STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000 Based on observation, interview, and record review, the facility failed to ensure one resident reviewed (Resident 297) was treated with respect and dignity by failing to ensure Resident 297's indwelling urinary catheter (medical device that helps drain urine from your bladder) drainage bag (holds the urine) had a dignity bag (a bag used to cover a urinary drainage bag, so it was not visible). This deficient practice had the potential to cause Resident 297 psychosocial harm and for the resident to feel embarrassed. Findings: During a review of Resident 297's Admission Record, the Admission Record indicated Resident 297 was admitted to the facility on [DATE], with diagnoses of cerebral palsy (congenital disorder of movement, muscle tone, or posture), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems) and hemiplegia (partial paralysis on one side of the body). During a review of Resident 297's minimum data set (MDS - an assessment tool), dated May 22, 2024, the MDS indicated Resident 297's BIMS (brief interview for mental status) score was 2, which indicated severe cognitive impairment. During an observation on June 3, 2024, at 7:28 a.m., in Resident 297's room, Resident 297 was lying in bed and the urinary catheter and drainage bag was hanging at the foot of the bed and the drainage bag did not have a dignity bag. During a concurrent observation and interview on June 3, 2024, at 7:39 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 acknowled there was no dignitity bag and stated that the resident should have a dignity bag covering his urinary catheter drainage bag. CNA 1 stated when the indwelling urinary catheter drainage bag is exposed it could make the resident feel embarrassed. During an interview on June 5, 2024, at 2:39 p.m., with the Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP stated all nursing staff are responsible for maintaining residents' indwelling urinary catheter. The DSD/IP stated all residents need a dignity bag to protect their privacy when the urinary catheter drainage bag is exposed because it could be embarrassing for the residents when it is exposed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 2021, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .be treated with respect, kindness, and dignity .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000 Based on observation, interview, and record review, the facility failed to accommodate the needs for one resident reviewed (Resident 30), when the call light button was observed not within reach. This failure had the potential for Resident 30 not to be able to call staff for assistance which could result in the resident's needs going unmet. Findings: On June 3, 2024, at 8:22 a.m., during an observation and concurrent interview with Resident 30, the resident's call light button was observed hanging on the wall at the head of the bed and secured to the wall by a clamp. Resident 30 stated he would not be able to reach the call light button secured to the wall. The call light button was not within the resident's reach. On June 3, 2024, at 8:41 a.m., during an observation and concurrent interview with Certified Nurse Assistant (CNA) 2, CNA 2 acknowledged Resident 30 was not able to reach the call light and the call light should be within reach. CNA 2 further stated the resident could not reach the call light hanging on the wall. CNA 2 further stated, he is in a wheelchair so if he tried to reach the call light, he could fall. CNA 2 also stated it is the facility's practice to have the call light within reach for all residents. On June 5, 2024, at 2:43 p.m., during an interview with the DSD/IP. The DSD/IP stated the call light should be within reach for all residents while in their rooms. The DSD/IP further stated if the call light is hanging behind the resident's bed, the resident would not be able to reach it. The DSD/IP also stated the risk associated with the call light not being within reach is that resident would not be able to call if he needed assistance. Resident 30's record was reviewed. Resident 30 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (muscle weakness or partial paralysis on one side of the body), history of falling and diabetes (a chronic disease that causes elevated levels of blood sugar). A facility policy titled, Answering The Call Light, revised March 2023, was reviewed. The policy indicated . When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on interview and record review, the facility failed to notify the resident's family member (FM) of the change in condition and transfer to the acute hospital for one of three residents reviewed for closed record (Resident 45). This failure resulted in Resident 45's FM looking for Resident 45 two days after Resident 45 had a change in condition and was transferred to the acute hospital on March 10, 2024. Findings: On June 6, 2024, Resident 45's record was reviewed. Resident 45 was admitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the prostate (cancer of