for the residents. Refer to F 636 Findings: During a review of the facility's policy titled, Quality Assessment and Performance Improvement, no revised date provided, indicated: a. The Goals of the QAPI committee is to: - Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately. - Support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problems. - Help departments and ancillary services implement systems to correct potential and actual issues in quality of care. - Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals. - Coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between facility staff, residents, and family members. b. The objectives of the QAPI plan are to: - Provide a means to identify and resolve present and potential negative outcomes related to resident care and services. - Reinforce and build upon effective systems and processes related to the delivery of quality care and services. - Provide structure and processes to correct identified quality and/or safety deficiencies. - Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Help departments and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability. - Provide a means to centralize and coordinate comprehensive QAPI activities in order to meet the needs of the residents and the facility. - Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program. During an interview on 12/16/24 at 11:23 am, Minimum Data Set Registered Nurse (MDS RN) stated unfortunately we are that far behind. It's just me and two other nurses. MDS RN indicated that there was a lot of MDS's not completed and that she had discussed the issue with her Administrator a few weeks ago and asked for more nursing hours in this department. MDS RN indicated that her main concern with the MDS's not being complete was that the residents care plans may not reflect the up-to-date interventions for their care. MDS RN stated It is a terrible feeling because I want to be sure things are good for our residents. During an interview on 12/17/24 at 2:43 pm with the Administrator, the Administrator stated, I knew we were behind, but not that much. I would expect the MDS RN reported to me, so I could do root cause analysis to find out what happened, and from there, we could go find the cause and fix it.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43739 Based on interview and record review, the facility's Quality Assessment and Assurance (QAA) committee failed to development and implement appropriate plans of action to correct identified deficiency related to infection control. As a result, deficient practices were present regarding infection control that had the potential to affect the safety and quality of care provided to residents. Refer to F 880. Findings: During a review of the facility's policy titled, Quality Assessment and Performance Improvement, no revised date provided, at the section of QAPI program, indicated: a. Design and scope: Goals, targets and benchmarks are established and measured based on the best available evidence. b. Governance and leadership: - Input is sought from facility staff, residents, family members and individuals who are involved in the care of residents. - Resources are allocated to conduct QAPI efforts. - Feedback, data systems and monitoring c. Systems are in place to monitor care and services: - Systems are designed to incorporate feedback from caregivers, residents, family, and staff as appropriate. - Care processes and outcomes are monitored using performance indicators. These performance indicators are measured against quality benchmarks and targets that the facility has established. - Adverse events are tracked, monitored, and investigated as they occur. - Action plans are implemented to prevent recurrence of adverse events. d. Performance improvement projects: - Performance improvement projects (PIPs) are initiated when problems are identified. - PIPs involve systematically gathering information to clarify issues and to intervene for improvements. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Systematic analysis and systematic action: - Root Cause Analysis (RCA) is used to determine whether identified issues are exacerbated by the way care and services are organized or delivered, and if so, how. - RCA serves as a highly structured approach to fully understanding the nature of an identified problem, its cause, and the implications of making changes to improve the problem. During a concurrent interview and record review on 12/17/24 at 2:43 pm with the Administrator, in the Administrator's office, the Administrator stated there's an ongoing Infection Control PIPs that the previous Infection Control Preventionist (IP) initiated in 5/2023. The Administrator stated the current IP had been conducting hand hygiene audit since 7/2024. While asked, the copies of hand hygiene audit report were reviewed, dated 7/9/24, and 7/16/24. The Administrator confirmed that there's no additional hand hygiene audit record. While asked for the documentation of the resource, the plan, the action, and the goal for the ongoing Infection Control Performance improvement project, the Administrator was not able to provide such documents. During a concurrent interview and record review on 12/18/24 at 8:15 am, with the Assistant Director of Nursing (ADON), the facility document titled, Hand Hygiene and Personal Protective Equipment QAPI Statement and Charter, was reviewed. The ADON admitted that the document did not contain the elements of PIPs which included root cause analysis - when, what, and how the infection control issues were identified, the feedback system, the plan of action, the implementation, the timeline, and the benchmark .etc. The ADON stated, the Continuous quality improvement (CQI) record is inside record, we were not allowed to show the record to outside people.