STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555330	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Postacute Care	8781 Lakeview Avenue Riverside, CA 92509

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure meals were served at the same time, for two of three residents (Residents 101 and 127) when: 1. Resident 101 was not served his lunch meal on March 17, 2025, at the same time as the other residents at the same table; and 2. Resident 127 was not served his lunch meal on March 17, 2025, and dinner meal on March 18, 2025, at the same time as the other residents at the same table. These failures increased the potential to negatively affect Resident 101 and 127's psychosocial well-being and could place the residents at risk to not consume the food served. Findings: 1. On March 17, 2025, at 12:10 p.m., during a concurrent meal observation and interview with Resident 101 in the dining room, Resident 101 was observed sitting on a wheelchair together with three other residents in the same table. The staff were observed to serve the food to the other three residents and did not provide the meal to Resident 101. Resident 101 was observed looking at the other residents who were eating and was observed to ask the staff, Donde esta mi comida (where is my food)? On March 17, 2025, at 12:50 p.m., a follow up observation of the dining room was conducted. Resident 101 was observed to be still waiting for his lunch tray while the other three residents seated with Resident 101 at the same table were finished eating their lunch. On March 17, 2025, at 1 p.m., during an interview conducted with Resident 101, he stated his food was not yet served and he was hungry. Resident 101 stated why other residents seated next to him in the same table had their food already. On March 17, 2025, at 1:10 p.m., the staff was observed to serve the food to Resident 101. In a concurrent interview with Resident 101, he stated finally I had my food. I thought they forgot me already. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 17, 2025, at 1:20 p.m., during an interview with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 101 received his meal tray after an hour because the tray was prepared and placed in the last meal cart. CNA 1 stated there was no system in place on how the food was served so she did not know who needed to be served first. CNA 1 stated meals should have been served in an organized manner so no resident would be left out. CNA 1 further stated I would feel awkward and uncomfortable if that would happen to me too. On March 17, 2025, at 1:39 p.m., during an interview with Registered Nurse (RN) 1, RN 1 stated the delivery of food was not organized and she was confused on which residents were supposed to receive meals in the dining room. RN 1 stated the facility should have been more organized and have a system in place when serving food in the dining room. RN 1 further stated, I will feel bad too if there was no meal for me and the others were eating. On March 19, 2025, Resident 101's record was reviewed. Resident 101 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar level). A review of Resident 101's History and Physical, dated June 6, 2024, indicated Resident 101 was mentally capable of understanding. A review of Resident 101's Minimum Data Set (MDS - a resident assessment took), dated February 25, 2025, indicated Resident 101 had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact). A review of Resident 101's Order Summary, dated July 9, 2024, indicated consistent carbohydrate diet with regular texture with regular liquid consistency. On March 20, 2025, at 4:13 p.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated she expected the staff to follow the facility's policy and procedure for resident's rights. The ADON stated all residents were equal and the rights should have been protected. The ADON further stated the staff assigned in the dining room should have considered Resident 101's feelings of not receiving and not eating his food while other residents had it. 2. On March 17, 2025 at 12:21 p.m., during a concurrent meal observation and interview with Resident 127 in the dining room, Resident 127 was observed sitting in a table together with two other residents and was watching the other residents eating their lunch meal. Resident 127 stated he was waiting for his food from staff. On March 17, 2025, at 12:52 p.m., Resident 127 was interviewed and stated, I want my food. On March 18, 2025 at 5:35 p.m., during a concurrent dinner observation and interview with Resident 127 in the dining room, Resident 127 was observed sitting at the same table with another resident. Resident 127 stated he was waiting for his meal tray for about 20 minutes and until now it was not served, while the other resident was already eating. Resident 127 further stated he was unhappy and upset to see other residents eating. On March 19, 2025, Resident 127's record was reviewed. Resident 127 was admitted to the facility on [DATE], with diagnoses which included depression, diabetes mellitus, and malnutrition. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 127's Minimum Data Set (MDS - a resident assessment tool), dated January 3, 2025, indicated Resident 127 had a BIMS score of 12 (cognitively intact). On March 20, 2025, at 9:33 a.m., during an interview with the Registered Dietitian (RD), the RD stated the residents including Resident 127 who ate in the dining room should have been served at the same time with the other residents at the same table. The RD further stated Resident 127's dignity was not honored, which had the potential to cause Resident 127 to feel upset and might not enjoy his meal. A review of the facility's policy and procedure titled, Exercise of Residents Rights, dated November 2017, indicated, .The facility protects and promotes the rights of each resident. It is the facility's policy to ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility .The facility must not .treat differentially or retaliate against a resident for exercising his/her rights . A review of the facility's policy and procedure titled, Resident Dignity & Personal Privacy, dated December 2016, indicated, .The facility provides care for residents in a manner that respects and enhance each resident's dignity .Dignity means that when interacting with the residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth .When providing care and services, staff must respect each resident's individuality, as well as honor and value their input .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50610 Based on interview and record review, the facility failed to ensure informed consents (process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention in order to obtain agreement or permission for care, treatment, or services) were obtained prior to the initiation and administration of psychotropic medications according to the facility's policy and procedure, for two of five residents reviewed for unnecessary medications (Residents 23 and 38). This deficient practice had the potential for the residents or the responsible party (RP) not to be informed of the risk and benefits of the psychotropic medications, and to make an informed decision, before receiving the medications. Findings: 1. On March 20, 2025, Resident 23's medical record was reviewed. A review of Resident 23's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses including insomnia (difficulty sleeping), depression, anxiety, dementia (loss of cognitive functioning, thinking, remembering and reasoning), and seizure. A review of Resident 23's Order Summary Report, included the following physician's orders: - Melatonin (medication used for insomnia) 5 mg (milligram, unit of measurement), 2 tablet by mouth at bedtime for inability to sleep, dated 9/4/2024 (September 4, 2024); and - Diphenhydramine (known as drowsy [sedating] medication used to relieve symptoms of allergy or short-term sleep problem) 25 mg, 2 capsule by mouth at bedtime for Itching, dated 9/15/2024 (September 15, 2024). Further review of Resident 23's electronic medical records reflected no informed consents were obtained from Resident 23 for the use of both Melatonin and Diphenhydramine. On March 20, 2025 at 3:44 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON reviewed Resident 23's medical record and verified both Melatonin and Diphenhydramine had been administered to Resident 23 at bedtime since September 4, 2024. The DON looked through the electronic medical records and stated no informed consents had been obtained from Resident 23 for the use of both Melatonin and Diphenhydramine. 2. On March 19, 2025, Resident 38's medical record was reviewed. Resident 38's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses including psychotic disorder (loss of contact with reality) with delusions (unshakeable false beliefs), anxiety, and dementia. A review of Resident 38's Order Summary Report, include the following physician's orders: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Depakote (medication used to treat mood episodes) delayed release sprinkle (a type of medication designed to delay release of a drug in the body) 125 mg, 1 capsule by mouth three times a day for labile mood manifested by uncontrollable crying and yelling, dated November 22, 2024. Further review of Resident 38's electronic medical records reflected no informed consent was obtained from the resident related to the use of Depakote. On March 20, 2025 at 3:44 p.m., during a concurrent interview and record review with the DON, the DON reviewed Resident 38's medical record and verified the last informed consent obtained for Resident 38's Depakote was in September 2023. The DON looked through the electronic medical records and stated no informed consents had been obtained for Resident 38's Depakote since September 2023. The DON stated an informed consent for the use of psychotropic medications should be renewed every six months. A review of the facility's policy and procedure (P&P) titled Psychoactive Medication Informed Consent, dated March 2024, indicated, .an informed consent is obtained for each resident's psychoactive medication .in writing by a physician for specified time period .The director of Nurses (DON) and/or its designee shall be responsible for implementation and enforcement of this policy .Prior to the administration of any psychoactive medications initiated, an informed consent for the specific medication will be obtained by the physician and verified by the nurse .Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided .The facility shall renew the written informed consent every six months .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988 Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable, and home like environment for the residents was provided when: 1. Comfortable temperature levels were not maintained for multiple resident rooms (Rooms 41B, 47C, and, 49B). This resulted in multiple residents feeling cold, especially at night (Residents 95, 102, and 119)and had the potential to have effect on resident's medical condition; and 2. There was no documented evidence weekly checks of laundry equipment were performed by the Maintenance Director (MD). In addition, additional laundry staff was not maintained to assist in washing and distributing personal clothing timely. This resulted in the residents' personal belongings to not be distributed timely and had the potential to affect the residents psychosocial well being; and Findings: 1. On March 17, 2025, at 11:01 a.m., a concurrent observation and interview was conducted with Resident 95 in his room. Resident 95 was in bed with multiple blankets, he stated he gets very cold especially at night, he needed to wear mittens and a beanie cap at night to get warm. On March 16, 2025, at 12 p.m., a observation and interview was conducted with Resident 102 in the dining room. Resident 102 was sitting in his gerichair with a thick blanket covering him. Resident 102 stated he gets cold in the facility. On March 16, 2025, at 12:16 p.m., an interview was conducted with Resident 119.Resident 119 stated the facility can get very cold especially at night when the weather outside is cold. On March 18, 2025, at 5 a.m., room temperatures were taken for every room in the facility using a temperature gun. The rooms with temperatures out of range (normal range is 71 to 81 degrees Fahrenheit [F - unit measurement]) were as followed: - room [ROOM NUMBER]: 67.8 degrees F; - room [ROOM NUMBER]: 70.4 degrees F; - room [ROOM NUMBER]: 70.0 degrees F; - room [ROOM NUMBER]: 68.2 degrees F; - room [ROOM NUMBER]: 67.8 degrees F; - room [ROOM NUMBER]: 67.3 degrees F; and - room [ROOM NUMBER]: 70.0 degrees F. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 19, 2025 at 5:32 a.m., an interview was conducted with LVN 1. LVN 1 stated she always felt cold during the nighttime, she always needed to wear a jacket. On March 19, 2025, at 5:40 a.m., an interview was conducted with CNA 2. CNA 2 stated it was always cold in the facility during the nighttime, they needed to wear their jackets most of the time. On March 19, 2025, at 5:55 a.m., an interview was conducted with CNA 3. CNA 3 states it was cold during the night a lot of the residents ask for extra blankets durung the nighttime. On March 19, 2025, at 6:30 a.m., an interview was conducted with Treatment Nurse 1.Treatment Nurse 1 stated he didn't have a problem with the temperature in the facility, but a lot of the residents complain about it being too cold. On March 19, 2025, at 11:32 a.m., an interview was conducted with [NAME], Maintenance Director (MD). The MD stated he picked three random resident rooms from each station daily to check the room temperatures. He had been using the temperature range of 68 degrees F to 85 degrees F. On March 19, 2025, a record review was conducted of the temperature logs taken by the MD on February 2025 at 8:30 a.m. The temperature log indicated the temperatures in Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 15, 16, 17, 18, 19, 20, 22, 25, 27, 28, 33, 34, 37, 40, 41, 42, 47, 49, 50, 51, 53, 54, 55, 59, 61, 63, and 64, were recorded to be between 68 to 70 degrees F. On March 19, 2025, a record review was conducted of the temperature logs taken by the MD on March 2025, at 10 a.m., The temperature log indicated the temperatures in rooms [ROOM NUMBER] were recorded at 70 degrees f. A record review of the procedure and policy titled, Residents Homelike Environment, dated December 2017, indicated, .the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Comfortable Temperatures . 2. On March 18, 2025, at 2:45 p.m., Resident 42 was interviewed. Resident 42 stated she lost two t-shirts and a pair of pants, and that the facility's washing machine broke down a month or so ago leading to a lot of misplaced belongings for the residents. Resident 42 stated she was hoping some of her clothes would still show up. A review of Resident 42's record indicated Resident 42 was originally admitted the facility on September 28, 2018, and readmitted to the facility on [DATE], with diagnoses which included heart failure. A review of Resident 42's Minimum Data Set (MDS - a clinical assessment tool), dated January 9, 2025, indicated Resident 42 had a BIMS (Brief Interview for Mental Status) score of 14 (cognitively intact). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 19, 2025, beginning at 2:02 p.m., an observation of the laundry room was conducted. In one corner of the folding area, on top of a table, was a pile of clothing covered with a white sheet. The Housekeeping and Laundry Supervisor (HLS) stated these were the residents' clothing which needed to be folded and distributed to them, and they would try to get to them the next morning since they were busy today. The HLS stated that pile was worst a month or so ago when the washing machine broke down. Upon observation of the clothes washers and dryers, clothes washer # (number) 1 and clothes dryer #1 were not running. The HLS stated clothes dryer #1 was not working, and they were only using clothes dryers #2, #3 and #4. The HLS further stated clothes washer #1 had not been working for 4 weeks, and only clothes washer #2 and #3 were in use. On March 19, 2025, at 2:14 p.m., Laundry Staff (LS) 2 was interviewed. LS 2 stated clothes dryer #1 had not been working since he started work at the facility three and a half months ago. On March 19, 2025, at 3:54 p.m., the Maintenance Director (MD) was interviewed. The MD stated he was overseeing maintenance of the clothes' washers and dryers, and if there were repairs beyond his scope, he would call (name of company) which services the machines, as well as the company which rents out the machines to the facility, to address needed repairs. The maintenance log was requested and concurrently reviewed with the MD. The document contained information on a monthly basis. The MD stated he checked the laundry equipment weekly on random days, and only logged findings that were not in compliance and what was done to address the issues. The MD stated he did not keep a daily or weekly log for the clothes washers or dryers. On March 20, 2025, at 11:48 a.m., a follow up observation of the laundry room was conducted. The pile of residents' clothing on top of the table in the corner of the folding area was observed uncovered and untouched. In a concurrent interview with the HLS, the HLS stated they still had not gotten to folding the clothes since there were more laundry to be dealt with today. A schedule for the day's laundry staff was requested. The HLS referred to the (Name of facility) Lint trap Log, for March 2025, and stated there was one laundry staff working currently, as indicated by the names on the column 4am-12pm Shift, and she was the second person helping out with the laundry. A review of the facility's plan of correction for a prior issue regarding lost clothing, completed February 4, 2025, indicated clothes dryer #1 and clothes washer #1 were fixed by the MD on January 10, 2025, but recent observations indicated otherwise. The plan of correction also indicated the MD would check the laundry equipment weekly to make sure equipment were in good working condition, and additional laundry staff was added to the daily schedule to help with washing and distributing clothing timely starting February 4, 2025. On March 21, 2025, at 3:36 p.m., the Administrator (ADM) was interviewed. After confirming with the MD, the ADM stated there was no weekly documentation by the MD to prove weekly check of the laundry equipment was done, and there should have been. The ADM further stated there should have been additional laundry staff to help with distribution of residents' clothing. The ADM stated there was no policy and procedure related to laundry services.

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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** 47374 Based on observation, interview and record review, the facility failed to ensure grievance were addressed, for one of three residents (Resident 55), when Resident 55 notified the facility staff of missing leg prosthesis. This failure had the potential for Resident 55 to have a decline in Activities of Daily Living (ADL) and could affect psychosocial and physical well being. Findings: On March 19, 2025, Resident 55's medical record was reviewed. Resident 55 was admitted to the facility on [DATE], with diagnoses which included respiratory failure with hypoxia (lungs fail to adequately oxygenate the blood, leading to low oxygen levels), absence of left leg below the knee, blindness in both eyes. A review of the History and Physical, dated May 25, 2022, indicated the resident had a fluctuating capacity to understand and make decisions. A review of Resident 55's Minimum Data Set (MDS - a resident assessment tool), dated October 14, 2024, indicated Resident 55's Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive impairment). A review of Resident Inventory List, dated June 29, 2022, indicated left leg prothesis (an artificial device replaces a missing body part), present at Resident 55's bedside. On March 17, 2025, at 10:33 a.m., an interview was conducted with Resident 55. Resident 55 stated the facility had lost her left below the knee prosthetic leg during a room change approximately seven (7) months ago. Resident 55 further stated the left leg prothesis was left behind and later could not be found. Resident 55 stated she had notified the charge nurse, the administrator, the Director of Nursing, and Social Service Assistant and had not had any feedback or follow up since her original report. Resident 55 stated she was very distressed by the leg not being found since she could no longer get out of bed or walk with her walker since prothesis was lost. Resident 55 further stated she had felt herself getting weaker because of the lack of using that leg. On March 18, 2025, at 10:04 a.m., the Social Service Director (SSD) was interviewed. The SSD stated Resident 55's left leg prosthesis was reported missing about seven (7) months ago. The SSD stated they had searched the storage garage but was not found. The SSD stated a request for a prosthesis replacement was passed on to the case manager sometime ago. On March 18, 2025, at 10:10 a.m., an interview with the Social Service Assistant (SSA) was conducted. The SSA stated the left leg prothesis was reported missing by Resident 55 in September 2024. The SSA stated she had spoken with Resident 55's insurance about the lost prothesis and then the case was handed to the Case Manager (CM). (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 18, 2025, at 10:23 a.m.,an interview with the CM was conducted. The CM stated she had been in contact with Resident 55's insurance for Durable Medical Equipment (DME) leg prothesis replacement from January 28, 2025 immediately after the SSA informed her of the loss. The CM further stated it would cause emotional issues and a possibility of decline in the Activities of Daily Living (ADLs) for Resident 55. A review of the facility policy and procedure titled, Theft and Loss, dated April 2018 indicated, .the facility to investigate all reports of stolen items .makes report to authorities and maintains documentation .to assure . resident's properties .are safeguarded and replaced in case of loss .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459 Based on interview and record review, the facility failed to ensure medications were administered according to the physician orders, for one of 37 residents reviewed, (Resident 148). This failure had the potential to inadequately control Resident 148's blood pressure, pulse rate, and blood sugars, which could affect Resident 148's overall health condition. Findings: On March 19, 2025, Resident 148's record was reviewed. A review of Resident 148's Admission Record, indicated Resident 148 was admitted to the facility on [DATE], with diagnoses which included hypertensive heart disease (heart issue that develops due to a long term high blood pressure), diabetes mellitus (abnormal blood sugar), and bradycardia (slow heart rate). A review of Resdient 148's Physician Order, dated December 12, 2024, indicated the following orders: - Clonidine HCL (a medication used to decrease blood pressure) Oral Tablet 0.1 milligrams (mg - unit measurement), Give 1 (one) tablet via PEG tube (tube inserted into stomach that brings nutrition directly to the stomach) every 8 (eight) hours for essential primary hypertension (high blood pressure). Hold if SBP (systolic blood pressure) < (less than) 110 or heart rate < (less than) 60; - Hydralazine HCL (medication used to decrease blood pressure) Oral Tablet, Give 75 mg via PEG tube three times a day for Hypertension Hold if SBP < 110 or HR <60; - Lantus Subcutaneous Solution (Insulin Glargine) Inject 15 units subcutaneously at bedtime for DM2 hold if BS < 60. A review of Resident 148's Medication Administration Record (MAR), for the months of February and March 2025, indicated, clonidine HCL was not administered to Resident 148 according to physician order on the following dates and times: - February 7, 2025, at 10 p.m.; - February 16, 2025, at 10 p.m.; - March 2, 2025, at 10 p.m.; and - March 12, 2025, at 6 a.m. In addition, clonidine was signed as administered to Resident 148 with no documented blood pressure and pulse rate readings on the following dates and times: - February 2, 2025, at 6 am, 2 p.m., and 10 p.m.; (continued on next page)