the prostate) and severe protein-calorie malnutrition (a condition when a person does not eat enough protein and calories). The history and physical (H&P), dated March 9, 2024, indicated Resident 45 was diagnosed a year ago but never followed up for treatment. Resident 45 was at the acute hospital for anemia (a condition in which the blood does not have healthy red blood cells and hemoglobin) that required blood transfusion, leg swelling, and generalized weakness alert but confused, and cachectic (significant loss of body fat and muscle) The physician order summary from March 8 to March 10, 2024, indicated an order of .oxygen 2-4 liters (a unit of measurement) per minute via nasal cannula (a device used to deliver oxygen though the nose) as needed for shortness of breath . The nurses notes from March 8, 2024, through March 10, 2024, indicated the following: . 03/08/2024, 17:47 (5:47 p.m.) V/S (VITAL SIGN - blood pressure, pulse rate, respiration and body temperature) 127/69, 92, 20, 97.8 . admitted .ALERT AND ORIENTED .WEAK LOOKING, CALM AND COOPERATIVE, DENIES ANY DISCOMFORT. OXYGEN AT 3LITERS/MIN TO MAINTAIN OXYGEN SATURATION (amount of oxygen in the blood) 90% AND ABOVE. NO SOB (SHORTNESS OF BREATH). NO LABORED BREATHING . 03/09/2024, 01:47 (1:47 A.M.) VS 98.2 -76-16 - 114/70. OXYGEN SATURATION 95% . 03/09/2024, 14:11 (2:11 P.M.) VS 98.5- 100- 25 110/57, OXYGEN SATURATION 98.5% . 03/10/2024, 00:42 (12:42 A.M.) VS 98.3 -70-16- 124/74 OXYGEN SATURATION 98% . 03/10/2024, 07:29 (7:29 A.M.)PATIENT STATED 3/10 (three out of ten pain scale) PAIN. NOTED WITH OXYGEN SATURATION OF 79 %, ON 5LITERS OF OXYGEN VIA MASK. BREATHING TREATMENT ADMINISTERED WITH NO EFFECT. OXYGEN SATURATION FLUCTUATING BETWEEN 89-96%. INCREASED TO 10LITERS VIA MASK. DENIED SOB AND DISTRESS. (Name of the Ambulance) ARRIVED AND TRANSFERRED TO (name of hospital) . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's document titled, SBAR (Situation, Background, Assessment, and Recommendation - a structured communication that help teams share information about the condition of a patient) Communication form . dated March 10, 2024, was reviewed. The document indicated on March 10, 2024, Resident 45 had a change in condition. The section under Name of Family/Health care Agent Notified, indicated SELF. The nurse's notes dated March 10, 2024, did not indicate the FM was notified of Resident 45's change in condition and transfer to the acute hospital. The admission record from the acute hospital dated March 4, 2024, indicated Resident 45's FM was his brother with the contact phone number. During a concurrent interview and record review, on June 6, 2024, at 9:05 a.m., with Registered Nurse (RN) 1. RN 1 stated she was not able to find FM's contact information in Resident 45's record. She stated on March 10, 2024, the Admission Record of Resident 45 had no contact information of FM. RN 1 stated Resident 45's FM was not notified of his transfer on March 10, 2024. RN 1 stated she was working when Resident 45's FM came to the facility to look for Resident 45 two days after Resident 45 was transferred out to the hospital. RN 1 stated Resident 45's FM was not aware what happened to Resident 45, on March 10, 2024, and did not know where he was transferred. During a concurrent interview and record review on June 6, 2024, at 9:20 a.m., with the Administrator (ADM), and the Registered Nurse Supervisor (RNS), the ADM stated Resident 45's information from the acute hospital would have entered the facility's portal (a secure internet website that contains patient health information) and might not have been uploaded by the facility's admission staff and entered into the system before Resident 45 was transferred out to the hospital. The ADM stated RN 1 did not know where to look for Resident 45's FM contact information. A review of the facility's policy and procedure titled,Change in a Resident's Condition or Status, dated September 2023, was reviewed. The policy indicated, .a nurse will notify the resident's representative when . there is a significant change in resident's physical, mental, or psychological status .it is necessary to transfer the resident to a hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility failed to update and revise the resident's care plan when one resident reviewed (Resident 8) was transferred to the hospital for chest pain. This failure had the potentail to delay the necessary care and services for Resident 8 when the care plan was not updated with specific measurable goals and interventions for his chest pain when he returned to the facility. Findings: On June 3, 2024, at 10:25 a.m., Resident 8 was observed sitting in her wheelchair playing a game on the television. Resident 8 denied any discomfort. During a review of Resident 8's record, the record indicated Resident 8 was admitted to the facility on [DATE], with diagnoses which included Congestive Heart Failure (CHF- heart failure), myocardial infarction (MI - a heart attack) and presence of cardiac pacemaker (a device used to control irregular heart