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41567 Based on observation, interview, and record review, the facility failed to ensure effective infection control practices when: 1. Facility staff did not perform hand hygiene during meal service. 2. Nursing unit resident nourishment rooms were not sanitary. (Refer to F812, F813, F925.) 3. Chemicals that were not food-safe were used to clean food contact surfaces in nursing unit nourishment rooms Refer to 812. 4. The RNA (Resource Nursing Assistant) Room was unsanitary and had live cockroaches. Refer to F925. 5. Resident 8's CPAP (continuous positive airway pressure-a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) and Nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) mask had white and brown spots throughout the masks and oxygen tubing on the floor where a bug was crawling. 6. A bed pan was stored under a resident's bed for her use. 7. Certified Nurse Assistant (CNA) didn't follow infection control policy while providing peri care (cleaning the vagina and anus after incontinence) to Resident 73. 8. Licensed Nurse (LN) didn't follow infection control policy while checking Resident 331's blood sugar. These failures exposed all residents, visitors, and staff to potentially harmful infections and diseases associated with poor health outcomes. Findings: 1. A review of the facility's policy titled Hand Hygiene dated [DATE], the policy indicated Hand washing is generally considered the single most important procedure for preventing the spread of Healthcare Associated infection. Hands must be washed: Between contact with different patients and Before handling or preparing food. An observation was made on [DATE] from 12:39pm to 1:15pm, in the Sierra dining room. CNA E was observed to carry a lunch tray to a table with bare hands, set it down, tuck her hair behind her left ear, remove the dinnerware and utensils from the tray and set them on the table. CNA E pushed a resident to the dining table with her bare hands on the handles of his wheelchair, opened straws and pushed them through the lids of drink cups, then stood back and rearranged her hair into a ponytail, sat at the table and fed him bites of food and drinks. At 1:15 pm, she cleared the table and pushed the resident to room [ROOM NUMBER] where she entered the room with the resident and shut the door. At no time during the observation period did CNA E sanitize her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview conducted on [DATE] at 1:20pm, when it was pointed out she had not sanitized her hands, CNA E had no reply. When asked if she had been trained on infection control, she indicated she wasn't sure, she thought perhaps she had been trained on it and had forgotten it over time. An observation was made on [DATE] at 8:47 am, of Nursing Assistant (NA) F exiting resident room [ROOM NUMBER] with a breakfast tray in her bare hands which she then placed into a meal cart, walked down the hallway, talked briefly with a resident standing in a doorway, then knocked on a closed door, pushed the handle and entered resident room [ROOM NUMBER]. At no time during the observation period did NA F sanitize her hands. In an interview conducted on [DATE] at 8:53 am, NA F affirmed that she did have infection control training and when asked what she might have done differently after putting the breakfast tray in the meal cart, stated she thought she should have sanitized her hands before entering room [ROOM NUMBER]. During an observation on [DATE] at 12:39 pm, a CNA delivered a tray to Resident 1. The CNA did not sanitize her hands or use gloves and opened a milk carton, putting her fingers on the mouth of the carton to open it. During a lunch dining observation, on [DATE] at 12:41 pm, a CNA delivered a tray to Resident 2. This CNA used hand hygiene and then put gloves on. She proceeded to touch Resident 2's blankets and the controller to the bed with the gloves on. Then she took lids off the food and opened the milk and a health shake without changing her gloves, touching the mouth of the cartons to open them. In an interview conducted on [DATE] at 12:42 pm, the Infection Preventionist (IP) nurse stated that staff are expected to perform hand hygiene before and after resident care and that they should wash hands between residents being fed, and if staff touched their own body or hair, they need to sanitize before resuming patient care. During an observation in the north dining room on [DATE] at 12:35 pm, the lunch trays were being served and staff were assisting residents with eating. *12:35 pm, Speech Therapist (ST) was observed touching Resident 334's hands and neck and picking up his fork to move his food around. *12:40 pm, without doing hand hygiene ST left the room to get a salad. *12:43 pm, RNA EE was assisting a resident with eating then got up from the table and without doing hand hygiene she picked up Resident 334's fork to help him with eating. Then without doing hand hygiene RNA EE went back to the first resident she was assisting and picked up his spoon and helped him to eat. *12:44 pm, without doing hand hygiene, ST came back into the room with a salad and gave it to Resident 334. She opened the salad dressing, grabbed his fork and stirred up the salad. ST then handed the fork to Resident 334 so he could feed himself. ST then touched her mouth with her fingers. Without doing hand hygiene she touched the rim of 334's cup, touched the inside of the pudding cup, and picks up a soiled napkin and wipes his face. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12:53 pm, without doing hand hygiene, ST walks over to another resident in the north dining room and adjusts his clothes that were falling off. She rubs the resident shoulder. 12:56 pm, without doing hand hygiene, ST starts to pick up soiled lunch dishes and placing them on the soiled cart. 1:00 pm, without doing hand hygiene, ST picks up resident 334's napkin and hands it to him to wipe his face. During an interview on [DATE] at 1:06 pm, ST indicated she was supposed to do hand hygiene when she came into the room and when she left. ST indicated that she did not do hand hygiene between residents because she did not think she had to. During an interview on [DATE] at 1:21 pm, RNA EE indicated that she did not do hand hygiene between residents, and she should have. In an interview conducted on [DATE] at 2:12 pm, when asked for her expectation of infection control practices for staff performing patient care or feeding, the Assistant Director of Nurses (ADON) stated her expectation is that staff will perform hand hygiene. Review of an undated untitled document provided by Administration showed headings titled Meal Pass Guidelines and Dining Service and included these guidelines for nursing: (Nursing) Hands should be sanitized prior to meal pass and between trays. Resident's hands should be sanitized upon entry to the dining room. It does not direct nursing staff to ensure hand sanitation prior to all meals for all residents. In an interview conducted on [DATE] at 12:42 pm, the Infection Preventionist (IP) nurse stated that staff are expected to perform hand hygiene before and after resident care and that they should wash hands between residents being fed, and if staff touched their own body or hair, they need to sanitize before resuming patient care. In an interview conducted on [DATE] at 2:12 pm, when asked for her expectation of infection control practices for staff performing patient care or feeding, the Assistant Director of Nurses (ADON) stated her expectation is that staff will perform hand hygiene. 42448 2. Nursing unit resident nourishment rooms were not sanitary (Cross Reference F812, F813, F925). Review of the 2022 Food and Drug Administration (FDA) Food Code ,d+[DATE].11 showed A) Equipment food-contact surfaces and utensils shall be clean to sight and touch . C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the [NAME] Nourishment Room, on [DATE] at 1:15 pm, three out of six condiment drawers were soiled with food debris, opened and discarded condiment packets, dust and grime. The refrigerator/freezer for resident snacks and personal food showed a buildup of grime, drips and unknown debris. The top of the refrigerator was dusty and held two large bowls, an unlabeled undated case of Pepsi, bottle of Pepsi, and some additional papers. The coffee cart had spills, dark stains, and held two used coffee cups with three used spoons. The countertop was soiled and stained, with uncleanable, chipped and missing edges. The floor was sticky and had a spill of clear fluid. A plastic closet labeled Staff Use Only held staff belongings such as purses, drink cups, jackets, with additional jackets and personal belongings draped over open doors and assembled on top of the cabinet. A corrugated box labeled as additional bathing cloths was stored on the counter and partially covered the sink. An observation of the East nourishment room on [DATE] at 1:45 pm, showed it also had a closet with staff personal belongings and opened staff beverages. The counters were not clean, and their edges were chipped, missing, and uncleanable. Soiled paper towel trash was left on the corner of the sink and counter. Two out of six condiment drawers were soiled with drips, unknown food debris and grime. The coffee cart was soiled and held two soiled cups adjacent to the coffee condiments. During an interview with the Maintenance Supervisor (Maint. Sup.) on [DATE] at 10:20 am, he was asked about the ongoing problem with cockroaches in the facility, including the surveyor's observations and sanitation concerns in the three nourishment rooms. He stated cockroaches were everywhere (in the world), and they could be brought in on staff coats or purses. He stated nursing staff also had storage for their personal items in their break room, and he wished staff belongings weren't in the nourishment rooms. During an observation of the North Nourishment Room, on [DATE] at 8:40 am, the staff microwave oven was rusted inside and had a soiled paper towel on the carousel. There were open staff beverages on the counter, and the plastic staff closet had jackets and purses hanging off it. The trash can was not covered. In a later interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on [DATE] at 3:20 pm, the DON stated the nourishment rooms were not break rooms, yet staff were allowed to store their personal belongings, food and beverage there, and a sign posted above the microwave oven in the North nourishment room stated Microwave only for staff. During an interview with Housekeeper R (HK R) on [DATE] at 9:15 am, she stated staff always had their beverages on the counter. During an interview with the Registered Dietitian (RD), on [DATE] at 1:05 pm, she stated the staff belongings and personal food and beverages in the nourishment rooms were a consistent problem. 