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Riverside Postacute Care	8781 Lakeview Avenue Riverside, CA 92509

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- February 3, 2025, at 2 p.m., and 10 p.m. A review of Resident 148's Medication Administration Record (MAR), for the months of February and March 2025, indicated, hydralazine was not administered to Resident 148 according to the physician's orders on the following dates and times: - February 3, 2025, at 5 p.m.; SBP was 107; - February 7, 2025, at 5 p.m.; no documentation; - February 16, 2025, at 5 p.m.; no documentation; - February 23, 2025, at 9 a.m.; pulse rate 58; and - March 9, 2025, at 1 p.m.; SBP was 106. A review of Resident 148's Medication Administration Record (MAR), for the months of February and March 2025, indicated, Lantus was not administered to Resident 148 according to the physician's orders on February 7 and 9, 2025, and on March 2, 2025. In addition, there was no documented evidence blood sugar was checked prior to administering Lantus for the months of February and March 2025. On March 20, 2025 at 4:30 p.m. an interview and concurrent record review was conducted with the Director of Nursing (DON). The DON stated medications were given if the MAR had a check with initials of the licensed nurse who administered it. The DON stated when the MAR had blank areaas where a vital sign, blood sugar or signature, then it was not done or administered to the resident. The DON stated there should be doucmented vital signs prior to administering or holding medication. The DON stated clonidine, hydralazine, and Lantus should be administered to Resident 148 according to the physician orders. A review of the facility's policy and procedure titled, Preparation and General Guidelines: Medication Administration - General Guidelines, dated 2006, indicated, .medications are administered in accordance with written orders of the attending physician .the resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are verified with a full signature in the space provided . A review of the facility's policy and procedure titled, Medication Administration: Documentation of Medication Administration, dated, April 1, 2011, indicated, .nursing staff shal document all medications administered to each resident on the resident's Medication Administration Record (MAR) .reason(s) why a medication was withheld, not administered, or refused .signature and title of the person administering the medication .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113 Based on observation, interview, and record review, the facility failed to ensure sufficient staff were provided to meet the needs of the residents when: 1. For 9 of 161 residents, (Residents 42, 56, 66, 91, 103, 107, 132, 267, and 417) complained that staff failed to assist with activities of daily living (ADL- daily care activities) in a timely manner; and 2. Three (3) of nine (9) confidentially interviewed residents from the Resident Council meeting complained that call lights were not being answered timely, food was being served late, and residents were left sitting in their urine and bowel for long periods of time. These deficient practices caused feelings of frustrations and anger, among the residents, and negatively affected the quality of care for the residents. Findings: 1a. On March 17, 2025, at 10:10 a.m., during an interview with Resident 417, Resident 417 stated the facility was short of nursing staff. Resident 417 stated there were long waits for the call bell to be answered and the Certified Nursing Assistants (CNAs) were always moving and apologizing for being late. Resident 417's record was reviewed. Resident 417's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included osteomyelitis of the vertebrae (bone infection that affects the spine). A review of Resident 417's history and physical, dated March 12, 2025, indicated Resident 417 had the capacity to make decisions. 1b. On March 17, 2025, at 10:20 a.m., during an interview with Resident 66, Resident 66 stated the call bell was not answered quickly and believed it was related to staffing. Resident 66 further stated the nurses needed more help, and sometimes the wait was 30 minutes or more. Resident 66's record was reviewed. Resident 66's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (lung diseases that block airflow), spinal stenosis (spaces inside the bones of the spine get too small), and bilateral primary osteoarthritis of hip (joint disease). Resident 66's Minimum Data Set (MDS- an assessment tool), indicated Resident 66 had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact), and Resident 66 uses a wheelchair, and requires partial to moderate assist with toileting, shower/bathing, putting/taking off footwear, lower body dressing, positioning from sit to standing, and tub/shower transfer. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1c. On March 17, 2025, at 12:08 p.m., an interview with Resident 103 was conducted. Resident 103 stated she waited for her medicine a long time. Resident 103 further stated the facility was short staffed and did not have enough people. Resident 103's record was reviewed. Resident 103 was admitted to the facility on [DATE], with diagnoses which included heart failure (the heart does not pump blood well), lumbar radiculopathy (pinched nerve of the lower back) and spinal stenosis. A review of Resident 103's MDS, dated [DATE], indicated the resident uses a wheelchair and a walker, and needs partial assistance with toileting, showering/bathing, upper and lower body dressing and personal hygiene. 1d. On March 18, 2025, at 8:49 a.m., Resident 267 was interviewed. Resident 267 stated while he was in a previous room, his roommate needed to get changed and could not get help. Resident 267 further stated the nurse stated, they would get his roommates' CNA for him. Resident 267 also stated there was a staffing issue at night. Resident 267's record was reviewed. Resident 267's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included hereditary and idiopathic neuropathy (damage to surrounding nerves), ankylosis of right hand (condition where bones fuse together), and muscle weakness. A review of Resident 267's MDS, dated [DATE], indicated Resident 267 had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact). 1e. On March 18, 2025, at 2:31 p.m., Resident 107 was interviewed. Resident 107 stated it took too long to answer the call light during the day and night shifts. Resident 107's record was reviewed. Resident 107 was admitted to the facility on [DATE], with diagnoses which included atherosclerosis (fatty deposits in arteries), and spondylosis (wear and tear of the spinal disks). A review of Resident's 107's MDS, dated [DATE], indicated Resident 267 had a BIMS score of 11 (moderate cognitive impact), and the resident was dependent for oral hygiene, toileting, shower/bath, upper body dressing, and personal hygiene. Resident 107's history and physical indicated the resident had intermittent capacity to make decisions. 1f. On March 18, 2025, at 2:45 p.m., Resident 42 was interviewed. Resident 42 stated every now and then the facility was short of CNA's and the residents waited 20 to 30 minutes to be attended to. Resident 42 also stated it happened mostly after the 3 o'clock shift and she heard other residents complain about waiting a long time for a CNA to come. Resident 42 further stated the CNA's do not check on them like they should, and it was bad on the weekends. Resident 42's record was reviewed. Resident 42 was admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure (lungs do not get enough oxygen in the blood), generalized osteoarthritis (flexible tissue at end of bones wear down), and muscle weakness. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 42's MDS, dated [DATE], indicated Resident 42 had a BIMS score of 14 (cognitively intact). 1g. On March 18, 2025, at 3:01 p.m., an interview with Resident 56 was conducted. Resident 56 stated she agreed with Resident 42 about staff shortage issues. Resident 56 also, stated we wait a long time for CNA's to respond, or they ignore you. Resident 56's record was reviewed. Resident 56 was admitted to the facility on [DATE], with diagnoses which included parkinsonism (brain condition that causes problems with movement), rheumatoid arthritis (immune system attacks tissues lining the joints), and generalized muscle weakness. Resident 56's MDS, dated [DATE], indicated the resident uses a wheelchair, and needs some help with lower extremity hip, knee, ankle, and foot. 1h. On March 18, 2025, at 3:08 p.m., an interview with Resident 132 was conducted. Resident 132 stated when he used the call light, someone would come in the room, turn off the call light and say, your CNA was busy and would be here soon. Resident 132 also stated other staff turned off the light and left the room without addressing the need. Resident 132 further stated he sat in his own bowel/stool for over 30 minutes waiting on a CNA to assist him and he felt helpless. Resident 132 stated he felt paralyzed because he could not do anything. On March 17, 2025, at 10:38 a.m., Resident 132's family member (FM) was an interviewed. The FM stated Resident 132 wore a diaper and it took a long time for staff to come clean and change him and that should not happen. Resident 132's record was reviewed. Resident 132 was admitted to the facility on [DATE], with diagnoses which included spinal stenosis, carpal tunnel syndrome (pressure on nerves in the wrist) and right and left artificial hip joints (surgical procedure that replaces hip joint). Resident 132's MDS, dated [DATE], indicated Resident 132 had a BIMS score of 15 (cognitively intact). 1i. On March 19, 2025, at 8:00 a.m., an interview was conducted with Resident 91. Resident 91 stated her call light was always hidden from her. Resident 91 stated today they finally put it out. She stated it took the staff a long time to answer her call light. Resident 91's medical record was reviewed. Resident 91 was admitted to the facility on [DATE], with diagnoses which included rheumatoid arthritis (inflammation affecting small joints of hands and feet), muscle weakness, and osteoarthritis. A review of Resident 91's MDS, dated [DATE], indicated Resident 91 had a BIMS score of 14 (cognitively intact), and the resident uses a wheelchair and a walker, and needs partial assistance with oral hygiene, and needs substantial/maximal assistance with toileting hygiene, showering and personal hygiene. Resident 91 was also dependent for upper and lower body dressing and putting on and taking off footwear. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On March 19, 2025, at 5:04 a.m., an interview with CNA 4 was conducted. CNA 4 stated she worked the night shift from 11 p.m. to 7 a.m. CNA 4 stated she normally cared for 25 residents per shift. CNA 4 stated they were on average responsible for 23-30 residents per shift for the past 2 months. CNA 4 stated she did not feel there was not enough staff to meet the needs of the residents, and she was not able to answer the resident's call lights in a timely manner leading to the resident's complaints. CNA 4 stated CNAs were sometimes pulled from resident care to do laundry tasks. CNA 4 stated she had to work double shift (16 hours/day) for about 4 to 5 times a week because there was not enough staff to cover the other shifts. CNA 4 stated she made management aware and nothing was being done. On March 19, 2025, at 6:17 a.m., an interview with CNA 5 was conducted. CNA 5 stated the past two to three months have been terrible. CNA 5 stated they were short staff for the night shift. CNA 5 stated they did not have enough staff to efficiently do her job. CNA 5 Stated on March 3, 2025, there were four (4) CNAs on the floor and one (1) CNA as a sitter on the night shift. CNA 5 stated she discussed this with the Licensed Vocational Nurse (LVN) and was told to do what she could. CNA 5 stated she was responsible for 23-32 residents on average for the past two months. She stated last week she was assigned to 52 Residents and was not able to complete her assignments efficiently. CNA 5 stated she did not get any offer for help. CNA 5 stated she informed the Registered Nurses (RN) that she had too many residents that she could not get to change the residents and charting not done. CNA 5 stated she had voiced her concerns about resident assignment to the Director of Staff Development (DSD) during huddles. She stated she had been asked to work overtime in the past three weeks. CNA 5 stated they were understaffed on the weekends too. On March 19, 2025, at 8:28 a.m., an interview with LVN 2 was conducted. LVN 2 stated she worked from 11 p.m. to 7 p.m. LVN 2 stated last night she was assigned 50 residents. LVN 2 stated on average she have 33 patients but lately she has been assigned 50 residents. LVN 2 stated the facility was not staffed enough for her to do her job safely. LVN 2 stated CNA's had expressed to her on multiple occasions they were not able to complete their assignments. On March 20, 2025, at 10:16 a.m., an interview with CNA 6 was conducted. CNA 6 stated she worked the am shift, 7 a.m. to 3 p.m. and has an average of 10 patients. CNA 6 stated the residents complained the call light was not answered, and they waited for an hour to get pain medicine and to be cleaned. CNA 6 also stated she does not feel she had enough time to do her work assignment safely, efficiently and effectively. Stated she told the charge nurse. On March 21, 2025, at 2:19 p.m., a concurrent interview and record review was conducted with the Assistant Director of Staff Development (ADSD). The ADSD stated the facility did not have any staffing waiver, nor resident care service waivers. The ADSD stated the facility was not consistent with meeting the Nursing Hours Per Patient Days (NHPPD). The ADSD stated the DSD and the Administrator (ADM) were also aware of the workload concerns. The ADSD further stated the facility had not consistently and sufficiently provided adequate care for four to five days a week. The ADSD further stated the night shift staff averaged 27-28 residents and from her understanding the night shift should be assigned 18-20 residents. The ADSD stated from February 2025 to March 2025, the facility lost about 5 staff on the night shift. The ADSD further stated a negative outcome of the night shift being understaffed could contribute to the lack of quality of care for the residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A concurrent review of the facility's Census and Direct Care Service Hours Per Patient Day, (DHPPD - measures the number of hours of direct care given to patients in skilled nursing facilities) records for multiple days in February and March 2025, indicated the actual CNA DHPPD were below the stated required minimum of 2.40 hours for five (5) of the 15 days reviewed. The CNA DHPPD hours ranged from 2.20 to 2. 30 as follows: - February 8, 2025 (Saturday): 2.20 hrs; - February 9, 2025 (Sunday): 2.24 hrs; - February 16, 2025 (Sunday): 2.30 hrs; - February 24, 2025 (Monday): 2.20 hrs; and - February 28, 2025 (Friday): 2.30 hrs. A review of the Nursing Staff Assignment And Sign-In Sheet, for the mentioned dates indicated one CNA provided care to a number of residents that ranged as follows: - February 8, 2025 (Saturday): PM (3 p.m. to 11 p.m.) shift = 14-15 residents, and NOC (11 p.m. to 7 a.m.) shift = 24-25 residents; - February 9, 2025 (Sunday): PM shift = 11-12 residents, and NOC shift = 20-22 residents; - February 16, 2025 (Sunday): PM shift = 12-13 residents, and NOC shift = 16-17 residents; - February 24, 2025 (Monday): PM shif t= 12-13 residents, and NOC shif t= 24-25 residents; and - February 28, 2025 (Friday): PM shift = 20-21 residents, and NOC shift = 23-24 residents. A review of the Nursing Staff Assignment And Sign-In Sheet, for the months of February 2025 and March 2025, indicated the NOC shift CNA were assigned to about 20 to 33 residents each on February 8, 9, 14, 15, 16, 19, 20, 24, 26, 27, and 28, 2025, and on March 1, 3, 4, and 15, 2025. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On March 21, 2025, at 4:36 p.m., an interview with the Director of Nursing DON was conducted. The DON stated the facility census impacted the staff greatly. The DON stated the facility had a higher census and not as much staff to provide care and services to the residents. The DON stated low staff could affect the safety of the residents. The DON stated the residents could not get the care they needed in a timely manner such as, not getting changed, staff not being able to address changes of condition in a timely manner, and pain not being managed. The DON stated the facility was continuing hiring efforts. The DON also stated staff informed her of the CNA shortages on NOC shift. The DON stated she was aware when the CNAs were assigned over 30 residents each during NOC shift. The DON stated they should not have had 30 residents each and that was not good. The DON stated she believed the average assigned resident for NOC shift should be 15-18 residents. The DON further stated she was aware of reports that residents were left in urine and stool. The DON stated the concern was for resident care and residents could develop skin issues and infections. The DON stated her expectations for short staff wass to be notified in a timely manner to brainstorm and get sufficient staff. The DON further stated the facility had not been safely, effectively, or sufficiently staffed in the last months. 2. On March 18, 2025, at 9:59 a.m., during a confidential resident council meeting, three (3) of nine (9) residents complained about call lights were not being answered timely, food was being served late, and residents were left sitting in their urine and bowel for long periods of time. A review of resident council meeting minutes, dated January 22, 2025, indicated the residents stated call lights were not being answered in a timely manner on all shifts. The resident council minutes also indicated the residents verbalized the CNAs were passing by a room with call light on and not answering them. A review of resident council meeting minutes, dated February 19, 2025, indicated the residents stated there was no teamwork within the CNAs, especially during breaks. The document also stated resident's medications were not being passed out on time on the NOC shift. A review of the facility's Facility Assessment, dated February 2025, indicated, .Staffing Plan .Based on resident population and their needs for care and support, the general approach to staffing to ensure adequate and sufficient staff to meet residents needs at any given time is to follow the State Mandated requirement for staffing guidelines .The State Mandated guidelines allow the following staffing guidance for direct care staff of RNs, LVNs, CNAs. However, the facility also includes follows a per patient per day staffing for other departments .The facility maintains a minimum of nursing hours per patient day (NHPPD) of 3.5 . with CNA hours is 2.4 .Certified Nursing Assistant total assigned staff .Days: 22, Evening: 15, and Nights :12. A review of the facility's policy and procedure titled, Staff Scheduling and Organization, dated July 2019, indicated .It is the facility's policy to deploy staff in sufficient number to meet performance standards of the staff and the service expectations and needs of the residents we serve .Some shifts are busier than others and therefore require more employees, while some shifts are less busy than others requiring fewer employees .Listen to employees respecting their needs as much as possible . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy and procedure titled, Answering the Call Lights, dated August 2017, indicated . The purpose of the procedure is to respond to the resident's request and needs .when requests are made and when call lights are used to respond to needs at the time of use . Residents' call light will be answered as soon as possible . A review of the facility's policy and procedure titled, Certified Nursing Assistant Job Description, dated October 19, 2015, indicated under the direction of the licensed nurse, the Certified Nursing Assistant delivers efficient and effective nursing care .Answers call light or bell promptly, delivers messages .Collaborates and coordinates with other departments to provide timely effective care consistent with individual needs, choices, and preferences .Stays and works beyond scheduled shift if needed to meet state staffing requirements and/or needs of patients .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50610 Based on observation, interview, and record review, the facility failed to ensure provision of pharmacy services met the needs of four of four residents when: 1. The licensed nurse discarded Resident 159's non-scheduled medication waste into a regular trash bin during the preparation for the medication administration. This failure had the potential for the misuse of the medications and environmental harm; 2. The licensed nurse left Resident 159's medications unattended on the resident's bedside table during the medication administration. This failure had the potential for misuse of the medications by the residents, facility staff and/or visitors; 3. Random controlled medication audit for Residents 12 and 128 did not reconcile. The medications were signed out of the Count Sheet (a controlled drug record, an inventory sheet that keeps record of the usage of controlled medications) but not documented on the electronic Medication Administration Records (eMAR) to indicate they were administered to the residents. These failures resulted in inaccurate accountability of controlled medications and the potential for abuse or diversion of controlled medications; and 4. Hydrocodone-Acetaminophen (narcotic pain medication) was not administered to Resident 103 during the scheduled time as evidence by nursing progress notes indicating medication not on hand, pending delivery and missing documentation of administration of the medication. This failure resulted in medications not given to the resident to meet the therapeutic needs and potential for worsening of the resident's medical conditions. Findings: 1. On March 17, 2025, at 8:52 a.m., a medication administration observation was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 was observed preparing Resident 159's medications which included 1 (one) sterile unit-dose vial of Ipratropium/Albuterol (nebulizer solution, combination medication used to open the air passages to the lungs to make breathing easier) inhalation solution. When LVN 2 grabbed the medications prepared for Resident 159 at the medication cart, she was observed dropping the sterile unit-dose vial of Ipratropium/Albuterol inhalation solution on the floor. After she dropped it, she was observed grabbing the medication from the floor and throwing it into a regular trash bin attached to the medication cart. She then grabbed a new sterile vial of the medication from the medication drawer and proceeded to administer the medications to Resident 159. On March 17, 2025, at 11:58 a.m., during an interview with LVN 2, she stated she was nervous while being followed by the surveyor during her medication administration preparation and it led her to quickly put the medication into a regular trash bin. LNV 2 further stated she should have discarded the unit-dose vial of inhalation solution into the medication disposition bin located in the medication room. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 19, 2025, at 8:47 a.m., during an interview with the Director of Nursing (DON), the DON stated the expectation was for the licensed nurse to discard the medication waste into the medication disposal bin located in the medication room and document in the medication destruction log book with the name of medication, name of the resident, the quantity of mediation discarded, prescription number assigned for the medication and signature of the licensed nurse disposing the medication. A review of the facility's policy and procedure titled, Disposal of Medications and Medication-related Supplies .Medication Destruction, dated February 3, 2025, indicated, .Ointments, creams, and similar substances are placed in trash receptable in the medication room .Tablets, capsules and liquids are .disposed of in another acceptable manner. The provider pharmacy is contacted if the facility is unsure of proper disposal methods for a medication . 2. On March 17, 2025, at 8:52 a.m., a medication administration observation was conducted with LVN 2. LVN 2 was observed administering total of five (5) medications for Resident 159. During the medication administration, LVN 2 was observed to leave the medications on Resident 159's bedside table and walked out of the resident's room to obtain supplies from the medication cart located in the hallway outside the resident's room. The following was observed: - Before starting the medication administration, LVN 2 left four (4) medications including two (2) pills, one (1) liquid oral solution, and one (1) packet of inhalation solution on Resident 159's bedside table then she went to get a cup of water; and - LVN 2 left all four (4) medications at the bedside when she went to get a nasal spray immediately after Resident 159 requested for as-needed administration. On March 17, 2025, at 11:58 a.m., during an interview with LVN 2, LVN 2 stated she had to get a cup of water and a nasal spray medication from the medication cart and left the prepared medications on the resident's bedside table. LVN 2 stated the medications should not be unattended because it could lead to risks that they could be taken by the wrong person or trashed by the resident. LVN 2 further stated she should have taken the medications with her when she had to walk out of the resident's room. On March 18, 2025, at 8:47 a.m., during an interview with the DON, the DON stated the licensed nurse should have taken the medications with her and never leave the medication unattended because the resident could have thrown the medications away or someone else could have taken the medications. A review of the facility's policy and procedure titled, Preparation and General Guidelines, IIA2: Medication Administration-General Guidelines, dated February 3, 2025, indicated, .The resident is always observed .to ensure that the dose was completely ingested . 3a. On March 18, 2025, at 10:39 a.m., medication cart was inspected with LVN 3. During a concurrent interview and record review with LVN 3, a review of Resident 12's count sheet for Norco (narcotic pain medication) 5-325 mg (milligram - unit of measurement) tablets and Medication Administration Record (MAR) for the month of March 2025 indicated the nursing staff signed out one tablet on the narcotic count sheet on March 7, 2025, at 9 a.m., and was not documented as administered on the MAR. LVN 3 verified one tablet of Resident 12's Norco 5-325 mg was unaccounted for on the March 2025 MAR for Resident 12. (continued on next page)