rhythm). The SBAR Communication Form (Situation Background Assessment Recommendation - communication between health care team about a patient's condition) dated April 10, 2024, indicated Resident 8 complained of severe chest pain and was transferred to the acute hospital. The history and physical (H&P) from the acute hospital indicated Resident 8 had CHF exacerbation (increase in or worsening) Resident 8 was readmitted to the facility on [DATE]. There was no documented evidence the care plan for Resident 8's chest pain was updated with new goals and interventions. On June 5, 2024, at 11:25 a.m., a concurrent interview and record review was conducted with the Registered Nurse Supervisor (RNS). The RNS stated the care plan for chest pain should have been updated with new goals and interventions when Resident 8 was readmitted on [DATE]. A review of the facility policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated March 2022, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each patient .Assessment of residents are on going and care plans are revised as information about the residents and resident's conditions change .The interdisciplinary team reviews and updates the care plan .when there has been a significant change in the resident's conditions .when the resident has been readmitted to the facility from a hospital stay .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 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** 29623 Based on observation, interview, and record review, the facility failed to obtain the pacemaker (a device used to treat irregular heart beats) information and include the information in the plan of care for two of three residents reviewed (Residents 8 and 97). This failure resulted in Resident 8 and 97 not being seen and evaluated by their cardiologists (doctor specializing in the heart) and the facility staff not having information about the residents' pacemaker, which could delay the necessary care and services if the pacemaker malfunctioned. Findings: 1. On June 3, 2024, at 10:25 a.m., Resident 8 was observed sitting in her wheelchair, playing agame on the television. Resident 8 denied any discomfort. During a review of Resident 8's record, the record indicated Resident 8 was admitted to the facility on [DATE], with diagnoses which included Congestive Heart Failure (CHF- heart failure), myocardial infarction (MI - a heart attack) and presence of a cardiac pacemaker. The SBAR Communication Form (Situation Background Assessment Recommendation - communication between health care team about a patient's condition) dated April 10, 2024, indicated Resident 8 complained of severe chest pain and was transferred to the acute hospital. The history and physical (H&P) from the acute hospital indicated Resident 8 had a Dual-lead left side pacer (a type of pacemaker). Resident 8 was readmitted to the facility on [DATE], with diagnoses which included CHF exacerbation (increase in or worsening) and presence of a cardiac pacemaker. The admission assessment dated [DATE], indicated the presence of a pacemaker in Resident 8's left upper chest. The history and physical (H&P) dated April 18, 2024, indicated Resident 8 had a pacemaker and the physician's assessment and plan was to regularly check the pacemaker function, battery life, and monitor heart rate and rhythm. There was no documented evidence in Resident 8's record the pacemaker information was obtained on Resident 8's initial admission on April 9, 2024, and readmission on April 16, 2024. Resident 8's care plan was reviewed. There was no documented evidence the pacemaker information was included in the plan of care upon admission or during readmission. On June 6, 2024, at 11:25 a.m., a concurrent interview and record review was conducted with the Registered Nurse Supervisor (RNS). The RNS stated Resident 8's pacemaker information was not obtained or included in the plan of care on the initial admission and upon readmission. The RNS stated there was no cardiologist information that could have provided the pacemaker information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview on June 3, 2024, at 7:40 a.m., with Resident 97 in his room, Resident 97 was awake, alert, and able to verbalize his needs. Resident 97 stated he was at the hospital for an infected wire in his pacemaker (a devise used to control irregular heart rhythm). Resident 97 stated he had bypass surgery (heart surgery) two years ago, and also had a pacemaker. During a review of Resident 97's record, Resident 97 was admitted to the facility on [DATE], with the diagnoses which included cellulitis (a bacterial skin infection), and the presence of pacemaker and Automatic Implantable Cardioverter Defibrillator (AICD - a device implanted into the chest to monitor and correct an abnormal heart rhythm or irregular heart beats). There was no documented evidence the pacemaker and AICD information was in Resident 97's record. There was no documented evidence Resident 97 or Responsible Party (RP) was asked about the pacemaker information upon initial