3. Chemicals that were not food-safe were used to clean food contact surfaces in nursing unit nourishment rooms (Cross Reference F812). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Housekeeping Assistant Manager (HK AMgr.) on [DATE] at 10:35 am, she stated the housekeeping staff cleaned the nursing unit nourishment rooms twice daily. They wiped the counters, mopped the floor, wiped out the refrigerator if it needed it, or cleaned the refrigerator once weekly. She stated staff used their facility disinfectant Quat-Stat 5 to wipe out the interior of the refrigerator and clean the counters, but Dietary department staff cleaned out any expired food. In a concurrent review of the Quat-Stat 5 label and interview with the Maint. Sup. there was no indication it was a food-safe chemical. The Maint. Sup. stated he would contact his chemical vendor to find out if it was food safe. In a follow-up interview with the Maint. Sup. on [DATE] at 1:25 pm he stated the only thing he could find about the Quat-Stat 5 was the MDS (Material Data Sheet), and it didn't say if the chemical was food safe. During an interview with Maintenance Supervisor (Maint. Sup.), on [DATE] at 9:10 am, stated they did not have a policy and procedure for cleaning surfaces. They just followed the chemical label instructions. During an interview with HK AMgr. on [DATE] at 8:25 am she stated the process for using Quat-Stat 5 throughout the facility was to wipe down surfaces and provide a five-minute dwell (wet) time. She stated that was how all staff were trained. Sometimes they used bleach to clean handrails and any rooms contaminated with C. Difficile (a bacteria). The HK AMgr. stated she trained her staff to clean the nourishment room refrigerators using Quat-Stat 5 to wipe down the shelving, doors, and seals, and to have a 5-minute wet time. Review of the Betco Quat-Stat 5 website https://www.betco.com/products/quatstat-5-disinfectant/34104?pageNumber=1 showed a use for disinfecting food processing facilities (factories), but not for food service facilities. The food processing facility instructions required a five-minute wet (dwell) time and rinsing all food contact surfaces with potable water prior to reuse, which was not the process being followed at this facility. Review of documents titled Infection Prevention and Control Manual, Environmental Services/ Housekeeping/ Laundry provided by Administration showed All chemicals should be used as the manufacturer recommends. Only cleaning supplies approved by the Infection Control Committee are to be used in this facility. 4. The RNA Room was unsanitary and had live cockroaches (Cross Reference F925). During an observation in the RNA (Resource Nursing Assistant) dining room on [DATE] at 7:35 am, the dining tables were soiled with visible streaks of grime, and there was an area with a dried red substance resembling blood. During an observation and concurrent interview with Housekeeper S (HK S) in the RNA room on [DATE] at 7:40 am, she stated the RNA room was where the RNA fed residents their meals daily. She stated she thought they cleaned that room at least three times daily. She began to clean the tables using a PDI Super Sani-Wipe cloth. She stated she usually used buckets and rags or sprayed a purple sanitizer solution (could not remember its name) and wiped with a rag, but she was unable to access her cart with the cleaning buckets at that time. HK S used one Sani-Wipe cloth to clean all three dining tables. She stated the sanitizer dried fast and didn't need to stay wet for any length of time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in the RNA room on [DATE] at 8:15 am, two live cockroaches were found on the floor in the RNA room. Further observation showed the floors were not clean and had a dark buildup of grime around the edges of the floor. The RNA room kitchen had uncleanable, chipped counters. A pink water bottle, silver purse, and a what appeared to be a packaged egg and cheese breakfast sandwich were stored on the kitchen counter. Review of the Centers for Disease Control and Prevention (CDC) website showed cockroaches may provoke allergic reactions and may harbor many forms of pathogenic (disease-causing) bacteria, including bacteria that cause food poisoning and dysentery. Cockroaches also harbor fungi and parasites and may be carriers of multi-drug resistant pathogens. https://search.cdc.gov/search/?query=cockroaches&dpage=1. Further review of the CDC website showed cockroaches are often found where food is eaten, and crumbs are left