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Riverside Postacute Care	8781 Lakeview Avenue Riverside, CA 92509

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 19, 2025, Resident 12's record was reviewed. A review of Reisdent 12's Admission Record, indicated Resident 12 was admitted to the the facility on January 21, 2025, with diagnoses which indicated neuralgia (sharp, shooting, or burning pain that occurs along the path of a nerve). A review of Resident 12's Medication Administration Record, included a physician's order, dated August 12, 2023, which indicated, Norco (brand name for hydrocodone-acetaminophen) 5-325 milligrams Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain. Further review of Resident 12's count sheet for Norco 5-325 mg tablets and MARs, for the months of December 2024, January 2025, February 2025, indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR on the following dates and times: - December 13, 2024, at 2000 (8 p.m.); - December 21, 2024, at 1000 (10 a.m.); and - December 28, 2024, at 0400 (4 a.m.). 3b. On March 18, 2025, at 10:39 a.m., during a concurrent interview and record review with LVN 3, Resident 128's count sheet for Tramadol (narcotic pain medication) 50 mg tablets and MAR dated March 2025 indicated the nursing staff signed out one tablet but did not document the administration on the MAR on March 6, 2025, at 9:30 a.m. LVN 3 verified one tablet of Resident 128's Tramadol 50 mg was unaccounted for on the March 2025 MAR. A review of Resident 128's record indicated Resident 128 had a physician's order, dated July 30, 2024, indicated, Tramadol 50 mg, Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain. On March 19, 2025, at 8:47 a.m., during an interview with the DON, the DON stated the expectation was for the licensed nurses to fill out the Controlled Drug Record after removing the controlled medication from the locked medication cart, and document on the resident's MAR after administering the controlled medication to the resident. A review of the facility's policy and procedure titled, Preparation and General Guidelines, IIa7: Controlled Medications, dated February 3, 2025, indicated, .When a controlled medication is administered, the licensed nurse administering the mediation immediately enters the following information on the accountability record and the medication administration record (MAR): Date and time of administration, Amount administered, Signature of the nurse administering the dose, completed after the medication is actually administered . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On March 18, 2025, at 12:08 p.m., during an interview with Resident 103 in the resident's room, the resident stated she had not received her routine Norco medications in a timely manner during March 2025. The resident further stated she was informed by nursing staff that pharmacy had sent only a few days' supply of Norco at a time which caused the late delivery of the medication on multiple days in March 2025. Resident 103 also stated she had been reminding the nurses to request refill ahead of time to receive the medication every 4 hours as scheduled. When asked which specific dates and times the Norco was not given, Resident 103 addressed she had missed her 10 p.m. dose of Norco 10-325 mg on March 11, 2025 due to sleep, then she woke up on March 12, 2025 around 12:30 a.m. and requested a dose of Norco to be given immediately. However, Resident 103 stated the license nurse told her she had to wait for 30 minutes until the next scheduled time. In addition, Resident 103 stated the facility could not provide Norco from the E-kit (Emergency Kit - an emergency storage box containing a small quantity of critical medications used in emergency situations) after her status was changed to hospice. On March 18, 2025, Resident 103's medical record was reviewed. A review of Resident 103's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included chronic pain syndrome with palliative care (specialized medical care that focuses on providing relief from pain). A review of Resident 103's Order Summary Report, included a physician's order, dated January 17, 2025, for Norco (Hydrocodone-Acetaminophen) 10-325 mg, Give 1 tablet by mouth every 4 hours for moderate to severe pain. The scheduled dose time for Norco was 0200 (2 a.m.), 0600 (6 a.m.), 1000 (10 a.m.), 1400 2 p. m.), 1800 (6 p.m.), and 2200 (10 p.m.). A review of the count sheet for Norco 10-325 mg tablet confirmed Norco was not removed from the medication cart on March 11, 2025 for 2200 (10 p.m.) scheduled time. The count sheet also indicated one tablet of Norco was removed on March 12, 2025 at 0114 (1:14 a.m.). In addition, the MAR indicated the tablet removed was administered to Resident 103 at 0200 (2 a.m.) as scheduled. A review of Resident 103's eMAR for March 2025 indicated there were missing documentation of administration of routine Norco medication. The MAR for the month of March 2025 indicated Norco 10-325 mg was documented as not administered on the following dates and times. In addition, the MAR showed chart code documentation with 19= Hold as per MD (physician)/See Progress Note, or 9=Other/See Progress Note indicating as to why the medication was not administered to Resident 103: - March 2, 2025, at 1400 (2 p.m.), chart code documented as 19; - March 2, 2025, at 2200 (10 p.m.), chart code documented as 9; - March 3, 2025, at 0200 (2 a.m.), chart code documented as 19; - March 3, 2025, at 0600 (6 a.m.), chart code documented as 19; - March 13, 2025, at 1800 (6 p.m.), chart code documented as 9; and - March 13, 2025, at 2100 (9 p.m.), chart code documented as 9. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 103's Progress Notes, to the MAR for the dates and times listed above indicated Norco 10-325 mg was out of stock and the medication was ordered from the pharmacy but the delivery was pending. On March 18, 2025, at 2:05 p.m., during a concurrent interview and record review with LNV 4, indicated the Resident 103's inventory count sheets for Norco 10-325 mg tablet indicated the medication was not removed from the locked medication cart on the dates and times listed above. This finding confirmed the medication was not administered to Resident 103. Furthermore, a review of the count sheet for Norco 10-325 mg from March 8, 2025 to March 13, 2025 indicated pharmacy had delivered 6 different count sheets with 5 tablets for each scheduled dose time. Each count sheets were written with AM, Morning, Noon, Afternoon, Evening, and Bedtime. On March 19, 2025, at 9 a.m., during a concurrent interview and record review conducted with DON, the DON verified the above findings. The DON stated the medications could have been given 1 hour before or 1 hour after from the scheduled time. The DON stated she did not know if the facility system would allow the licensed nurse to document in the MAR for early administration outside of the 1 hour before and 1 hour after window specified in the facility's policy for the medication administration. The DON stated the expectation for the licensed nurse was to contact the physician and get an approval for an early administration when the resident needed medication immediately. The DON stated the facility did not have an E-kit for hospice residents, but she would contact the hospice pharmacy and see if the facility could obtain an E-kit for the hospice residents. On March 20, 2025 at 4:29 p.m., during an interview with the DON, the DON stated the hospice pharmacy informed her the physician had only ordered 5 doses at a time for each scheduled time between March 8, 2025 and March13, 2025. The DON also stated the facility did not have policies and procedures for pain management specific for hospice residents. Further review of the pharmacy-applied label attached on one of the six count sheets indicated the physician had approved the total quantity of 30 tablets for Norco 10-325mg and it allowed only 5 tablets of supply for each dosing scheduled time. A review of the facility's policy and procedure titled, Preparation and General Guidelines, IIA2: Medication Administration-General Guidelines, dated February 3, 2025, indicated, .Medications are administered in accordance with written orders of the attending physician .At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications .If a dose of regularly scheduled medication is withheld, or given at other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled . A review of the facility's policy and procedure titled, Medication Ordering and Receiving from Pharmacy, IC4: Ordering and Receiving Controlled Medications, dated February 3, 2025, indicated, .Scheduled II controlled substance medications are reordered when a (seven-day) supply remains to allow for transmittal of the required original written prescription to the pharmacist .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50610 Based on interview and record review, the facility failed to ensure the facility's Consultant Pharmacist (CP) identified irregularities with medication therapy and made recommendations to the prescribing physicians during the monthly Medication Regimen Review (MRR), for three of five residents reviewed for unnecessary medications (Residents 38, 42, and 126) when: 1. Resident 38 was on duplicate Vitamin D (supplement) orders and received twice each day; 2. Resident 126 was on duplicate Omeprazole (medication for indigestion and heartburn) orders and received four times each day; and 3. Resident 42 was on routine opioid (medication for moderate to severe pain) therapy without bowel regimen. These failures resulted in Resident 38 and 126 to receive a wrong dose of medications and had the potential for Resident 42 to receive unsafe medication use and/or residents not achieving highest therapeutic outcomes. Findings: 1. On March 19, 2025, a review of Resident 38's Admission Record, indicated Resident 38 was admitted to the facility on [DATE], with diagnoses which included myocardial infarction (heart attack). A review of Resident 38's Order Summary Report, included the following physician's order: - Vitamin D (Cholecalciferol) (a type of Vitamin D), Give 2000 IU by mouth in the morning for supplement, ordered on February 21, 2025, for start date of February 22, 2025; and - Vitamin D 50 mcg (microgram, unit of measurement) (2000 UT) (unit, strength or dose of vitamin D) (Cholecalciferol), Give 1 tablet by mouth in the morning for supplement, ordered on February 20, 2025, for start date of February 21, 2025. A review of Resident 38's Medication Administration Record (MAR), for the months of February 2025 and March 2025, indicated nursing staff administered two tablets of Vitamin D 2000 units to Resident 38 each day for a month from February 22, 2025, to March 19, 2025, at 0900 (9 a.m.) on the following dates: - February 23, 24, 25, 26, 27, 28 and - March 1, 2, 3, 4, 5, 6, 7, 9, 15, 16, 17, 18, 19. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 20, 2025, at 3:44 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON verified the Vitamin D order was duplicated with the same strength, frequency, indication, and dose scheduled time, and the duplicated amount of medication was administered to Resident 38. On March 21, 2025, at 3:15 p.m., during a telephone interview with the facility's Consultant Pharmacist (CP), the CP acknowledged she had missed identifying and reporting the irregularity related to the duplicated Vitamin D orders during her monthly MRR done for February 2025. The CP also stated she would have made a recommendation to the physician if she had identified it since the resident should have not been on the duplicated therapy with same medication and same dosing regimen. 2. On March 19, 2025, a review of Resident 126's Admission Record, indicated Resident 126 was admitted to the facility on [DATE], with diagnoses which included malnutrition. A review of Resident 126's Order Summary Report, included the following physician's orders: - Omeprazole Delayed Release 20 mg (milligram, unit of measurement), Give 1 capsule by mouth two times a day for GERD (gastroesophageal reflux disease, a chronic condition where stomach acid frequently flows back into the esophagus, the tube connecting the mouth to the stomach) and causes heartburn and/or indigestion), Administer before meal, dated July 31, 2024, with dosing time scheduled for 0630 (6:30 a.m.) and 1630 (4:30 p.m.); and - Omeprazole Delayed Release 20 mg, Give 20 mg by mouth two times a day for Indigestion until 04/16/2025 (april 16, 2025), dated February 15, 2025, with dosing time scheduled for 0900 (9 a.m.) and 1700 (5 p.m.). During a review of Resident 126's Medication Administration Record (MAR), dated February 2025 and March 2025, indicated nursing staff administered 4 capsules of Omeprazole 20 mg to Resident 126 each day for a month from February 15, 2025, to March 18, 2025, on the following dates: - February 16,17, 18, 19, 20, 21, 22, 25, 26, 27, 28; and - March 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17 18. Further review of MAR dated March 2025 indicated the nursing staff administered 3 capsules of Omeprazole 20 mg at 6:30 a.m., 9 a.m., and 4:30 p.m. on the following dates: - March 1, 2025; and - March 6, 2025. On March 20, 2025 at 4:02 p.m., during a concurrent interview and record review with the DON, the DON verified the omeprazole order was duplicated with the same strength, frequency, and indication, and the duplicated amount of medication was administered to Resident 126. The DON stated the nurses should have contacted the physician to clarify the duplicate order of omeprazole, not continuing the same medications and documenting its administrations four times a day. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 21, 2025, at 3:15 p.m., during a telephone interview with the facility's CP, the CP stated she had missed identifying and reporting the irregularity related to the duplicated omeprazole orders during her monthly MRR done for February 2025. The CP also stated she would have made a recommendation to the physician if she had identified it since the resident should have not been on the duplicated therapy with same medication and same dosing regimen. 3. A review of Resident 42's medical record indicated Resident 42 was admitted to facility with diagnoses including chronic pain syndrome, osteoarthritis (wear and tear joint disease that can cause pain and reduced movement), muscle spasm (muscle cramp), neuromuscular dysfunction of bladder (condition that can lead to problems with bladder control and emptying), UTI (urinary track infection, infection in urinary system), neuropathy (nerve damage that can causes pain in different parts of body), generalized muscle weakness (loss of strength in muscles), cerebral infarction (type of stroke), Depression, Insomnia (difficulty falling asleep), Alzheimer's disease with early onset (a brain disorder that slowly destroys memory and thinking skills). A review of the physician's order indicated the following: - Percocet (narcotic, opioid pain medication) 10-325 mg (Oxycodone-Acetaminophen, generic for Percocet), Give 1 tablet by mouth three times a day for Chronic Pain Syndrome, dated January 20, 2025. A review of Resident 42's care plan, physician's orders and MARs indicated there was no bowel management regimens addressed, suggested or ordered for Resident 42 although the resident had been on routine opioid therapy, Percocet, since January 20, 2025. A review of Resident 42's MAR dated March 2025 indicated Resident 42 had been compliant with her routine opioid therapy due to her pain conditions and the Percocet had been administered to the resident three times a day as scheduled. On March 20, 2025, at 4:02 p.m., during a concurrent interview and record review with the DON, the DON verified the findings with Resident 42's routine Percocet given to the resident three times a day as scheduled. The DON acknowledged the opioids could cause constipation which could significantly impact quality of life if left unmanaged. The DON also verified there had been no bowel regimen ordered for the resident's routine Percocet therapy since the Percocet was ordered on January 20, 2025. On March 21, 2025, at 3:15 p.m., during a telephone interview with the facility's CP, the CP stated she had missed identifying whether the Resident 42 had been on any bowel regimen for the resident's routine Percocet therapy. The CP also stated she would have made a recommendation with as-needed bowel regimens to the physician if she had identified the missing bowel regimen for the resident's routine opioid, Percocet, therapy. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled, Pain Management Program, last reviewed February 3, 2025, indicated, .Monitor appropriately effectiveness and/or adverse consequences (e.g., constipation .) including defining how and when to monitor the resident's symptoms and degree of pain relief .Strategies that may be employed when establishing the medication regimen include .Reducing or preventing anticipated adverse consequences of mediations (e.g., bowel regimen to preventing constipation related to opioid analgesics) .Adverse consequence3s related to analgesics can often be anticipated and to some extent prevented or reduced. For example, opioids routinely cause constipation, which may be minimized by an appropriate bowel regimen .Pharmacist will serve as a resource to other professionals in the use of analgesics .about medication use, potential side effects . A review of the facility's policy and procedures titled, Consultant Pharmacist Reports, last reviewed February 3, 2025, indicated, .The MRR include evaluating the resident's response to medication therapy to determine that the resident maintain the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy .In performing medication regimen reviews, the consultant pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards .The consultant pharmacist identifies irregularities through a variety of sources including: Medication Administration Records (MARs prescribers' orders, progress notes of prescriber, nurses, and/or consultants .Potential or actual medication errors .Duplication of medication orders includes a written rationale for the duplication and evidence of monitoring for both efficacy and cumulative adverse medication effects .Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's (active record) and reported to the Director of Nursing, and/or prescriber as appropriate .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 50610 Based on interview and record review, the facility failed to ensure the residents were free from unnecessary medications when same medications were ordered for the same strength, frequency and indication and not reviewed and clarified to prevent duplication of therapy, for two of five unnecessary medications sampled residents (Residents 38 and 126): 1. Resident 38 was on duplicate Vitamin D (supplement) orders and received twice each day; and 2. Resident 126 was on duplicate Omeprazole (medication for indigestion and heartburn) orders and received four times each day. These failures resulted in Resident 38 and 126 receiving excessive dose of medications and had a potential to result in accumulation of medication in the residents' body and adverse effects. Findings: 1. On March 19, 2025, a review of Resident 38's clinical record indicated Resident 38 had the following physician's orders: - Vitamin D (Cholecalciferol) (a type of Vitamin D), Give 2000 IU by mouth in the morning for supplement, ordered on February 21, 2025 for start date of February 22, 2025; and - Vitamin D 50 mcg (microgram, unit of measurement) (2000 UT) (unit, strength or dose of vitamin D) (Cholecalciferol), Give 1 tablet by mouth in the morning for supplement, ordered on February 20, 2025 for start date of February 21, 2025. During a review of Resident 38's Medication Administration Record (MAR) dated February 2025 and March 2025, it indicated nursing staff administered two tablets of Vitamin D 2000 units to Resident 38 each day for a month from February 22, 2025 to March 19, 2025 at 0900 (9 a.m.) on the following dates: - February 23, 24, 25, 26, 27, 28; and - March 1, 2, 3, 4, 5, 6, 7, 9, 15, 16, 17, 18, 19. During a concurrent interview and record review on March 20, 2025 at 3:44 p.m. with the Director of Nursing (DON), the DON verified the Vitamin D order was duplicated with the same strength, frequency, indication and dose scheduled time, and the duplicated amount of medication was administered to Resident 38. 2. On March 19, 2025, a review of Resident 126's clinical record indicated Resident 126 had the following physician's orders: (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Omeprazole Delayed Release 20 mg (milligram, unit of measurement), Give 1 capsule by mouth two times a day for GERD (gastroesophageal reflux disease, a chronic condition where stomach acid frequently flows back into the esophagus, the tube connecting the mouth to the stomach, and causes heartburn and/or indigestion), Administer before meal, dated July 31, 2024 with dosing time scheduled for 0630 (6:30 a.m.) and 1630 (4:30 p.m.); and - Omeprazole Delayed Release 20 mg, Give 20 mg by mouth two times a day for Indigestion until 04/16/2025, dated February 15, 2025 with dosing time scheduled for 0900 (9 a.m.) and 1700 (5 p.m.). During a review of Resident 126's Medication Administration Record (MAR) dated February 2025 and March 2025, it indicated nursing staff administered 4 capsules of Omeprazole 20 mg to Resident 126 each day for a month from February 15, 2025 to March 18, 2025 on the following dates: - February 16,17, 18, 19, 20, 21, 22, 25, 26, 27, 28; and - March 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18. Further review of MAR dated March 2025 indicated the nursing staff administered 3 capsules of Omeprazole 20 mg at 6:30 a.m., 9 a.m., and 4:30 p.m. on the following dates: - March 1, 2025; and - March 6, 2025. On March 20, 2025 at 4:02 p.m., during a concurrent interview and record review with the DON, the DON verified the omeprazole order was duplicated with the same strength, frequency and indication, and the duplicated amount of medication was administered to the resident 126. The DON stated the nurses should have contacted the physician to clarify the duplicate order of omeprazole, not continuing the same medications and documenting its administrations four times a day. A review of the the facility's policy and procedure titled, Preparation and General Guidelines, IIA2: Medication Administration - General Guidelines, dated February 3, 2025, indicated, .if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule .If a dose seems excessive considering the resident's age and condition .the nurse calls .Pharmacy .for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification .

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Riverside Postacute Care	8781 Lakeview Avenue Riverside, CA 92509

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50610 Based on observation, interview, and record review, the facility failed to ensure the medication error rate during the medication administration observation was less than 5% when, the facility had a cumulative medication error rate of 13.79%. Four medication errors occurred out of 29 opportunities during the medication administration, for one of three residents (Resident 154). This failure resulted in medications not given in accordance with the physician's orders and the facility's policy and procedures, which had the potential for residents not receiving the full therapeutic effects of the medications and worsening of the residents' medical conditions Findings: On March 17, 2025 at 9:13 a.m., a medication administration observation was conducted with LVN 4. LVN 4 was observed preparing and administering total of 14 medications to Resident 154. Included in the medications were one nasal spray of fluticasone propionate 50 mcg (micrograms - unit of measurement), 1 tablet of Vitamin D3 50 mcg (2000 IU [International Units]), with 11 more oral pills, and 1 unit-dose vial of inhalation solution. On March 17, 2025, a review of Resident 154's medical records indicated the following physician's orders: - Azelastine (medication used to relieve allergic nasal symptoms) Nasal Solution, 1 application in both nostrils two times a day for seasonal allergies for 10 days, dated March 1, 2025; - Fluticasone Propionate (mediation used to relieve allergic nasal symptoms) Suspension 50 mcg/act (microgram per actuation, Each actuation/pressing the pump or nozzle of the nasal spray delivers 50 mcg of fluticasone propionate), 2 sprays in each nostril every 24 hours as needed for Allergies, dated January 17, 2025; - Vitamin D3 125 mcg (5000 IU) Give 1 tablet by mouth one time a day for Supplement, dated January 20, 2025; and - Cyanocobalamin (Vitamin B12) 1000 mcg, 1 tablet by mouth one time a day for Supplement, dated February 4, 2025; On March 17, 2025, during a medication reconciliation review with the Medication Administration Record (MAR) dated March 2025, it indicated the followings medication errors: - Scheduled Azelastine nasal spray was not observed administered to Resident 154 during the medication administration. There was no documentation of administration in the MAR; - As-needed order of Fluticasone Nasal Spray for allergy was administered to Resident 154 instead of scheduled Azelastine nasal spray for seasonal allergies. The administration of Fluticasone was documented in MAR; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One tablet of Vitamin D3 2000 IU was administered to Resident 154 instead of the physician's order of Vitamin D3 5000 IU. The administration was documented in MAR for the order of Vitamin D3 5000 IU; and - Cyanocobalamin 1000 mcg order was not observed administered to Resident 154 during the medication administration. There was no documentation of administration in the MAR. On March 17, 2025, at 12:05 p.m., during a concurrent interview and record review with LNV 4, LVN 4 looked up the physician's orders, and confirmed she had administered Fluticasone nasal spray instead of Azelastine nasal spray. LVN 4 could not locate the azelastine nasal spray from her medication cart. LVN 4 stated, someone might have misplaced it, but will reorder from pharmacy, LVN 4 also was asked to check the bottle of Vitamin D3 stored in her medication cart, Then she verified she had administered Vitamin D3 2000 IU instead of Vitamin D3 5000 IU. When asked to show the bottle of Vitamin D3 5000 IU, LNV 4 stated Vitamin D3 5000 IU was not available in her medication cart and utility room, so she would need to ask the supplier to order it. LVN 4 also verified cyanocobalamin was not administered to Resident 154 during her morning medication administration. On March 17, 2025 at 12:30 p.m., during an interview with the Director of Nursing (DON), the DON stated the licensed nurse should have checked the Vitamin D3 dose shown on the MAR against the bottle of Vitamin D3 for the correct strength. The DON also stated the expectation for the licensed nurses was to check the MAR for scheduled medications, then review the medications in stock with the physician's orders during medication preparation. A review of the facility's policy and procedures titled, Preparation and General Guidelines, IIA2: Medication Administration-General Guidelines, dated February 3, 2025, indicated, .Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label .Medications are administered in accordance with written orders of the attending physicians .The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given .At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50610 Based on observation, interview, and record review, the facility failed to ensure, for one of five residents reviewed for unnecessary medications (Resident 119), was free from a significant medication error, when phenobarbital (medication used to treat seizure) was not administered to Resident 119, as evidenced by missing documentation of administration of the medication. This failure had the potential to result in seizure for the resident due to not receiving the full therapeutic effect of the medication. Findings: On March 18, 2025, a review of Resident 119's Admission Record, indicated Resident 119 was admitted to the facility on [DATE] with diagnoses which included epilepsy (seizure). A review of Resident 119's Order Summary Report, included a physician's order for Phenobarbital 32.4 mg, Give 7 (seven) tablet by mouth at bedtime for seizures, give 7 (seven) tablets for a total of 226.8 mg (milligrams - unit of measurement, ordered date January 30, 2025. A review of Resident 119's Medication Administration Record (MAR), for the month of March 2025, indicated Resident 119 did not receive phenobarbital dose on March 11, 2025. There was no documentation made in Resident 119's MAR and the nursing's progress notes as to why the dose of phenobarbital was not administered to Resident 119 on March 11, 2025 and whether the resident's physician was notified. A review of Resident 119's Controlled Drug Record (CDR, an accountability sheet that tracks narcotic removal with the nurse's initial, date, and time), indicated there was no documentation made on the CDR for March 11, 2025, which indicated no phenobarbital tablet was removed from the locked medication cart on March 11, 2025. On March 18, 2025, at 4:17 p.m., during an interview with Resident 119 at the facility's dining room, Resident 119 stated he had experienced seizures when he did not get his seizure medication, phenobarbital, for 4 days in the past. Resident 119 further stated his seizure medication was not ordered by the facility although he had reminded the Licensed Vocational Nurses (LVN), previous Director of Nursing (DON), and previous Administrator to reorder his phenobarbital medication. On March 18, 2025, at 4:53 p.m., during a concurrent interview and record review with Licensed Vocational Nurse (LVN) 5, LVN 5 verified Resident 119's March 2025 MAR and the progress notes that Resident 119 did not receive phenobarbital on March 11, 2025. LVN stated she did not work on March 11, 2025, so she did not know phenobarbital dose was not given to Resident 119. LVN 5 could not find any notes from the nursing's progress note regarding Resident 119's phenobarbital administration for March 11, 2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 19, 2025, at 8:47 a.m., during a concurrent interview and record review with the DON, the DON verified the findings and stated she was not aware the phenobarbital dose not given to Resident 119 on March 11, 2025. The DON confirmed no nursing's progress note was documented on March 11, 2025. The DON stated the nursing staff should have notified the Resident 119's physician if the dose was missed and documented on the progress notes with physician's responses and explanation as to why the medication was not given to Resident 119. The DON further stated Resident 119 had a seizure in the past when the resident did not get his phenobarbital medication. The DON acknowledged missing one day dose of phenobarbital could potentially cause a seizure for Resident 119. On March 22, 2025, at 3:15 p.m., during a telephone interview with the Consultant Pharmacist (CP), the CP stated if she finds any missing record of administration in the MAR, she notifies the physician and facility staff immediately so that the resident's condition can be checked. The CP also stated missing a dose of phenobarbital could cause resident to have seizure. A review of the facility's policy and procedure titled, Preparation and General Guidelines, IIA2: Medication Administration-General Guidelines, last reviewed February 3, 2025, indicated, .Medications are administered in accordance with written orders of the attending physician .At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications .If a dose of regularly scheduled medication is withheld, or given at other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled .

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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** 50610 Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medications in accordance with the facility policy and procedures and/or manufacturer's instructions when: 1. IV (intravenous) Mini-bag plus containers removed from or in an opened manufacturer's overwrap without beyond use dates were stored in IV Cart, Medication Cart 2, and Medication Cart 4; 2. Total of three expired medications were stored in Treatment Cart, Medication Cart 1, and Medication Cart 2; and 3. One discontinued medication was kept in stock in Medication Cart 2 along with other active medications. These failures had the potential for the residents to receive medications beyond their effective dates, receive expired medications and had the potential for residents to have access to the discontinued medications and administer it unsafely. Findings: 1a. On March 17, 2025, at 9:13 a.m., during a medication administration observation with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed preparing and administering 14 medications for Resident 154 at Medication Cart 4. The medications included one tablet of Fenofibrate (medication used to lower high cholesterol levels) 48 mg (milligram - unit of measurement). The pharmacy-applied label on the fenofibrate medication card was observed with the expiration date cut off. The filled date on the label indicated 03/13/25 (March 13, 2025). On March 17, 2025, at 12:05 p.m., during an interview with LVN 4, LVN 4 verified the expiration date was cut off from the pharmacy label and she could not identify the correct expiration date on the label. LVN 4 stated she had missed checking the fenofibrate's expiration date prior to administering the medication to the resident. LVN 4 also stated she should have called the pharmacy and requested a replacement of fenofibrate medication card with a new card containing the expiration date on the pharmacy label. On March 19, 2025, at 8:47 a.m., during an interview with the Director of Nursing (DON), the DON stated the nurses were expected to check the expiration date on the pharmacy-applied prescription labels upon the delivery of medications, and the expiration date on the labels should be clearly readable. The DON stated the nurses should have called the pharmacy to request a replacement of the medication in case of any errors identified from the pharmacy labels including the missing expiration date. The DON also stated the LN should have checked the expiration date of medication prior to administering the medication to the resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Medication Ordering and Receiving from Pharmacy IC10: Medication Labels, dated February 3, 2025, indicated, .Each prescription medication label includes . Expiration date of medication . A review of the facility's policy and procedure titled, Medication Ordering and Receiving from Pharmacy IC3: Ordering and Receiving Medications from the Dispensing Pharmacy, dated February 3, 2025, indicated, .A licensed nurse receives medications delivered to the facility .verifies medications received and direction for use with the medication order form, promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor .Improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy .Medication containers having .illegible labels .are returned to the dispensing pharmacy for relabeling or destroyed in accordance with the medication destruction policy . 1b. On March 18, 2025, at 8:56 a.m., during an inspection of IV Cart with the Assistant Director of Nursing (ADON), the [NAME]'s (name of manufacturer) 0.9% Sodium Chloride IV solution (sterile solution of salt and water for intravenous administration) 50 mL (milliliter - unit of measurement) MINI-BAG Plus Containers (small, sterile IV bag designed for easy mixing and administration of IV medication) and 0.9% sodium chloride IV solution 100 mL MINI-BAG Plus Containers were observed removed from the manufacturer's original package/overwrap or stored in several opened manufacturer's multi-pack overwrap. The bags were further observed not marked with beyond use date (BUD - the date a product should no longer be used) based on manufacturer recommendations. There were no labels on the bags indicating the date opened when the bags were first removed from the manufacturer's overwrap. The pharmacy-applied labels attached on the outside of the manufacturer's opened multi-pack overwrap indicated the following information: - SODIUM CHLORIDE 0.9% 100ML, NURSE TO MIX AND ACTIVATE WITH 100ML NS AND 2GM (gram, unit of measurement) VIAL OF CEFAZOLIN (antibiotic medication used to treat infection) THEN INFUSE INTRAVENOUSLY OVER 30 MINUTES EVERY 8 HOURS UNTIL 5/5/25 (May 5, 2025), Exp (expiration date): 11/12/2025 (November 12, 2025); - SODIUM CHLORIDE 0.9% 100ML, NURSE TO MIX AND ATTACH 2 GM CEFTRIAXONE (antibiotic medication used to treat infection) WITH 100 ML NS AND INFUSE INTRAVENOUSLY OVER 30 MINS EVERY 2 HOURS UNTIL 3/22/25 (March 22, 2025), Exp: 11/09/2025 (November 9, 2025); - SODIUM CHLORIDE 0.9% 50ML, NURSE TO MIX AND ACTIVATE 1 VIAL CEFEPIME (antibiotic medication used to treat infection) 2GM WITH 50ML NS AND INFUSE INTRAVENOUSLY OVER 30 MINUTES TWICE DAILY FOR 7 DAYS FOR UTI, Exp: 03/09/2026 (March 9, 2026); - SODIUM CHLORIDE 0.9% 50ML, NURSE TO MIX AND ACTIVATE CEFTRIAXONE (antibiotic medication used to treat infection) 1GM VIAL WITH 50ML NS AND INFUSE INTRAVENOUSLY OVER 30MINS (minutes) DAILY FOR UTI (urinary tract infection) FOR 6 DAYS, Exp 03/14/2026 (March 14, 2026); and - SODIUM CHLORIDE 0.9% 50ML, NURSE TO MIX AND ACTIVATE 1 VIAL ERTAPENEM (antibiotic medication used to treat infection) 1GM WITH 50ML NS AND INFUSE INTRAVENOUSLY OVER 30 MINUTES DAILY FOR 7 DAYS FOR UTI, Exp: 03/13/2026 (March 13, 2026). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 18, 2025, at 8:56 a.m., during a concurrent interview with the ADON, the ADON stated the pharmacy had delivered the multi-pack packages containing four MINI-BAG Plus containers inside. The ADON stated she was unsure whether the multi-pack packages were delivered opened by the pharmacy, or the facility's licensed nurses (LN) had to cut the multi-pack packages to remove the bags. The ADON further stated once the LN removed the bag from the multi-pack package, the pharmacy supplied label had to be attached to the bag by the LN for resident use. The ADON stated pharmacy had also delivered the IV bags removed from the manufacturer's overwrap with resident specific pharmacy labels attached on the bags. On March 18, 2025 at 9:48 a.m., during an interview with the facility's Consultant Pharmacist (CP), the CP acknowledged that without an opened date indicated on the pharmacy labels or the bags, the LN would not be able to find out the duration of storage for how long the out-of-overwrap bags could be stored at the room temperature, and the expiration dates the bags should be discarded by. On March 21, 2025, at 10 a.m., during an interview with the DON, the DON stated the pharmacy had provided the facility with supporting document regarding the storage duration for the MINI-BAG Plus containers. A record review of the undated document received on March 21, 2025 from the pharmacy titled, Injectable Medications - Policy 20.10, Appendix D, indicated, .Stability outside of overwrap: Intravenous solutions are packaged with an overwrap that prevents evaporation through the wall of the bag. Stability of the solution can be compromised if unwrapped for a length of time prior to use. Overwrap should ideally be removed just prior to use. However, solution that have been removed from the overwrap maybe given the below beyond use dates as long as the manufacturer expiry date is not exceeded .Beyond use date once removed from overwrap for [NAME] bag size of 50 mL or less is 7 days .Beyond use date once removed from overwrap for [NAME] bag size of 100 mL or greater is 20 days .IV solution bags unwrapped should be discarded if the date opened or the do not use after date is not indicated on the bag . During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy IC10: Medication Labels, dated February 3, 2025, the P&P indicated, .Each infusion therapy product label contains .Date after which the mixture must not be used .improperly or inaccurately labeled medications are rejected and returned to the dispending pharmacy .Under no circumstances are unattached labels requested or accepted from the pharmacy. Only the pharmacy may place a label on the medication container . During a review of the facility's P&P titled, Medication Storage in the Facility ID2: Infusion Therapy Products Storage, dated February 3, 2025, the P&P indicated, .infusion therapy products . are stored .following the manufacturer's recommendations .Infusion therapy products' expiration dates and storage conditions are monitored by the consultant pharmacist during the inspection of medication storage areas . 1c. On March 18, 2025, at 10:39 a.m., an inspection of Medication Cart 2 and concurrent interview was conducted with LNV HB. An unused vial of Lantus (insulin medication) 100 units/mL (concentration of insulin, unit of measurement) for injection was observed stored in the medication cart without an open date. The medication's fill date on the pharmacy applied label indicated March 13, 2025. (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 interview with LVN HB, LVN HB verified the Lantus vial without an open date was stored in the medication cart at a room temperature. LVN HB did not know when the vial was removed from the refrigerator and stated the LN should have written the date opened when the vial was first removed from the medication refrigerator. During an interview on March 19, 2025, at 8:47 a.m. with the DON, the DON stated the nurses were expected to date the insulin vials when first opened or removed from refrigeration. The DON further stated the insulin vial stored in the medication cart without an open date should have been discarded. During a review of the facility's P&P titled, Preparation and General Guidelines, IIA3: Vials and Ampules of Injectable Medications, dated February 3, 2025, the P&P indicated, .vials .of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal .The date opened and the initials of the first person to use the vial are recorded on multidose vials (on the vial label or an accessory label affixed for that purpose) . 2a. On March 18, 2025, at 9:12 a.m., an inspection of Treatment Cart and concurrent interview was conducted with the Treatment Nurse/LVN NW. An opened package of Euroresearch's (name of manufacturer) sterile BIOPAD Collagen (dressing composed of collagen that can accelerate wound healing process, supplied sterile in a single package, for one-use only) was observed stored in the treatment cart with a half content left in the package. During a concurrent interview on March 18, 2025, at 9:32 a.m. with LVN NW, LVN NW stated the sterile package was no longer sterile once the package was opened and it should have been disposed after first opened for use. During an interview on March 19, 2025, at 8:47 a.m. with the DON, the DON stated once the sterile package was opened and used partially, the remaining contents in the package were contaminated and no longer in sterile condition, therefore, it should have been disposed properly by taking the remaining opened package to the medication room and discard it into a pharmaceutical waste bin. 2b. On March 18, 2025, at 10:09 a.m., an inspection of Medication Cart 1 located at Nursing Station 1 and concurrent interview was conducted with ADON. An opened box of Omeprazole (medication used to treat indigestion or heartburn) DR (delayed release drug designed to release the active ingredient later than immediately after administration) 20mg five tablets for house stock were observed with the manufacturer's expiration date indicated for 2025/02 (February 2025). During a concurrent interview with ADON, the ADON verified the findings and stated the medication had expired and should have been removed from the medication cart and disposed of. During an interview on March 19, 2025, at 8:47 a.m. with the DON, the DON stated the expired medication should not be stored in the medication cart and it should have been discarded properly. During a review of the facility's P&P titled, Medication Storage in the Facility ID1: Storage of Medications, dated February 3, 2025, the P&P indicated, .Outdated, contaminated, or deteriorated medications and those in containers that are .without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2c. On March 18, 2025, at 10:39 a.m., an inspection of Medication Cart 2 located at Nursing Station 2 and concurrent interview was conducted with LNV HB. An Lantus SoloStar (insulin medication) pen for injection was observed with an opened date written for 2/15/25 (February 15, 2025) and stored in the medication cart at a room temperature. During a concurrent interview with LVN HB, LVN HB verified the findings and stated the insulin pen should have been discarded within 28 days from the opened date indicated. LVN HB acknowledged the insulin pen had expired and should have been discarded. During an interview on March 19, 2025, at 8:47 a.m. with the DON, the DON stated LN should be checking the medications in the medication cart every shift daily. During a review of the facility's P&P titled, Preparation and General Guidelines, IIA3: Vials and Ampules of Injectable Medications, dated February 3, 2025, the P&P indicated, .injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal . According to the manufacturer's prescribing information for Lantus SoloStar indicated .Storage conditions . 3mL single-patient-use SoloStar prefilled pen .Not in-use (unopened) Room Temperature (below 86 F [30 C]) 28 days .Once you take your SoloStar out of cool storage, for use or as a spare, you can use it for up to 28 days. Do not use it after this time . 3. On March 18, 2025, at 10:39 a.m., an inspection of Medication Cart 2 located at Nursing Station 2 and concurrent interview was conducted with LNV HB. An amber bottle of Promethazine DM (medication used reduce coughing and runny nose) syrup was observed stored in the medication cart with a direction Give 10mL by mouth every 8 hours as needed for cough/congestion until 03/04/2025 (March 4, 2025) 23:59 (11:59 p.m.). During a concurrent interview with LVN HB, LVN HB verified the findings and stated the order of promethazine DM had been discontinued and the physician reordered the same medication for the same resident. LVN HB then showed another bottle of promethazine DM stored in the same medication cart which was delivered by pharmacy for the current active order. During an interview on March 19, 2025, at 8:47 a.m. with the DON, the DON stated the nurses were expected to discard the discontinued medication and replace with a new order upon delivery. During a review of the facility's P&P titled, Disposal of Medications and Medication-related Supplies IE5: Medication Destruction, the P&P indicated, Discontinued medications .which do not qualify for return to the pharmacy for credit, are destroyed .

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure a dental consultation was provided, for one of two residents reviewed for dental (Resident 38). This failure has the potential to place the resident at high risk for complications related to dental needs due to the possible delay in providing dental devices. Findings: On March 20, 2025, at 9:01 a.m., during a concurrent observation and interview with Resident 38 in her room, Resident 38 was observed touching her lower right gums while talking to a staff. Resident 38 stated she felt something in her gums and was painful to touched. Resident 38 further stated there was a bump and it hurts when she bites hard food. On March 20, 2025, Resident 38's record was reviewed. Resident 38 was admitted to the facility on [DATE], with diagnoses that included protein-calorie malnutrition (reduce protein and calories needed by the body). A review of Resident 38's Minimum Data Set (MDS - an assessment tool), dated December 21, 2024, indicated Resident 38 had a BIMS (Brief Interview of Mental Status) score of 6 (severe cognitive impairment). A review of Resident 38's Situation Background Assessment Request (SBAR-nurses note) Communication Form, dated March 4, 2025, indicated, .resident has sore/bump on lower tooth .LVN (Licensed Vocational Nurse) checked up on resident and saw a red/white bump on the resident's lower tooth (front tooth). Bump is located on the bottom of tooth and gum. Resident stated she has pain when she touches it with her tongue and it bothers her when she eats .LVN notified PCP (Primary Care Physician) .Doctor requested a dental consult . A review of Resident 38's PAIN ASSESSMENT, dated March 4, 2025, indicated, .toothache .on lower incisor .Resident stated it only hurts when area is touched and has discomfort when she eats . A review of Resident 38's Care Plan Report, dated March 4, 2025, indicated, .The resident has oral/dental health problems .bump on tooth and gum .Coordinate arrangements for dental care .as ordered . On March 20, 2025, at 9:03 a.m., during a concurrent interview and record review with Registered Nurse (RN) 1, RN 1 stated Resident 38 had a bump on her gums and complaint of pain to touch few days ago and the physician ordered to arrange for dental consult. RN 1 stated Resident 38 was not seen by the facility dentist. RN 1 further stated Resident 38 should have been arranged dental consult to prevent further dental complications. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 20, 2025, at 9:15 a.m., during a concurrent interview and record review of the facility's Dental Visit Report, with the Social Service Director (SSD), the SSD stated the dentist was in the facility on March 14, 2025, and Resident 38 was not listed. The SSD stated Resident 38 should have been included for dental checkup or should have been arranged outside dental checkup if facility dentist was not available. The SSD further stated if a resident dental condition was not addressed, Resident 38 could suffer from pain, could not eat and may lead to weight loss. On March 20, 2025, at 9:15 a.m., during an interview with the Facility Dentist (FD), the FD stated he received dental referral from SSD and he would check all the residents that were listed. The FD stated, Mouth affects everything, Resident 38 should have been seen right away to prevent complications. The FD further stated, I'm always available, and I come right away. A review of facility's policy and procedure titled, Referrals, Social Services, dated April 2018, indicated, . Social services personnel shall coordinate most resident referrals with outside agencies .Referrals will include .dental .The Social Services (SS) Director and/or its designee shall be responsible for implementation and enforcement of this policy .

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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. 44504 Based on interview and record review, the facility failed to ensure the dietetic services supervisor had received at least six hours of dietary service in-service training as required by Title 22 of the California Code of Regulations (State Agency regulations) prior to assuming full time duties as dietetic services supervisor. This failure resulted in the lack of required in-service training hours by the dietary service supervisor and could potentially affect the operations in the dietary services. Findings: On March 18, 2025, at 9:30 a.m., an interview was conducted with the Food and Nutrition Services Director (FNS) and Registered Dietitian (RD). The FSN stated she is a Certified Dietary Manager and was not aware she needed to complete six hours of in-service training specific to the California dietary service requirements contained in Title 22 of the California Code of Regulations (CCR) prior to assuming full time duties as a dietetic services supervisor at the healthcare facility. The RD stated she was aware all Certified Dietary Managers needed to have six hours of in-service training of the Title 22 of the California Code of Regulations (CCR) prior to assuming full time duties as a dietetic services supervisor but she was not aware the FSN did not have the six hours required of in-service training. A review of the facility's document titled, Job Description, dated 2023, indicated, .POSITION .Food and Nutriton Services Director .QUALIFICATIONS .Must meet the qualification of a Food and Nutriton Services Director as stated under State and Federal regulations . According to the Title 22 California Code of Regulations, published on December 25, 2015, .Dietetic Service Staff .If a registered dietitian is not employed full-time, a full-time person who meets the training requirements to be a dietetic services supervisor specified in section 1265.4(Bb) of the Health and Safety code shall be employed to be responsible for the operation of the food service . According to the California Health and Safety Code 1265.4(b), .The dietetic services supervisor shall have completed at least one of the following educational requirements .Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility .

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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. 44504 Based on observation, interview, and record review, the facility failed to ensure the dietary staff safely and effectively carried out the functions of food and nutrition services when (Cross Reference F812): 1. The food service workers did not follow the manufacturer's guideline regarding the length of time for testing the red bucket Quaternary (Quat) sanitizer (sanitizing solution used for sanitizing food contact surfaces); 2. The food service workers did not know the appropriate concentration of the Quat sanitizer; 3. Diet Aides (DA) 1 and 3 were unable to demonstrate the proper steps to clean the dirty meal carts; 4. [NAME] (CK) 2 and Diet Aide 2 did not know how to calibrate the food thermometer; and 5. Diet Aides 3 and 4 did not know how long they need to submerge washed kitchen ware in the sanitizer sink. These failures had the potential to cause foodborne illness (illness caused by food contaminated with bacteria, viruses, parasites or toxins) for 153 out of 153 sampled residents who received foods from the kitchen. Findings: 1. On March 17, 2025, a review of the test strip manufacturer's guidelines indicated the test strip need to be dipped into the Quat sanitizer for 10 seconds. On March 17, 2025, at 3:59 p.m., an observation was conducted with DA 3. DA 3 was asked to demonstrate to check the concentration of the Quat sanitizer in the sanitizer bucket. DA 3 dipped the test strip into the sanitizer for 1 second, the test strip was unable to read the sanitizer concentration without showing any change in the color. DA 3 was observed the second time and DA 3 used another sanitizer bucket and dipped the test strip into the Quat sanitizer bucket for 3 seconds. On March 17, 2025, at 4:07 p.m., a concurrent observation and interview was conducted with CK 2. CK 2 was asked to demonstrate to check the concentration of Quat sanitizer in the sanitizer bucket. CK 2 stated he needed to dip the test strip into sanitizer for 15 seconds. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 20, 2025, at 9:33 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated the test strip needed to be dipped into the Quat sanitizer for 10 seconds. The RD explained if food services workers did not follow manufacturer guideline's time length in dipping the test strip into Quat sanitizer, it could result in an inaccurate reading of the sanitizer concentration which could not ensure the effectiveness of the sanitizer. The RD explained using ineffective Quat sanitizer could result to not properly sanitize food contact surfaces which could cause cross contamination and lead to food borne illness. A review of the facility's policy and procedure titled, QUATERNARY AMMONIA LOG POLICY, dated 2023, indicated, .POLICY .The concentration of the ammonium in the quaternary (Quat) sanitizer will be tested to ensure the effectiveness of the solution . Read instructions on quaternary container and the test strips for proper concentration, length of time the strip needs to be in contact with the solution .when testing for concentration 2. On March 17, 2025, a review of the manufacturer's guidelines for Quat sanitizer posted above the three compartment sink indicated, .Testing solution should be between 200 -400 parts per million (ppm - a unit of measurement) . On March 17, 2025, at 11:53 a.m., an interview was conducted with DA 2. DA 2 was asked to test the Quat sanitizer in the sanitizer bucket. DA 2 stated Quat sanitizer needed to be between 200 -300 ppm. DA 2 stated 400 ppm was not right concentration because the concentration was too strong. On March 17, 2025, at 3:37 p.m., an interview was conducted with DA 4. DA 4 was asked to test the Quat sanitizer in the sanitizer bucket. DA 4 stated Quat sanitizer range needed to be between 200 -300 ppm. DA 4 stated 400 ppm was not right because the sanitizer was too concentrated. On March 17, 2025, at 3:59 p.m., an interview was conducted with DA 3. DA 3 was asked to demonstrate to check the concentration of Quat sanitizer in the sanitizer bucket. DA 3 stated Quat sanitizer should be only in 200 ppm. On March 17, 2025, at 4:07 p.m., a concurrent observation and interview was conducted with CK 2. CK 2 was asked to demonstrate to check the concentration of Quat sanitizer in the sanitizer bucket. CK 2 stated Quat sanitizer should be only in 200 ppm. CK 2 stated 200 - 400 was not right concentration. On March 20, 2025, at 9:33 a.m., a phone interview was conducted with the RD. The RD stated Quat Sanitizer should be between 200 - 400 ppm. and all food service workers should know the concentration range. A review of the facility's policy and procedure titled, QUATERNARY AMMONIA LOG POLICY, dated 2023, indicated, .POLICY .The concentration of the ammonium in the quaternary (Quat) sanitizer will be tested to ensure the effectiveness of the solution . Read instructions on quaternary container and the test strips for proper concentration, length of time the strip needs to be in contact with the solution .when testing for concentration 3. On March 17, 2025, at 9:59 AM, an interview was conducted with DA 1. DA 1 was asked to demonstrate how to clean used meal cart. DA 1 stated she used green bucket (soap and water) to clean the meal cart and then sanitize with sanitizer. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 17, 2025, at 3:59 PM, an interview was conducted with DA 3. DA 3 was asked to demonstrate how to clean used meal cart. DA 3 stated he only used sanitizer to clean the used meal cart. On March 20, 2025, at 9:33 AM, an interview was conducted with the RD. The RD stated not using cleaning procedure with wash, rinse and sanitizer could result not properly sanitize the used meal cart which cause cross contamination and lead to food borne illness. A review of the facility Policy and procedure (P&P) titled, SANITATION, dated 2023, the P&P indicated, . PROCEDURE: .4. Each employee shall know how to .clean all equipment . A review of the facility's policy and procedure titled, SHELVES, COUNTERS, AND OTHER SURFACES INCLUDING .FOOD PREPARATION ., dated 2023, indicated, CLEANING PROCEDURE: 1. Remove any large debris and wash surface with a warm detergent solution .Rinse with clear water .Spray with a sanitizer . 4. On March 17, 2025, at 4:07 p.m., a concurrent observation and interview was conducted with CK 2. CK 2 was asked to demonstrate how to calibrate the thermometer used to check the temperature of the food to be served. CK 2 got a cup of ice filled with water and then put the thermometer inside. CK 2 stated he needed to calibrate the thermometer to 40 degrees Fahrenheit (F - a unit of measurement). On March 18, 2025, at 11:11 a.m., a concurrent observation and interview was conducted with DA 2. DA 2 was asked to demonstrate how to calibrate the thermometer. DA 2 got a cup of ice filled with water and then put the thermometer inside. DA 2 stated she needed to calibrate the thermometer to 39 F. On March 20, 2025, at 9:33 a.m., an interview was conducted with the RD and the FSN. The RD stated the thermometer needed to be calibrated to 32 F. The FSN stated the potential risk for thermometers which were not properly calibrated by the dietary staff when they check the food temperature could cause foodborne illnesses. A review of the facility's policy and procedure titled, THERMOMETER USE AND CALIBRATION, dated 2023, the indicated, .Food thermometers are to be used properly and calibrated to ensure accurate temperature reading .If the thermometer does not read 32 F, then the thermometer must be calibrated or discarded . A review of the professional reference retrieved from the Centers for Disease Control and Prevention (CDC) document titled, Food Safety, dated October 15, 2021, indicated, .Food is safely cooked when the internal temperature gets high enough to kill germs that can make you sick. The only way to tell if food is safely cooked is to use a food thermometer. You can't tell if food is safely cooked by checking its color and texture . Use a food thermometer to ensure foods are cooked to a safe internal temperature . 5. On March 17, 2025, a review of the manufacturer's guidelines for three compartment sink cleaning procedures posted above three compartment sink indicated, .Place items in Sanitizing Solution for 1 minute . On March 17, 2025, at 3:37 p.m., an interview was conducted with DA 4. DA 4 was asked how long he need to submerge the washed kitchen ware in the sanitizer in the sanitizing sink. DA 4 was unable to answer the question. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 17, 2025, at 3:59 p.m., an interview was conducted with DA 3. DA 3 was asked how long he need to submerge the washed kitchen ware in the sanitizer in the sanitizing sink. DA 3 stated washed kitchen ware need to be submerged into the sanitizer for 10 seconds. On March 20, 2025, at 9:33 a.m., an interview was conducted with the RD and the FSN. Both of the RD and the FSN stated they were unsure how long washed kitchen ware needed to be submerged into the sanitizer in the sanitizing sink.

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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. 44504 Based on observations, interviews and record reviews, the facility failed to ensure food were prepared according to the prescribed recipe, when: 1. [NAME] 1 did not add margarine to a fortified diet during the noon meal on March 17, 2025; 2. Food service workers did not have a system to distinguish a diet Jello for Controlled Carbohydrate Diet during the noon meal on March 17, 2025; 3. [NAME] 2 did not use the right scoop to portion salad for dinner on March 18, 2025; 4. [NAME] 2 did not use the right scoop to portion meat for dinner on March 18, 2025; and 5. Diet Aide 5 did not measure the amount of shredded cheese to be placed in cheese quesadilla on March 18, 2025. These failures had the potential to negatively impact the residents' nutritional status and further compromising the resident's medical status. Findings: 1. On March 17, 2025, a review of the facility's document titled Fortified Menu Plan (diet with added extra nutrients to increase the calories and/or protein density to promote improvement residents' nutrition status) posted next to the trayline (a system of food preparation in which trays move along an assembly line), indicated, .lunch .vegetable per menu. Extra 1/2 oz melted margarine On March 17, 2025, starting at 12:40 p.m. to 1:08 p.m., a concurrent observation and meal tray ticket (menu based on the resident's diet physician order and food preference) review was conducted with Resident 5, 86, 14, 83, 102, 22, and 72, at the dining room, during lunch meal observation. Resident 5, 86, 14, 83, 102, 22, and 72's meal ticket indicated, Fortified. Resident 5, 86, 14, 83, 102, 22, and 72's served lunch meal was observed without margarine served on the vegetable. On March 17, 2025, at 1:08 p.m., a concurrent observation, interview and meal tray ticket review was conducted with Resident 72 and Certified Nurse Aide (CNA) 2 at dining room. Resident 72 meal ticket indicated, Fortified. Resident 72's served lunch meal was observed, there was no margarine on served vegetable. CNA 2 confirmed there was no margarine on any food items served as entree including the vegetable. On March 18, 2025, at 10:27 a.m., an interview was conducted with [NAME] (CK) 1. CK 1 stated during lunch, fortified diet residents should receive margarine on the served vegetable. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 18, 2025, at 10:46 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated fortified diet residents should serve margarine on their vegetable during lunch. The RD explained fortified diet residents who had an order for fortified diet did not get the extra calories per diet menu plan which could affect their nutritional status since there was no margarine on the vegetable. A review of Resident 5, 86, 14, 83, 102, 22, and 72's physician diet order, indicated the residents had an order for fortified diet. A review of the facility's policy and procedure titled, FORTIFIED DIET, dated 2020, indicated, DESCRIPTION: The Fortified Diet is designed for residents who cannot consume adequate amounts calories and/or protein to maintain their weight or nutritional status. NUTRITIONAL BREAKDOWN: The goal is to increase the calories density of the foods commonly consumed by the resident. The amount of calories increase should be approximately 300 - 400 per day. FOODS: Examples of adding calories may include - Extra margarine or butter to food items such as vegetables . A review of the facility's policy and procedure titled, MENU PLANNING, dated 2023, indicated, .The menu are planned to meet nutritional needs of residents in accordance with .Physician's orders .PROCEDURES . Standardized recipes .used in food preparation . A review of the facility's policy and procedure titled, FACILITY REGISTERED DIETITAN APPROVAL OF MENUS, dated 2023, indicated, .The facility Registered Dietitian has reviewed the menus and spreadsheets and has agreed that the menus meet the therapeutic needs . 2. A review of the facility provided Cooks Spreadsheet (the document used to guide food service workers on food items, portions, and therapeutic diet), dated March 17, 2025, indicated, Controlled Carbohydrate Diet (CCHO) served Diet Gelatin (Jello). On March 17, 2025, at 11:30 a.m., an observation was conducted with Dietary Aide (DA) 7 at the kitchen. DA 7 was observed putting Jello on meal tray. On March 17, 2025, starting at 12:41 p.m. to 1:11 p.m., a concurrent observation and meal tray ticket review was conducted with Residents 86, 80, 83, 133, 127, 72, and 101, during lunch meal observation at the dining room. Resident 86, 80, 83, 133, 127, 72, and 101's meal ticket indicated, CCHO. Residents 86, 80, 83, 133, 127, 72, and 101, were observed to receive red colored Jello which looked the same as the regular Jello and there was no label to indicate the Jello was diet. On March 18, 2025, at 10:22 a.m., an interview was conducted with DA 7. DA 7 stated she could not distinguish which Jello was diet and which Jello was regular without a label on the Jello. On March 18, 2025, at 10:46 a.m., an interview was conducted with the RD. The RD stated the Jello needed to be labeled diet or regular. The RD stated CCHO diet residents should be served diet Jello per menu plan. The RD stated there could be a potential risk for residents with CCHO diet who consumed regular Jello could increase the resident's blood sugar level. A review of Resident 86, 80, 83, 133, 127, 72, and 101's physician diet order, indicated Residents 86, 80, 83, 133, 127, 72, and 101's were on CCHO diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility document titled, CONTROLLED CARBOHYDRATE DIET (CCHO), dated 2020, indicated, .CCHO, is a meal plan without specific calories levels for diabetic residents. Instead of counting calories; the carbohydrates are evenly, systematically and consistently distributed through three meals and evening snacks in an effort to maintain a stable blood sugar level throughout the day .The carbohydrates are controlled through portion control and avoiding some concentrated sweets .Provide .Diet gelatin .Diet fruits packed in water or 100% fruit juice, not syrup . A review of the facility's policy and procedure titled, MENU PLANNING, dated 2023, indicated, .The menu are planned to meet nutritional needs of residents in accordance with .Physician's orders . A review of the facility's policy and procedure titled, FACILITY REGISTERED DIETITAN APPROVAL OF MENUS, dated 2023, indicated, .The facility Registered Dietitian has reviewed the menus and spreadsheets and has agreed that the menus meet the therapeutic needs . 3. On March 18, 2025, a review of the facility provided Cooks Spreadsheet, dated March 18, 2025, indicated, . Tossed [NAME] Salad: Regular portion .1/2 cup . On March 18, 2025, at 4:42 p.m., an observation was conducted with the Food and Nutrition Services Director (FNS). The FNS was observed using the blue scoop (1/4 cup) to portion the green salad. On March 21, 2025, at 9:33 a.m., a concurrent interview and review of the Cooks Spreadsheet dated March 18, 2025 was conducted with the RD and the FSN. The FSN stated [NAME] (CK) 2 started using blue scoop to portion the green salad. The FNS stated she jumped in to help CK 2 as he was running out of time. The FSN did not realize CK 2 used the wrong scoop to portion the green salad. After reviewing the Cooks Spreadsheet, the RD and the FSN acknowledged CK 2 served half portion less than the menu plan. The RD stated Residents did not get the proper nutrition and the right amount serving size they were supposed to get per menu plan which could lead to nutritional deficit and could potentially result in weight loss. A review of the facility's policy and procedure titled, MENU PLANNING, dated 2023, indicated, .The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician's order and, to the extent medically possible, in accordance with the most recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences . A review of the facility's policy and procedure titled, FACILITY REGISTERED DIETITAN APPROVAL OF MENUS, dated 2023, indicated, .The facility Registered Dietitian has reviewed the menus and spreadsheets and has agreed that the menus meet the therapeutic needs . 4. A review of the facility provided Cooks Spreadsheet, dated March 18, 2025, the Cooks Spreadsheet indicated . Beef Teriyaki: Regular portion: number (#) 12 scoop . On March 18, 2025, at 5:21 p.m., an observation was conducted with CK 2 at trayline. CK 2 was observed using # 8 scoop (4 oz) instead of # 12 scoop (3.25 oz) per menu to portion the beef teriyaki . (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 21, 2025, at 9:33 a.m., a concurrent interview and review of the Cooks Spreadsheet dated March 18, 2025, was conducted with the RD and the FSN. After reviewing the Cooks Spreadsheet, the RD and the FSN acknowledged CK 2 served more meat per planned menu to the residents. The RD stated the residents did not get the proper nutrition and the right amount of protein serving size they were supposed to get per planned menu which could lead to excess nutrients intake and resulted to weight gain. The RD stated CK 2 gave more meat to the residents, and he might run out of meat during trayline. A review of the facility's policy and procedure titled, MENU PLANNING, dated 2023, indicated, .The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician's order and, to the extent medically possible, in accordance with the most recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences . A review of the facility's policy and procedure titled, FACILITY REGISTERED DIETITAN APPROVAL OF MENUS, dated 2023, indicated, .The facility Registered Dietitian has reviewed the menus and spreadsheets and has agreed that the menus meet the therapeutic needs . 5. On March 18, 2025, at 4:48 p.m., a concurrent observation and interview was conducted with DA 5 at the cook area. DA 5 was observed to make cheese quesadilla. DA 5 grabbed two (2) handful of shredded cheese from a plastic container without measuring and then put on the flour tortilla to make cheese quesadilla. DA 5 stated she had no idea how much shredded cheese she used to make the cheese quesadilla. DA 5 was unable to locate the cheese quesadilla recipe. On March 20, 2025, at 9:33 a.m., an interview was conducted with the RD and the FSN. The FSN stated DA 5 needed to follow the recipe and should use a scoop to measure the shredded cheese to be placed on the flour tortilla to make cheese quesadilla. The RD stated the residents could receive inconsistent nutrients needs if the recipe were not followed . A review of the facility's policy and procedure titled, MENU PLANNING, dated 2015, indicated, . PROCEDURES .Standardized recipes .used in food preparation .