assessment. On May 17, 2024, Resident 97 had a change in condition with low hemoglobin (a protein in red blood cell that carries oxygen) and was transferred out to the hospital. Resident 97 was readmitted to the facility on [DATE], with diagnoses which included anemia (low iron in the body) and presence of AICD. There was no documented evidence the pacemaker information was obtained when Resident 97 was readmitted back to the facility. During a concurrent interview and record review on June 6, 2024, at 10:49 a.m., with the RNS, Resident 97's care plan was reviewed. The care plan for pacemaker did not include Resident 97's pacemaker information and AICD. The RNS stated the pacemaker and the AICD information should have been obtained upon admission and readmission. The facility's policy and procedure titled, Pacemaker, Care of a Resident .dated September 2023, was reviewed. The policy indicated, . For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission .The name, address and telephone number of the cardiologist .Type of pacemaker .Type of leads .Manufacture and model .Serial number .Date of implant . Paced rate When the resident's pacemaker is monitored by the physician, document the date and results of the pacemaker surveillance .how the resident's pacemaker was monitored .type of heart rhythm, functioning of utilization and battery life .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44173 Based on observation, interview, and record review, the facility failed to provide respiratory care and treatment in accordance with the facility's policy and procedure for one of three residents (Resident 147) reviewed for oxygen administration when Resident 147 was administered oxygen without a physician's order. This failure had the potential to result in ineffective oxygen therapy, respiratory distress, and decline in Resident 147's health condition. Findings: On June 3, 2024, at 7:05 a.m., Resident 147 was observed in bed, in her room. Resident 147 was using oxygen at two liters (a unit of measurement) per nasal cannula (a tube used to deliver oxygen through the nose) attached to an oxygen concentrator (a machine that supplies oxygen). On June 4, 2024, at 12:22 p.m., Resident 147 was observed sitting in the wheelchair, transported by a staff back to her room. Resident 147 was using oxygen at two liters per nasal cannula attached to an oxygen tank (a portable container that supplies oxygen). Resident 147 stated she was using the oxygen all day and all night. Resident 147 stated she had oxygen since she was admitted to the facility on [DATE]. On June 5, 2024, at 9:27 a.m., Certified Nursing Assistant (CNA) 3 was observed in Resident 147's room. CNA 3 stated Resident 147 was taken to her physical therapy session. CNA 3 stated Resident 147 was using her oxygen. On June 5, 2024, at 9:31 a.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 147 was using oxygen. LVN 1 stated Resident 147 did not have an order for oxygen administration when Resident 147 was admitted to the facility on [DATE]. LVN 1 stated there should be a physician's order for oxygen administration. On June 5, 2024, at 3:16 p.m., a concurrent interview and record review was conducted with the Registered Nurse Supervisor (RNS). The RNS stated Resident 147 did not have an order for oxygen administration upon admission on May 28, 2024. She stated there should be a physician's order before oxygen could be administered to Resident 147. Resident 147's record was reviewed. Resident 147 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD - lung disease that cause breathing problems and restricted air flow). Resident 147's care plan, dated May 29, 2024, indicated .Focus . ALTERATION IN IN RESPIRATOTY STATUS/RISK FOR SOB DUE TO: CHF (congestive Heart Failure - a serious condition when the heart cannot pump blood efficiently), RESPIRATORY DISTRESS, COUGH . Interventions/Tasks .ADMINISTER OXYGEN AT (SPECIFY) LITER VIA (SPECIFY) AS ORDERED . There was no documented evidence of a physician's order to administer oxygen to Resident 147 since admission on May 28, 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy and procedure titled, Oxygen Administration, revised March 2023, was reviewed. The policy indicated, .Verify that there is a physician's order .Review the physician's orders or facility protocol for oxygen administration .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 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. 