behind. Practices to decrease cockroach populations include remove water and food sources; clean dishes, crumbs, and spills right away; store food in airtight containers; keep trash in a closed container; seal cracks in cabinets, walls, baseboards, and around plumbing. https://www.cdc.gov/asthma/control/ Review of the 2022 FDA Food Code ,d+[DATE].111 showed The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (B) Routinely inspecting the PREMISES for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control .; and (D) Eliminating harborage conditions. , d+[DATE].13 showed The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. Review of an undated facility policy titled Pest Control showed The facility is committed to implementing an effective pest control program in compliance with federal, state and local regulations. Its purpose was to maintain a safe and healthy environment for residents, staff and visitors by preventing, identifying, and addressing pest infestations within the skilled nursing facility. Preventive measures included Proper Waste Management: Ensure that garbage is stored in sealed containers and removed from the facility regularly and Food Storage: Verify that all food items are store in airtight containers and kept in designated storage areas and Environmental Maintenance: Maintain cleanliness in and around the facility. 43755 5. During an observation and interview with CNA CC on [DATE] at 10:18 am, Resident 8's room was observed. CNA CC indicated that Resident 8's CPAP and nebulizer were dirty with brown and white spots and needed cleaning. Resident 8's oxygen tubing was on the floor where a bug was noted to be crawling, and it should not be. CNA CC continued to indicate that there was a dirty gown thrown on the floor because she threw it there after she helped Resident 8 get dressed this morning and did not pick it up. CNA CC confirmed that the floor was dirty with brown and black matter and that there were lots of boxes sitting on the floor and chairs with items overflowing out of them. CNA CC indicated that these were infection control issues and needed addressing. CNA CC indicated that there is not enough storage room for residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Infection Prevention and Control Manual, Resident Care dated 2019, indicated All nursing activities will be performed in a manner to minimize the potential for infection to residents 1. Items used for resident care will be cleaned, disinfected per facility policy . 5. Residents' rooms will be clean and orderly. 6. During an observation on [DATE] at 11:47 am, room [ROOM NUMBER] was observed. Underneath Bed A was a bed pan used for residents to urinate in while in bed. The bed pan was not in a bag or sitting on a barrier. The resident in bed A indicated that she used the bed pan at night and put it under the bed when she was done with it. During a concurrent observation and interview with LN DD on [DATE] at 11:55 am, room [ROOM NUMBER] was observed. LN DD indicated that the bed pan was not supposed to be under the bed and that is should have been cleaned after each use and kept in the bathroom in a plastic bag. LN DD indicated that this was an infection control issue. 45315 7. During a concurrent observation and interview on [DATE] at 10:11 am, Resident 73 was observed lying in bed wearing an incontinent brief that contained urine and feces. Certified Nurse Assistant (CNA) D was observed providing peri care (cleaning the vagina and anus after incontinence) to Resident 73. CNA D was in the middle or providing peri care and stopped to look through the top drawer of Resident 73's nightstand and was touching personal care items (toothbrush, hairbrush, mouth wash) with dirty gloves. Resident 73's bed linen was soiled with urine and required to be changed. The urine soaked lined was placed on the floor and remained there until after all care had been provided (approximately 20 minutes). CNA D confirmed, dirty linen was not to be placed on the floor and stated, CNA D was not sure why. CNA D stated, It's just not allowed. CNA D confirmed, touching Resident 73's personal care items while wearing dirty gloves. CNA D was asked if that was considered an infection control concern and CNA D stated, not sure and stated, I've never heard of changing gloves after providing peri care, before going into the resident's drawer, and was unaware if CNA D's actions was considered an infection control concern. During an interview on [DATE] at 8:39 am, with the DON, the observations made on [DATE] at 10:41 am, regarding CNA D were discussed. DON stated, the observations made, should not have happened and confirmed dirty linen on the floor and touching personal care items with dirty gloves was an infection control concern. 