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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. 50705 Based on observation, interview, and record review, the facility failed to ensure food were served at appropriate temperatures, were palatable (the taste and/or flavor of the food) and with variety of foods, according to the residents' preferences and the facility's policy and procedure, for nine residents (Resident 23, 35, 52, 66, 91, 103,107, 132, and 146) out of 153 residents who receive food from the kitchen. This failure placed residents at potential risk to decrease nutritional intake and affect the resident's nutritional status. Findings: (Cross reference 805) On March 17, 2025, at 10:02 a.m., during an interview with Resident 52, Resident 52 stated, Served food is warm not hot; cold food not cold; like ice cream sometimes is melty. On March 17, 2025, at 10:20 a.m., during an interview with Resident 66, Resident 66 stated, The food mostly does not have much taste; 80 percent of the time. On March 17, 2025, at 11:30 a.m., during an interview with Resident 91, Resident 91 stated, Food served same thing day after day. The food is cold. On March 17, 2025, at 11:59 a.m., during an interview with Resident 146, Resident 146 stated, The food sucks. Somedays food is warm and somedays its cold and bland. On March 17, 2025, at 12:08 p.m., during an interview with Resident 103, Resident 103 stated, Food is not good. It is cold. On March 18, 2025, at 9:57 a.m., during an interview with Resident 35, Resident 35 stated, Every breakfast comes cold. On March 18, 2025, at 2:12 p.m., during an interview with Resident 23, Resident 23 stated, Food is bland and cold when it served. On March 18, 2025, at 2:25 p.m., during an interview with Resident 107, Resident 107 stated, A lot of times food its cold and bland. On March 18, 2025, at 3:03 p.m., during an interview with Resident 132, Resident 132 stated, Food is cold. On March 18, 2025, at 6:29 p.m., during a concurrent interview and test tray (to evaluate the quality of a meal during a meal service and identify any areas for improvement) conducted at dining room with the Food and Nutrition Service Director (FNS), a test tray was conducted to check the food temperature and palatability of the regular and puree diet meals. The following temperatures were obtained from the test tray: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Regular diet for beef teriyaki: 111 degrees Fahrenheit (F - a unit of measurement); [NAME] bean: 100 F; Rice: 100 F. - Pureed diet: Mashed potatoes: 105 F; Carrot: 104 F. In a concurrent interview, the FNS acknowledged pureed beef teriyaki was not the right diet texture. The FNS stated pureed beef teriyaki did not have a smooth mashed potato texture with the beef fiber still intact. The FNS stated the residents could choke on it, the resident could spit out the beef which could lead to decreased intake and cause weight loss. The FNS stated [NAME] (CK) 2 needed to use ground meat or pureed the beef longer to make it smooth like mashed potato texture. The FNS admitted CK 2 prolonged boiling green beans which caused the green beans to have an olive color. The FNS acknowledged the served beef teriyaki meat for regular diet was tough and mashed potatoes taste gross. On March 20, 2025, at 9:33 a.m., during an interview with the Registered Dietitian (RD), the RD stated serving cold and unpalatable food could lead to the residents' decreased meal intake. The RD explained decreased meal intake could result in residents to not receive the proper nutrition they needed, which could cause weight loss and nutritional deficiency. A review of the facility's policy and procedure titled, MEAL SERVICE, dated 2023, indicated, .POLICY .Meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner, and served at the appropriate temperatures .Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot .Recommended Temperature at Delivery to Resident .Hot Entree more than or equal to 120 degrees Fahrenheit .Starch: more than or equal to 120 degrees Fahrenheit .Vegetables: more than or equal to 120 degrees Fahrenheit . A review of the facility's policy and procedure titled, FOOD PREPARATION, dated 2023, indicated, .POLICY: Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. PROCEDURE . Prepared food will be sampled. The Food and Nutrition Services employee who prepares the food will sample it to be sure food has a satisfactory flavor and consistency .Poorly prepared food will not be served-such food is to either be improved, prepared again, or replaced with an appropriate substitution. Note that increased amounts of herbs and spices (not salt) may be added, since potency of products may vary .

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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. 44504 Based on observation, interview, and record review, the facility failed to ensure the appropriate food texture was provided when: 1. For 13 of 13 residents who received pureed diet (is a diet with food texture need to blend until smooth for residents who have difficulty chewing and/or swallowing) received pureed meat that were not smooth with meat fiber still intact for dinner on March 18, 2025; 2. For Resident 39 who had a physician order for nectar thick liquid received lumpy milk and a regular shake during lunch on March 18, 2025; 3. For Resident 85 who had physician ordered for nectar thick liquid received pudding consistency milk and Jello during lunch on March 18, 2025; and These failures had the potential to place the residents at risk of choking, aspiration (when food is breathed into the lungs), coughing and decreased meal or fluid intake. Findings: 1. On March 18, 2025, at 4:38 p.m., a concurrent observation and interview was conducted with [NAME] (CK) 2. CK 2 was observed preparing pureed meat. CK 2 stated he was preparing 18 servings of pureed meat for residents on pureed diet. On March 18, 2025, at 6:29 p.m., a test meal (to evaluate the quality of a meal during a meal service and identify any areas for improvement) was performed for palatability of the puree diet with the Food and Nutrition Services Director (FNS). The pureed beef texture was observed to have beef fiber still intact. The FNS stated pureed foods should be smooth with mashed potato texture. The FNS stated currently served pureed beef texture not smooth with fiber of meat still intact. The FNS stated CK 2 should leave the beef in the blender to be blended for a longer period to reach the smooth mashed potato texture. The FNS stated residents on pureed diet could choke with this texture and spill out the beef which lead to decrease meal intake and could potentially result in weight loss. A review of the facility document titled Diet Type Report, dated March 19, 2025, indicated Residents 1, 16, 34, 41, 39, 67, 85, 97, 117, 121, 152, 157 and 318 had physician's order for pureed diet. A review of the facility document titled, Pureed Diet, indicated, .The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be of a smooth and moist consistency and able to hold its shape (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On March 17, 2025, at 11:32 a.m., a concurrent observation, interview, and record review of the instructions of making thickened liquid was conducted with Diet Aide (DA) 6. DA 6 was observed preparing nectar thick liquid. DA 6 stated he followed the chart instructions making nectar liquid. The chart instructions of making thickened liquid was reviewed, which indicated, .Measure the recommended amount of [brand (thickener)] to achieve desired consistency .Slowly add [brand (thickener)] to liquid while stirring briskly until dissolved. Liquid will thicken within 1-5 minutes. Recommended Usage: Desired Consistency: Nectar -Like .1 tablespoon per 4 fluid oz serving . DA 6 was observed add thickener and milk according to the instructions and then stirred the liquid. The thickener was observed to be still on the bottom of the cup. On March 17, 2025, at 1:20 p.m., a concurrent observation, interview, and review of Resident 39's meal ticket was conducted at Resident 39's bedside with Licensed Vocational Nurse (LVN) 6 and Certified Nurse Aide (CNA) 2. Resident 39's meal ticket indicated, Nectar thick liquid, 4 fluid ounces (oz- a unit of measurement) 2 percent (%) milk; 4 fluid oz supplement shake. The 4 fluid oz 2% milk was observed with the thickener still sit on the bottom of the cup. LVN 6 and CNA 2 acknowledged the served nectar thick milk was not mix well with lumps and still had some thickener on bottom of the cup. LVN 6 acknowledged Resident 39 received regular shake. LVN 6 stated Resident 39 could aspirate if the resident consumed the regular shake. On March 18, 2025, at 10:46 a.m., an interview was conducted with the RD. The RD stated Resident 39 should receive nectar thick shake instead of regular shake. The RD explained Resident 39 could potentially cough and aspirate with drinking regular health shake. The RD stated the residents who were on nectar thick liquid who received lumpy liquid could discourage them to drink the liquid which could lead to decreased fluid intake. A review of Resident 39's physician order, dated July 14, 2023, indicated, Diet . nectar thick liquid consistency . 3. On March 17, 2025, at 1:20 p.m., a concurrent observation, interview, and review of Resident 85's meal ticket was conducted with LVN 6. Resident 85's meal ticket indicated, Nectar thick liquid. Resident 85 was observed to receiv Jello and pudding thick consistency milk. LVN 6 stated it would discourage Resident 85 to drink the pudding consistent milk. LVN 6 stated Resident 85 was not suppose to receive Jello because Jello would melt in her mouth and could become regular liquid which could cause coughing and aspiration. On March 18, 2025, at 10:46 a.m., an interview was conducted with the RD. The RD stated Residents who were on nectar thick liquid could not have Jello because Jello would melt in mouth and could cause coughing and aspiration. The RD stated it would discourage Resident 85 to drink pudding consistency milk which could lead to decrease fluid intake. A review of Resident 85's physician order, dated February 1, 2025, indicated, .Diet . nectar thick liquid consistency . A review of the facility's policy and procedure titled, DIET ORDERS, dated 2023, indicated, .POLICY: Diet orders as prescribed by the physician will be provided by the Food and Nutrition Services Department . (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility document titled, NUTRITIONAL MANAGEMENT OF THICKENED LIQUIDS, dated 2020, indicated, DESCRIPTION .Aspiration is, often, the result of Dysphagia (difficulty swallowing) and prevention of aspiration is the goal when utilizing thickened liquids. Thickened liquids help to slow the movement of liquids/drinks, allowing residents to have better control over their swallow. Dysphagia is characterized by coughing or choking after swallowing, pocketing of food in the check, excessive drooling, runny nose or eyes, gargled voice after eating, or poor tongue control .All liquids/drinks should be thickened to meet the prescribed order .Nectar thick liquids-Flows off spoon; pours slower than thin drinks; sippable; thin liquids will require thickening .Avoid foods that become liquids at room temperature e.g .gelatin (Jello) . A review of the facility's policy and procedure titled, MEAL SERVICE, dated 2023, indicated, .Meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner .

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 44504 Based on observation, interview, and record review, the facility failed to ensure bedtime snacks were offered and were sufficient, for 153 of 153 residents who received food from the kitchen. This failure had the potential to affect the nutritional and psychosocial wellbeing of residents. Findings: On March 18, 2025, at 9:59 a.m., during the confidential resident council meeting, five out of 10 residents stated bedtime snacks were not offered and sufficient for them. On March 18, 2025, at 10:06 a.m., an interview was conducted with Resident 120. Resident 120 stated she is diabetic, and the facility did not have sugar free or diabetic evening snacks available for her. On March 18, 2025, at 7:09 p.m., a concurrent observation and interview was conducted with Dietary Aide (DA) 3 at the kitchen. There were three plastic containers observed in the walk in refrigerator. Each container stored two (2) sandwiches, 12 individual single serving package graham crackers; 10 individual single serving package saltine crackers, six (6) bananas; three (3) oranges, two (2) Jello, two (2) apple sauce and two (2) puddings. DA 3 stated the Activity staff would come to the kitchen daily around 7:00 p.m. and took those snacks to be distributed to the residents. On March 19, 2025, at 2 p.m., an interview was conducted with the Activity Assistant (AS) 1. AS 1 stated she went to the kitchen around 7 p.m. to get evening snacks and offered them to the residents. AS 1 stated she needed more evening snacks because most of the residents wanted snacks and requested more than one snack. AS 1 stated the residents love fruits, she usually did not have enough fruit offered to the residents. AS 1 stated since there were not enough snacks to distribute, there fore no snacks were left available in the station counter for those residents who missed the time period when she offered the snacks. On March 19, 2025, at 2:14 p.m., an interview was conducted with AS 2. AS 2 stated current provided evening snacks were not enough to offer to the residents. AS 2 stated she needed more snacks to distribute to the residents. On March 20, 2025, at 9:33 a.m., a phone interview was conducted with the Registered Dietician (RD). The RD stated, the facility is like a home for the residents if residents were not offered or did not get enough bedtime snacks, the residents did not feel they are at home, they feel hungry and unhappy. A review of the facility's policy and procedure titled, Nourishment Policy, dated March 2016, indicated, . bedtime snacks of a nourishing quality will be offered routinely to all residents unless contraindicated .