46393 Based on interview and record review, the facility failed to ensure accurate accountability of controlled medications (those with high potential for abuse and addiction) for three of four random sampled residents (Residents 1, 18, and 247) when a random controlled medication audit did not reconcile. The controlled medications were signed out of the Medication Count Sheet (a controlled drug record, an inventory sheet that keeps record of the usage of controlled medications) but not documented on the Medication Administration Records (MAR) to indicate they were administered to the residents. The failure resulted in inaccurate accountability of controlled medications, which had the potential for misuse or diversion. Findings: The Medication Count Sheets for controlled medications for four random residents receiving PRN (as-needed) controlled medications were requested for review during the survey and indicated the following: 1. Resident 247 had a physician's order, dated March 24, 2024, for Norco (hydrocodone-acetaminophen, a potent controlled medication for pain) 5/325 milligram (mg, unit of measurement) tablet, 1 tablet by mouth every 6 hours as needed for moderate pain 4-6. During a concurrent interview and record review on June 4, 2024 at 10:49 a.m. with the Registered Nurse Supervisor (RNS), a review of Resident 247's Medication Count Sheet for Norco 5/325 mg and MAR dated May 2024 indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - May 30, 2024, at 10 (or 11) a.m.; and - May 31, 2024 at 5:12 p.m. During this interview and record review, the RNS acknowledged two Norco 5/325 mg tablets for Resident 247 were unaccounted. The RNS stated she would review and follow-up regarding the discrepancies as listed above. 2. Resident 1 had a physician's order, dated April 21, 2024, for Norco 5/325 mg tablet, 1 tablet by mouth every 4 hours as needed for moderate pain 4 - 6. During a concurrent interview and record review on June 4, 2024 at 11:12 a.m. with the RNS, a review of Resident 1's Medication Count Sheet for Norco 5/325 mg and MARs (dated April and May 2024) indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - April 26, 2024 at 6 (or 8) a.m.; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- May 7, 2024 at 8:30 p.m.; - May 12, 2024 at 4:50 p.m.; - May 25, 2024 at 4 p.m.; and - May 28, 2024 at 3 p.m. During this interview and record review, the RNS acknowledged one Norco 5/325 mg tablet for Resident 1 was unaccounted in April 2024 and four tablets were unaccounted in May 2024. The RNS stated she would review and follow-up regarding the discrepancies listed above. 3. Resident 18 had a physician's order, dated April 8, 2024, for Norco 10/325 mg tablet, 1 tablet by mouth every 4 hours as needed for moderate to horrible pain 4 - 10. During a concurrent interview and record review on June 4, 2024 at 11:28 a.m. with the RNS, a review of Resident 18's Medication Count Sheet for Norco 10/325 mg and MARs (dated May and June 2024) indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - May 22, 2024 at 9:00 p.m.; - May 23, 2024 at 9:00 a.m.; - May 23, 2024 at 4:45 p.m.; - May 24, 2024 at 3:30 p.m.; - May 25, 2024 at 9 a.m.; - May 25, 2024 at 9 p.m.; - May 27, 2024 at 8 a.m.; - May 28, 2024 at 10:30 a.m.; - May 29, 2024 (time illegible); - May 31, 2024 at 10 a.m.; - May 31, 2024 at 9 p.m.; - June 1, 2024 at 9 a.m.; - June 2, 2024 at 9:30 a.m.; - June 3, 2024 at (illegible, looks like 11 a.m.); (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- June 3, 2024 at 5:30 p.m.; and - June 3, 2024 at 9:30 p.m.; During this interview and record review, the RNS acknowledged 11 Norco 10/325 mg tablets for Resident 18 were unaccounted in May 2024 and five tablets were unaccounted in June 2024. The RNS stated she would review and follow-up regarding the discrepancies as listed above. During an interview on June 4, 2024 at 11:46 a.m. with the Licensed Vocational Nurse (LVN) 2, LVN 2 described the facility's process of controlled medication administration as follows: - Nursing staff complete assessment of the resident's pain; - sign-out the pain medication from the medication count sheet; and - document the administration in the resident's chart on the MAR. During a follow-up interview on June 4, 2024 at 3:46 p.m. with the RNS, she confirmed the discrepancies and acknowledged the missing documentations in the MAR for the dates and times as listed above for residents 247, 1, and 18. During a review of the facility's P&P titled Administering Medications, dated April 2023, indicated, .The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication .the individual administering the medication records in the resident's medical record .the date and time the medication was administered; the dosage; the route of administration .the signature and title of the person administering the drug . During a review of the facility's P&P, titled Controlled Substances, dated September 2023, indicated, .An individual resident controlled substance record is made for each resident who will be receiving a controlled substance. The record contains: name of the resident; name and strength of the medication; number on hand .Upon Administration: The nurse administering the medication is responsible for recording .name of resident receiving the medication; name, strength and dose of the medication; time of administration; method of administration; quantity of the medication remaining; and signature of nurse administering medication .