8. During a concurrent observation and interview on [DATE] at 7:25 am, LN was observed checking Resident 331's blood sugar, utilizing the glucometer (a medical device that was used to collect a blood sample and obtain a blood sugar level on diabetic residents). After LN A obtained Resident 331's blood sugar, LN A placed the glucometer and bottle of test strips (the test strip slides into the glucometer and contained the blood sample) on the nightstand without a barrier. After LN A removed gloves and sanitized LN A's hands, LN A picked up the dirty glucometer with ungloved hands and the bottle of test strips and placed them in the front right pocket of LN A's uniform top. LN A walked Resident 331 to the dining room, walked to the medication cart, and placed the glucometer and bottle of test strips on top of the medication cart without using a barrier. LN A used a cleansing wipe from a container with the brand name Sani-Wipe and wiped down the glucometer, one time, with one wipe, then placed the glucometer immediately in the top drawer of the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 947 am, LN A confirmed the observations and stated, LN A should not of placed the glucometer and bottle of test strips on Resident 331's nightstand without using a barrier. LN A stated, LN A should not of placed the dirty glucometer and bottle of test strips in LN A's pocket and should have cleaned the top of the medication cart after disinfecting the glucometer. LN A was unaware if the glucometer needed to remain wet with the disinfectant for a specific amount of time to kill bacteria (also known as the wet time). A review of the Sani-Cloth container indicated, the wet time for the product to disinfect an item, was two minutes. During a concurrent interview and record review on [DATE], the DON, confirmed the observations made while LN A checked Resident 331's blood sugar and stated, that was an infection control concern and shouldn't have happened. DON reviewed the glucometer's manufactures recommendations, titled User's Guide, revised [DATE], and stated, the User Guide indicated, after the glucometer was cleaned, the glucometer would be disinfected with an approved disinfecting wipe, and required to remain wet for the duration of time that the cleaning wipes instructions indicated. DON reviewed the approved list of disinfecting wipes, located in the User Guide and confirmed, Sani-Wipes were not an approved disinfectant wipe to use with the glucometer. DON confirmed, the User Guide indicated, disinfecting the glucometer was a 2-step process.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and facility review the facility failed to ensure they maintained an effective pest control program when: 1. An unidentified bug was seen crawling in resident room [ROOM NUMBER]. 2. Cockroaches were seen crawling around in the Restorative Nursing Assistant (RNA)room (the dining room that Residents eat in which includes a small kitchen area). This failure had the potential to cause a health hazard to the residents and did not honor their right for a homelike environment. Findings: During a review of the facility's policy titled Pest Control (undated), the policy indicated The facility is committed to implementing an effective pest control program in compliance with federal, state and local regulations. The purpose of the policy was To maintain a safe and healthy environment for residents, staff and visitors by preventing, identifying, and addressing pest infestations within the skilled nursing facility. 4. Preventive Measures . The maintenance Department will . Maintain cleanliness in and around the facility 1. During an observation on 12/10/24 at 10:00 am, in resident room [ROOM NUMBER] bed B, an unidentified bug, that resembled an earwig, was noticed crawling along the baseboard around Resident 8's oxygen tubing. The room had five cardboard boxes on the floor with papers, clothes, and magazines and packages overflowing out of them. The floor, baseboards and the floor under the wall heater/air-conditioner was observed to have black and brown grime and a buildup of brown matter. There was a strip of tattered black tape with white fuzzy build up on the floor. During an observation on 12/10/24 at 11:06 am, resident room [ROOM NUMBER] was observed having 13 cardboard boxes stacked on the floor and on a chair. The boxes contained coffee mate creamer, canned goods, backpacks, a white package, and a white blanket that were overflowing out of the boxes onto the floor. During an interview on12/11/24 at 1:44 pm, Resident 8 stated I know they have little black bugs. Resident 8 indicated she had seen them before. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/24 at 12:20 pm, Maintenance Supervisor (Maint Sup) indicated he was responsible for facility maintenance, pest control, and housekeeping. They have had occasional pest problems with water bugs, spiders and earwigs. They have a monthly pest control service. Review of monthly pest reports showed ongoing issues with cockroaches for more than the [AGE] year. When asked what additional actions the facility was taking to eradicate cockroaches, Maint Sup indicated they had a big problem in the therapy room once and had to take everything out of it to clean and treat it. He stated they try to keep residents' food and possessions cleaned up but that's difficult. He stated cockroaches are everywhere, but in spite of the facility's eradication efforts, they could still easily be brought in on employee or visitor clothing, purses, and other personal belongings (perpetuating the problem). During an interview on 12/13/24 at 8:16 am, Maint Sup indicated that the pest control company comes on a monthly basis but does not spray rooms, they just spray outside the facility. Maint Sup indicated that every day the resident rooms should be cleaned but they have been short staffed in housekeeping, and he did not know when the last deep cleaning of room [ROOM NUMBER] had been done. A concurrent observation and interview with Maint Sup on 12/13/24 at 8:44 am, Resident room [ROOM NUMBER], and 322 were observed. The Maint Sup indicated that these rooms were dirty and needed to be cleaned. The Maint Sup indicated that there were a lot of boxes in these rooms and indicated that the boxes should not be there because they can bring in bugs and rodents. 