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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** 50705 Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and distributed in accordance with professional standards for food service safety when: 1. Dust was observed on several areas (dry storage room and back door frame) in the kitchen; 2. Dietary Aide (DA 4) and Engineering Plant Director (EPD) had facial hair and were not wearing a hair restraint; 3. Two opened food items were exposed to the air in the walk-in freezer; 4. The walk in refrigerator gasket was found to have black grime buildup; 5. Three baking pans of pizza were stored underneath the steam table which was near a sanitizer bucket, and with air gap; 6. Wilting produce (three cucumbers and 2 green bell peppers) were found in the walk in refrigerator; 7. The cabinet used to store kitchen ware had chipped wood; 8. Two hot waterspouts had calcium buildup; 9. Unsanitary ice bags were placed on the floor of the facility lobby; 10. Eight expired boxes of English muffins were found in dry storage pantry; 11. A dirty rag was placed on the clean coffee cart; 12. The food service workers did not follow the manufacturer's guideline regarding the length of time for testing the red bucket Quaternary (Quat) sanitizer (sanitizing solution used for sanitizing food contact surfaces); 13. The food service workers did not know the appropriate concentration of the Quat sanitizer; 14. Diet Aides (DA) 1 and 3 were unable to demonstrate the proper steps to clean the dirty meal carts; 15. [NAME] (CK) 2 and Diet Aide 2 did not know how to calibrate the food thermometer; and 16. Diet Aides 3 and 4 did not know how long they need to submerge washed kitchen ware in the sanitizer sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's failures to ensure a safe and sanitary condition had the potential to result for microorganisms (a microscopic organism, especially a bacterium, virus, or fungus) that harbor foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease) to come in contact with residents' food which would cause food-borne illness to a population of 153 of 153 residents who received food from the kitchen and are medically compromised. Findings: 1. On [DATE], at 9:29 a.m., a concurrent observation and interview was conducted with the Food and Nutrition Services Director (FNS) in the kitchen. Dust was observed on the doorway frames of the dry storage pantry . The FNS stated dust were found on the dry storage pantry's doorway frames. On [DATE], at 9:58 a.m., a concurrent observation and interview were conducted with the FNS at the back door entrance to the kitchen. Dust was observed on the doorway frames. The FNS verified dust on the doorway frames at the entrance back door. On [DATE], at 9:33 a.m., a telephone interview with the Registered Dietitian (RD) and FNS was conducted. The RD stated dust should not be in the kitchen because it could cause cross contamination. During a review of the U.S. Federal and Drug Administration (FDA) Food Code 2022, ,d+[DATE].13 Nonfood-Contact Surfaces , the Food code indicated, 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. 2. On [DATE], at 12:07 p.m., an observation was conducted with Dietary Aide (DA) 4 in the kitchen. DA 4's facial hair was observed to be not restrained while DA 4 was working in the tray line. On [DATE], at 4:16 p.m., an observation and interview with the FNS was conducted in the kitchen. The EPD was observed to have facial hair and was not restrained while working in the walk-in refrigerator. The FNS stated the EPD should wear a beard net. The FNS stated the staff with facial hair, including DA 4 should wear a beard net to prevent cross contamination. On [DATE], at 9:33 a.m., a telephone interview with the RD was conducted. The RD stated facial hair should be covered when in the kitchen because it could fall in the food and cause cross contamination. A review of the policy and procedure titled, Dress Code, dated 2023, indicated, .Proper Dress: If applicable, beards and mustaches (any facial hair) must wear beard restraint . 3. On [DATE], at 10:14 a.m., a concurrent observation, and interview was conducted with the FNS at the reach-in freezer. One open bag of frozen carrots, and another open bag of frozen green beans were found exposed to air in the reach-in freezer. The FNS stated frozen food items should be sealed to prevent freezer-burn, and other food items from falling into the exposed frozen vegetables to prevent unappetizing taste and potential cross contamination. On [DATE], at 9:33 a.m., a telephone interview with the RD was conducted. The RD stated the opened food items should be sealed in order to preserve freshness and taste. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the policy and procedure titled, Procedure For Freezer Storage, dated 2023, indicated, . Procedure: Store frozen foods in an airtight moisture-resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn . 4. On [DATE], at 11:21 a.m., a concurrent observation and interview was conducted with the FSN in the walk-in refrigerator. Black grime build up was observed on the refrigerator door's gasket. The FNS stated the refrigerator gasket needs to be replaced to prevent cross contamination. On [DATE], at 9:33 a.m., a telephone interview with the RD was conducted. The RD stated the walk-in refrigerator door's gasket not supposed to have black grime buildup which could cause cross contamination. During a review of the policy and procedure titled, SANITATION, dated 2023, indicated, .All .equipment shall be kept clean . 5. On [DATE], at 3:29 p.m., a concurrent observation and interview was conducted with the FNS at the trayline. Three pans of pizza were observed at the bottom of the trayline shelf, next to the cleaning and sanitizer buckets, and with an air gap. The FNS stated We don't do that, because it can cause cross contamination. On [DATE], at 9:33 a.m., a telephone interview with the RD and the FNS was conducted. The RD stated the pizza should have been placed on a higher surface, to prevent cross contamination. During a review of the policy and procedure titled, Sanitation, dated 2023, indicated, .Do not use cleaning products or sanitizer in the food preparation or food storage areas in any way that could result in contamination of exposed food items. 6. On [DATE], at 11:21 a.m., a concurrent observation and interview was conducted with the FNS in the walk-in refrigerator. Three wilted cucumbers and two wilted bell peppers were observed on the refrigerator shelf. The FNS stated the refrigerator gasket needs to be replaced to prevent cross contamination. The FNS further stated the wilted vegetables need to be thrown away, so the residents could not get sick from being served spoiled vegetables. On [DATE], at 9:33 a.m., a telephone interview with the RD and the FNS was conducted. The RD stated wilted vegetables should not be in the refrigerator because it can affect the freshness of other produce in the refrigerator. The RD further explained stated wilted vegetables could lead to bacteria growth and cross contamination of other produce stored in refrigerator. During a review of the facility's policy and procedure titled, Procedure for Refrigerated Storage, dated 2023, indicated, .Produce will be be .free of any wilting or spoilage . 7. On [DATE], at 11:48 a.m., an observation was conducted with the FNS in the kitchen. Chipped wood werer observed on the shelves used to store kitchenware. The FNS stated the cabinets should not be chipped because it can cause cross contamination. On [DATE], at 9:33 a.m., a telephone interview with the RD and the FNS was conducted. The RD stated the cabinet wood should not be chipped, because it could cause cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Sanitation, dated 2023, indicated, .All .counters shall be .free from .chipped areas . 8. On [DATE], at 11:49 a.m., an observation was conducted with the FNS in the kitchen. Calcium buildup was observed on two hot waterspouts. On [DATE], at 9:33 a.m., a telephone interview with the RD and the FNS was conducted. The RD stated the calcium buildup should be removed, because it could get in the food and water and could cause cross contamination. During a review of the policy and procedure titled, Sanitation, dated 2023, indicated, .All utensils, couters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions .cracks, and chipped areas . 9. On [DATE], at 8:34 a.m., an observation was conducted in the lobby. Bags of ice were observed on the floor and at the front desk. On [DATE], at 11:27 a.m., an interview was conducted with the EPD. The EPD confirmed the facility had to get the ice this morning because last night someone accidentally turned off the ice machine. On [DATE], at 9:33 a.m., a telephone interview with the RD and the FNS was conducted. The RD stated ice should not be on the floor or the desk, because it was not sanitary and could cause contamination of the ice. During a review of the policy and procedure titled, Sanitation, dated 2023, indicated, .Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner . 10. On [DATE], at 11:50 a.m., an observation was conducted in the kitchen. A dirty rag was observed on the clean coffee cart. On [DATE], at 9:33 a.m., a telephone interview with the RD and the FNS was conducted. The RD stated dirty rags should not be placed in the kitchen. The RD stated the dirty rags needed to be in a basket for soiled laundry. The RD stated dirty rags in the kitchen could cause cross contamination. During a review of the U.S. Federal and Drug Administration (FDA) Food Code 2022, ,d+[DATE].14 Wiping Cloths, Use Limitation. , the Food code indicated, .Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration 11. On [DATE], at 9:40 a.m., a concurrent observation and interview were conducted with the FNS in the kitchen. Eight boxes of English muffins, with an expiration date of [DATE], were found in the dry storage pantry. The FNS stated expired food items should not be stored as the food could be served to residents and potentially cause illness. On [DATE], at 9:33 a.m., a telephone interview with the RD and the FNS was conducted. The RD stated expired food should not be in the kitchen because it could harm someone. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the U.S. Federal and Drug Administration (FDA) Food Code 2022, indicated, .Annex 3: Manufacturer's use-by dates .Manufacturers assign a date to products for various reasons, and spoilage may or may not occur before pathogen growth renders the product unsafe. Most, but not all, sell-by or use-by dates are voluntarily placed on food packages . Although it is a guide for quality, it could be based on food safety reasons. It is recommended that food establishments consider the manufacturer's information as good guidance to follow to maintain the quality (taste, smell, and appearance) and salability of the product. If the product becomes inferior quality-wise due to time in storage, it is possible that safety concerns are not far behind . 12. On [DATE], a review of the test strip manufacturer's guidelines indicated the test strip need to be dipped into the Quat sanitizer for 10 seconds. On [DATE], at 3:59 p.m., an observation was conducted with DA 3. DA 3 was asked to demonstrate to check the concentration of the Quat sanitizer in the sanitizer bucket. DA 3 dipped the test strip into the sanitizer for 1 second, the test strip was unable to read the sanitizer concentration without showing any change in the color. DA 3 was observed the second time and DA 3 used another sanitizer bucket and dipped the test strip into the Quat sanitizer bucket for 3 seconds. On [DATE], at 4:07 p.m., a concurrent observation and interview was conducted with CK 2. CK 2 was asked to demonstrate to check the concentration of Quat sanitizer in the sanitizer bucket. CK 2 stated he needed to dip the test strip into sanitizer for 15 seconds. On [DATE], at 9:33 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated the test strip needed to be dipped into the Quat sanitizer for 10 seconds. The RD explained if food services workers did not follow manufacturer guideline's time length in dipping the test strip into Quat sanitizer, it could result in an inaccurate reading of the sanitizer concentration which could not ensure the effectiveness of the sanitizer. The RD explained using ineffective Quat sanitizer could result to not properly sanitize food contact surfaces which could cause cross contamination and lead to food borne illness. A review of the facility's policy and procedure titled, QUATERNARY AMMONIA LOG POLICY, dated 2023, indicated, .POLICY .The concentration of the ammonium in the quaternary (Quat) sanitizer will be tested to ensure the effectiveness of the solution . Read instructions on quaternary container and the test strips for proper concentration, length of time the strip needs to be in contact with the solution .when testing for concentration 13. On [DATE], a review of the manufacturer's guidelines for Quat sanitizer posted above the three compartment sink indicated, .Testing solution should be between 200 -400 parts per million (ppm - a unit of measurement) . On [DATE], at 11:53 a.m., an interview was conducted with DA 2. DA 2 was asked to test the Quat sanitizer in the sanitizer bucket. DA 2 stated Quat sanitizer needed to be between 200 -300 ppm. DA 2 stated 400 ppm was not right concentration because the concentration was too strong. On [DATE], at 3:37 p.m., an interview was conducted with DA 4. DA 4 was asked to test the Quat sanitizer in the sanitizer bucket. DA 4 stated Quat sanitizer range needed to be between 200 -300 ppm. DA 4 stated 400 ppm was not right because the sanitizer was too concentrated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], at 3:59 p.m., an interview was conducted with DA 3. DA 3 was asked to demonstrate to check the concentration of Quat sanitizer in the sanitizer bucket. DA 3 stated Quat sanitizer should be only in 200 ppm. On [DATE], at 4:07 p.m., a concurrent observation and interview was conducted with CK 2. CK 2 was asked to demonstrate to check the concentration of Quat sanitizer in the sanitizer bucket. CK 2 stated Quat sanitizer should be only in 200 ppm. CK 2 stated 200 - 400 was not right concentration. On [DATE], at 9:33 a.m., a phone interview was conducted with the RD. The RD stated Quat Sanitizer should be between 200 - 400 ppm. and all food service workers should know the concentration range. A review of the facility's policy and procedure titled, QUATERNARY AMMONIA LOG POLICY, dated 2023, indicated, .POLICY .The concentration of the ammonium in the quaternary (Quat) sanitizer will be tested to ensure the effectiveness of the solution . Read instructions on quaternary container and the test strips for proper concentration, length of time the strip needs to be in contact with the solution .when testing for concentration 14. On [DATE], at 9:59 AM, an interview was conducted with DA 1. DA 1 was asked to demonstrate how to clean used meal cart. DA 1 stated she used green bucket (soap and water) to clean the meal cart and then sanitize with sanitizer. On [DATE], at 3:59 PM, an interview was conducted with DA 3. DA 3 was asked to demonstrate how to clean used meal cart. DA 3 stated he only used sanitizer to clean the used meal cart. On [DATE], at 9:33 AM, an interview was conducted with the RD. The RD stated not using cleaning procedure with wash, rinse and sanitizer could result not properly sanitize the used meal cart which cause cross contamination and lead to food borne illness. A review of the facility Policy and procedure (P&P) titled, SANITATION, dated 2023, the P&P indicated, . PROCEDURE: .4. Each employee shall know how to .clean all equipment . A review of the facility's policy and procedure titled, SHELVES, COUNTERS, AND OTHER SURFACES INCLUDING .FOOD PREPARATION ., dated 2023, indicated, CLEANING PROCEDURE: 1. Remove any large debris and wash surface with a warm detergent solution .Rinse with clear water .Spray with a sanitizer . 15. On [DATE], at 4:07 p.m., a concurrent observation and interview was conducted with CK 2. CK 2 was asked to demonstrate how to calibrate the thermometer used to check the temperature of the food to be served. CK 2 got a cup of ice filled with water and then put the thermometer inside. CK 2 stated he needed to calibrate the thermometer to 40 degrees Fahrenheit (F - a unit of measurement). On [DATE], at 11:11 a.m., a concurrent observation and interview was conducted with DA 2. DA 2 was asked to demonstrate how to calibrate the thermometer. DA 2 got a cup of ice filled with water and then put the thermometer inside. DA 2 stated she needed to calibrate the thermometer to 39 F. On [DATE], at 9:33 a.m., an interview was conducted with the RD and the FSN. The RD stated the thermometer needed to be calibrated to 32 F. The FSN stated the potential risk for thermometers which were not properly calibrated by the dietary staff when they check the food temperature could cause foodborne illnesses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, THERMOMETER USE AND CALIBRATION, dated 2023, the indicated, .Food thermometers are to be used properly and calibrated to ensure accurate temperature reading .If the thermometer does not read 32 F, then the thermometer must be calibrated or discarded . A review of the professional reference retrieved from the Centers for Disease Control and Prevention (CDC) document titled, Food Safety, dated [DATE], indicated, .Food is safely cooked when the internal temperature gets high enough to kill germs that can make you sick. The only way to tell if food is safely cooked is to use a food thermometer. You can't tell if food is safely cooked by checking its color and texture .Use a food thermometer to ensure foods are cooked to a safe internal temperature . 16. On [DATE], a review of the manufacturer's guidelines for three compartment sink cleaning procedures posted above three compartment sink indicated, .Place items in Sanitizing Solution for 1 minute . On [DATE], at 3:37 p.m., an interview was conducted with DA 4. DA 4 was asked how long he need to submerge the washed kitchen ware in the sanitizer in the sanitizing sink. DA 4 was unable to answer the question. On [DATE], at 3:59 p.m., an interview was conducted with DA 3. DA 3 was asked how long he need to submerge the washed kitchen ware in the sanitizer in the sanitizing sink. DA 3 stated washed kitchen ware need to be submerged into the sanitizer for 10 seconds. On [DATE], at 9:33 a.m., an interview was conducted with the RD and the FSN. Both of the RD and the FSN stated they were unsure how long washed kitchen ware needed to be submerged into the sanitizer in the sanitizing sink.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 44504 Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly when trash and used gloves were found on the floor surrounding the dumpsters. This failure had the potential to attract pests and cause infection control issue. Findings: On March 17, 2025, at 9:23 a.m., a concurrent observation and interview was conducted with the Food and Nutrition Services Director (FNS) outside the back kitchen at the dumpsters area. Food residual were observed on the grass near the entrance door of the kitchen. Trash and used gloves were found on the floor surrounding the dumpster area and gate area. The FNS stated the back kitchen area's floor need to be kept clean otherwise it would promote bacterial growth, attract pests, and it is infection control issue. On March 20, 2025, at 9:33 a.m., a phone interview was conducted with the Registered Dietician (RD). The RD stated the outside back kitchen floor should be kept clean. The RD explained trash, used gloves and food residual could attract pests and had potential to cause infection control issue. During a review of the facility's policy and procedure titled, MISCELLANEOUS AREAS, dated 2023, indicated, .GARBAGE AND TRASH .Trash Procedure .Garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. TRASH COLLECTION AREA: The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean .

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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. 50204 Based on interview and facility record review, the facility failed to ensure a written Quality Assurance Performance Improvement (QAPI - a systematic, interdisciplinary, comprehensive, and data-driven approach to maintain and improve safety, quality of care, and quality of life of the residents) plan in place to address the facility's systemic process issues related to staffing, dietary, and laundry services. These failures resulted in multiple residents to not receive appropriate services from Certified Nursing Assistant (CNA) staffing, dietary, and laundry services. In addition, these failures had the potential to place other residents residing at the facility to be at risk for not achieving their highest physical, mental, psychosocial well-being. Findings: On March 17, 2025 to March 21, 2025, during the facility's recertification survey, systemic issues were identified with sufficient nursing staff (see findings under F725), food services (see findings under F804), laundry services (see findings under F584). On March 21, 2025, at 11:30 a.m., an interview and a concurrent record review was conducted with the Administrator (ADM) to discuss the facility's QAPI program. The ADM stated the QAPI committee consisted of the ADM, the Director of Nursing, the Medical Director, the Infection Preventionist, the Pharmacy consultant, the Laboratory representative, and the heads of the facility departments. The ADM stated the facility did not have a QAPI program which identified, corrected, and improved the issues related to CNA staffing, dietary services, and laundry services for their residents. A review of facility's policy and procedure titled, Quality Assurance & Performance Improvement (QAPI) Committee, dated July 2022, indicated, .The committee develops, implements and monitors appropriate plans of action to address quality issues identified internally or by regulatory agencies .The committee collects and maintains all audits, reports, and worksheets containing confidential date and clinical issues . The QAPI Committee responsibilities include identifying and responding to quality deficiencies throughout the facility and oversight of the QAPI program when fully implemented, develop and implement corrective action and monitor performance goals or target are achieved and revising corrective action .

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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** 40988 Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were upheld when: 1. During lunch meal observation on March 17, 2025, Resident 36's IV (intravenous- into the vein) tubing was observed touching the food on her plate; 2. Two laundry staff stated they did not routinely check the washer and dryer temperatures. In addition, they were not able to state what the temperature requirements were for washing and drying linen and clothes; and 3. One laundry staff was observed placing linen that was touched by a resident, back into an uncovered linen cart. In addition, the laundry staff covered the clean linen in a large linen bin, with a linen cover that came in contact with the floor. These failures had the potential to spread infection among the vulnerable residents of the facility. Findings: 1. On March 17, 2025, at 12:08 p.m., an observation of the lunch meal service at the dining room was conducted. Resident 36 was observed seated at a dining table. An IV access was on top of Resident 36's left hand, with the tubing loose, without an end cap, and was touching the food on her plate. On March 20, 2025,a t 9:08 a.m., Registered Nurse 1 was interviewed. RN 1 confirmed she was the licensed nurse who taped Resident 36's IV tubing onto her left hand. RN 1 stated if the IV tubing was exposed like that and was touching the food, there was a high risk for infection to occur. RN 1 further stated the IV tubing should have been taped securely in place to prevent the tubing from touching the food and getting contaminated. On March 21, 2025, at 1:56 p.m., the Infection Preventionist (IP) was interviewed. The IP stated Resident 36's IV tubing should have been taped to her hand, and maybe a netting put in place, to secure it to the hand and prevent it from touching the food on her plate, otherwise she could get an infection. A review of the facility's policy and procedure titled, PREVENTING INTRAVENOUS CATHETER-RELATED INFECTIONS, dated April 1, 2011, indicated, .The purpose of this procedure is to maximally reduce the risk of infection associated with indwelling intravenous (IV) catheters .Any time that dressing is not intact or end caps are missing, the catheter has potential of contamination . 2. On March 19, 2025, at 2:02 p.m., an observation of the laundry room was conducted in the presence of the Housekeeping and Laundry Supervisor (HLS) and Laundry Staff (LS) 1. Clothes dryers #2, #3 and #4 were on and in use, as well as clothes washers #2 and #3. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 44504 Based on observation, interview, and record review, the facility failed to ensure equipment in the kitchen was maintained in a safe operating condition when condensation ice buildup was found on the fans in the reach in freezer. This failure had the potential to place 153 out of 153 residents who received food from the kitchen at risk for not receiving quality of foods. Findings: On March 17, 2025, at 10:11 a.m., an observation of the reach in freezer at kitchen was conducted. Condensation ice buildup was observed on the two fans in the reach in freezer. Puddle of ice buildup was observed on the surface of a box of cut corn located at the second shelf. On March 17, 2025, at 10:43 a.m., an interview was conducted the Food and Nutrition Services Director (FNS) and [NAME] (CK)1 in front of the reach in freezer at the kitchen. The FNS acknowledged the reach in freezer was not working properly with condensation ice buildup. CK 1 stated condensation ice buildup at the reach in freezer randomly happened in the past two (2) weeks. On March 18, 2025, at 11:27 a.m., an interview was conducted with the Engineering Plant Director (EPD). The EPD stated the reach in freezer defrost time had messed up with the daylight saving time change. The EPD further stated temperature fluctuations lead to condensation and eventually ice formation which could affect the quality of foods stored in the freezer. The EPD stated he did not receive any verbal or written work ordered from the dietary department regarding malfunction of the reach in freezer. A review of facility policy and procedure tilted, Sanitation, dated 2023, indicated, .all .equipment shall be . maintained in good repair .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555330	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Postacute Care	8781 Lakeview Avenue Riverside, CA 92509

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	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44504 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the facility remained free of pests when four bugs, one (1) spider, and one (1) house fly were found in the kitchen. This failure had the potential to place 153 out of 153 residents who received food from the kitchen at risk for food borne illnesses (illness caused by food contaminated with bacteria, viruses, parasites or toxins). Findings: On March 17, 2025, at 10:30 a.m., a concurrent observation and interview with the Food and Nutrition Services Director (FNS) was conducted at the dry storage room inside the kitchen. Four bugs (brown color with wings) and one spider were observed on the ceiling. The FNS stated the kitchen should not have any pests as it could cause cross contamination (bacteria are unintentionally transferred from one substance or object to another with harmful effect) of the foods stored in dry storage and lead to food borne illnesses. On March 18, 2025, at 5:30 p.m., an observation was conducted in front of steamtable inside the kitchen. A house fly was observed to land on the window. On March 20, 2025, at 9:33 a.m., a phone interview was conducted with the Registered Dietician (RD). The RD stated the kitchen supposed to be pests free to prevent cross contamination and infection control issue. A review of the facility's policy and procedure titled, Pests Control, dated April 2018, indicated, .POLICY: It is the policy of the facility to maintain an ongoing pest control program to ensure the building premises and its grounds are kept free of insects, rodents, and other pests. PURPOSE: To ensure that facility is free of insects, rodents and other pest that could compromise the health, safety and comfort of residents, staff and visitors . A review of the facility's policy and procedure titled, MISCELLANEOUS AREAS, dated 2023, indicated, .FLY AND VERMIN CONTROL Flies are carries of disease and are a constant enemy of high standards of sanitation in the Food & Nutrition Services Department .