2. During an observation on 12/12/24 at 7:40 am, a German cockroach was observed running on the counter, under the microwave and behind the stove of the of the RNA dining room. During an interview on 12/13/24 at 8:16 am, Maint Sup indicated he did not know when the RNA room had been deep cleaned. Maint Sup stated, normally they just wipe down counter tops and mop. EV indicated that the pest control comes on a monthly basis and the kitchen was sprayed monthly but other rooms inside the facility were done on an as needed basis. During an interview on 12/13/24 at 8:26 am, Housekeeping Assistant Manager (HSK AMgr) (who is MAINT SUP's assistant and oversees the cleaning) indicated she did not know when the RNA room had been deep cleaned and usually, they just clean tables, mop and check supplies. HSK AMgr confirmed that residents eat in this room. During an interview on 12/13/24 at 8:34 am, Environmental Services (EVS)) indicated that he cleaned the RNA room during the day shift. EVS indicated that his cleaning process consisted of taking soiled table clothes out and putting in new ones. Wiping down the tables and moping floor. EVS indicated occasionally he would see bugs in the RNA room. He continued to say that a couple of weeks ago he saw bugs, but the pest control company was not called, and the room was not deep cleaned after that. During a concurrent observation and interview with HSK AMgr and MAINT SUP on 12/13/24 at 8:40 am, the RNA room was observed. The rooms' floor had black and brown grime on the floor around the baseboards. EV and MAINT SUP indicated that the room was dirty and needed a deep cleaning including stripping of the wax and rewaxing the floors because the current wax had been placed over the dirty floor. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/16/24 at 8:19 am, the RNA dining room was observed with the HSK AMgr. There were three cockroaches on the floor that had been killed that day by the surveyors. HSK AMgr verified the 3 cockroaches in the RNA room and indicated they had a problem with cockroaches. 42448 During the facility survey spanning 12/10/24 through 12/18/24, multiple live cockroaches were seen on the floor and on the kitchen counter in the RNA (Restorative Nurse Assistant) dining room by the survey team. The RNA room was where the RNA normally fed residents their daily meals. Review of the 2022 Food and Drug Administration (FDA) Food Code 6-501.111 showed The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (B) Routinely inspecting the PREMISES for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12, 7-206.12, and 7-206.13; and (D) Eliminating harborage conditions. 4-602.13 showed The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. Review of the Centers for Disease Control and Prevention (CDC) website showed cockroaches may provoke allergic reactions and may harbor many forms of pathogenic (disease-causing) bacteria, including bacteria that cause food poisoning and dysentery. Cockroaches also harbor fungi and parasites and may be carriers of multi-drug resistant pathogens. https://search.cdc.gov/search/?query=cockroaches&dpage=1 Review of the University of Florida entomology department website showed German cockroaches each lay 30-40 eggs at a time and are primarily found in kitchen/food areas, garbage bins, and under sinks. They adulterate food or food products with their feces and defensive secretions, physically transport and often harbor pathogenic organisms, may cause severe allergic responses, and can bite humans. https://entneMaint Supept.ufl.edu/creatures/[NAME]/roaches/german.htm Further review of the CDC website showed cockroaches are often found where food is eaten, and crumbs are left behind. Practices to decrease cockroach populations include remove water and food sources; clean dishes, crumbs, and spills right away; store food in airtight containers; keep trash in a closed container; seal cracks in cabinets, walls, baseboards, and around plumbing. https://www.cdc.gov/asthma/control/ Review of an undated facility policy titled Pest Control showed The facility is committed to implementing an effective pest control program in compliance with federal, state and local regulations. Its purpose was to maintain a safe and healthy environment for residents, staff and visitors by preventing, identifying, and addressing pest infestations within the skilled nursing facility. Preventive measures included Proper Waste Management: Ensure that garbage is stored in sealed containers and removed from the facility regularly and Food Storage: Verify that all food items are store in airtight containers and kept in designated storage areas and Environmental Maintenance: Maintain cleanliness in and around the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations of the facility's nourishment rooms (nursing unit food storage room for residents) on 12/10/24 at 13:15 PM (West wing) and 13:45 PM (East wing), and on 12/13/24 at 8:40 AM (North wing) the rooms were comingled with large plastic closets full of employee personal belongings. Coats were draped over the open doors, and the top of the closet held more belongings. Opened employee beverages were stored on top of the closets and on nourishment room counters. The trash was not covered in all three nourishment rooms. One floor was soiled and sticky. The counters and drawers were not clean, and one resident refrigerator and freezer was soiled with drips and grime. (Cross Reference F812 and F813). During an interview with the Maintenance Supervisor (Maint. Sup.) on 12/12/24 at 10:20 pm he stated he was responsible for facility maintenance and housekeeping. He stated they had occasional pest problems with water bugs, spiders and earwigs, but they had a monthly pest control service. A concurrent review of recent monthly pest reports (5/17/24, 7/18/24, 8/18/24, 9/19/24, 10/9/24, 10/17/24, 11/21/24) showed the facility had an ongoing issue with German Cockroaches. The 5/17/24 report described German cockroaches heavily present with 92 cockroaches found. The 11/21/24 report showed no major activity to report despite 52 German cockroaches found. When asked if there were any additional actions the facility was taking to eradicate cockroaches, the Maint. Sup. stated they previously had a big problem with them in the therapy room and had to take everything out to clean and treat it. He stated they tried to keep resident's personal food and possessions cleaned up but that was difficult. He stated cockroaches were everywhere (in the world), and despite the facility's eradication efforts, cockroaches could still be easily brought into the facility on employee or visitor clothing, purses, and other personal belongings (perpetuating the problem). When asked about the potential for employee coats, purses and open food/beverages to attract cockroaches to the resident nourishment rooms, the Maintenance Manager replied, the closets for employees were put in there during COVID, had never been taken out, and he wished staff belongings weren't there. Review of a monthly pest report dated 1/18/24, showed Upon inspection of interior monitors in kitchen we have noticeable activity of German Cockroaches specifically in dish pit and cook line would recommend a deep cleaning and treatments. During multiple observations in the kitchen during the survey dating 12/10/24 through 12/16/24, Tin Cats (cockroach traps) were seen in the dish room and cook's preparation areas of the kitchen, but no live cockroaches were seen. During an interview with Kitchen Staff P (KS P) on 12/12/24 at 12:05 PM, she stated the kitchen has had insects and cockroaches. She stated she hadn't seen any recently, but she saw them most often in the dish room area. During an interview with Housekeeper (HK) S on 12/13/24 at 9:15 AM she stated staff always have (open) beverages on the counter in the resident nourishment rooms. During an interview with the Dietary Services Manager (DSM) on 12/16/24 at 11:40, he stated they had cockroaches in the kitchen at times, and it took the kitchen staff two days to do the process to empty out the kitchen for a deep clean with the pest control company, and then put it back. He stated it was an ongoing problem that facility staff stored their opened beverages on counters in resident nourishment rooms, but he threw them away when he found them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555281	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oroville Hospital Post-Acute Center	1000 Executive Parkway Oroville, CA 95966

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Registered Dietitian (RD) on 12/16/24 at 13:05, she stated staff belongings and personal food was a consistent problem in the resident nourishment rooms. During an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 12/16/24 at 15:20 PM, the live cockroaches seen in the RNA room by surveyors, and the longstanding problem with cockroaches in the facility was discussed. The ADON stated the RNA dining room was normally used by the RNAs to feed residents their meals daily, and if cockroaches were seen they were reported. When asked if employee belongings, employee food and beverages, open trash and lack of sanitation in the nourishment rooms could contribute to the cockroach presence in the facility, the DON and ADON stated the closets were placed in there during COVID, and never taken out. The DON and ADON agreed employees stored their belongings in the nourishment rooms, however the nourishment rooms were not break rooms, and staff were not supposed to store their food and beverages there. They stated the facility did not have a policy and procedure regarding storage of employee personal belongings. When asked what the facility was doing to eradicate cockroaches in the building, the DON and ADON replied they have a pest control service. The DON and ADON stated there were no Quality Assurance/Performance Improvement (QAPI) processes in place to address the on-going presence of potentially disease-carrying cockroaches in the facility despite the unsuccessful efforts of the pest control company to eradicate the problem.