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49613 Based on observation, interview, and record review, the facility had a medication error rate of 13.89% when five medication errors occurred out of 36 opportunities during medication administration for two out of four residents (Residents 32 & 101). This failure resulted in medications not given according to physician's orders and had the potential for Resident 32 and Resident 101 to not receive the full therapeutic (relating to the healing of disease) effects of the medication. Findings: 1. During a medication pass observation on June 3, 2024, at 8:01 a.m., Licensed Vocational Nurse (LVN) 3 was observed removing an automatic blood pressure (BP-pressure of blood in blood vessels) cuff machine from inside the medication cart and then proceeded into Resident 101's room. LVN 3 applied the automatic BP cuff on Resident 101's left arm. When the machine completed measuring the resident's BP, LVN 3 stated the BP result (BP result consists of two numbers: the top number or systolic blood pressure [SBP] and the bottom number or diastolic blood pressure [DBP]) reading was 124 over 57. LVN 3 stated Resident 101's BP medications would not be given because the resident's BP was too low. During the same medication pass observation at 8:11 a.m., LVN 3was observed preparing and administering one capsule of gabapentin (to treat nerve pain) 300 milligram (mg, unit of measurement) to Resident 101. A review of Resident 101's medical records indicated the following physician's orders: a. Gabapentin oral capsule, give 300 mg by mouth in the morning, dated May 31, 2024; b. Carvedilol (to treat high blood pressure) oral tablet, give 12.5 mg by mouth in the morning, hold for SBP less than 110, HR (heart rate or pulse) less than 60, dated May 31, 2024; and c. Losartan/Hydrochlorothiazide (to treat blood pressure) 50/12.5 mg, give one tablet by mouth in the morning, hold for SBP less than 110, HR less than 60, dated May 31, 2024. There was no carvedilol 12.5 mg tablet or losartan/ hydrochlorothiazide 50/12.5 mg tablet given during the medication administration observation as mentioned above. During a concurrent interview and record review on June 3, 2024 at 12:42 p.m. with LVN 3, Resident 101's physician's orders as listed above were reviewed. LVN 3 verified the physician's orders for carvedilol and losartan/hydrochlorothiazide indicated to hold If SBP less than 110 or HR less than 60. LVN 3 confirmed Resident 101's BP result was 124/57 and HR result was 91 during the medication administration. LVN 3 acknowledged he misread the bottom number of the BP result 57 as being Resident 101's HR. LVN 3 acknowledged both the carvedilol and losartan/ hydrochlorothiazide tablets did not meet the hold parameters as ordered by the physician and should have been administered to Resident 101. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on June 6, 2024 at 10:15 a.m. with the Registered Nursing Supervisor (RNS), the RNS stated the expectation was for nursing staff to give the blood pressure medications if the parameters were met as ordered by the physician unless the resident refused. 2. During a medication pass observation on June 3, 2024 at 8:16 a.m., LVN 3 was observed preparing and administering nine medications to Resident 32, including one escitalopram (brand name: Lexapro, used to treat depression) 10 mg tablet. A review of Resident 32's medical records indicated the following physician's orders: a. Lexapro oral tablet 5 mg (escitalopram), give 5 mg by mouth one time a day, dated May 30, 2024; b. Ferrous Sulfate (iron tablet, used for low iron supplementation) 325 mg tablet, give 325 mg by mouth two times a day, dated March 20, 2024; and c. Lidocan External Patch 5 % (lidocaine, used for pain), apply to midback topically in the morning, dated April 2, 2024. There was no ferrous sulfate 325 mg tablet or lidocaine 5 % patch given during the medication administration observation as mentioned above. During a concurrent interview and record review on June 3, 2024 at 12:48 p.m. with LVN 3, Resident 32's physician's order for escitalopram tablet was reviewed and LVN 3 verified the physician's order indicated escitalopram 5 mg by mouth one time a day. LVN 3 acknowledged escitalopram 10 mg tablet was given to Resident 32 instead of escitalopram 5 mg tablet as indicated on the physician's order. LVN 3 acknowledged the dose of escitalopram given should have matched the dose on the physician's order. Regarding the ferrous sulfate 325 mg tablet and the lidocaine 5% patch, LVN 3 acknowledged they were not given to Resident 32 on June 3, 2024 at 9 a.m. LVN 3 stated, I missed it, and added I can do it right now. During an interview on June 6, 2024 at 10:19 a.m. with the RNS, regarding the ferrous sulfate tablet and lidocaine patch not given to Resident 32 on June 3, 2024 at 9 a.m. as ordered by the physician, the RNS stated the medications should have been given according the orders unless the resident refused and the nurse documented the resident's refusal in the medical record. During an interview on June 6, 2024 at 10:24 a.m. with the RNS, the RNS acknowledged the discontinued escitalopram 10 mg tablet should not have been administered. When asked regarding the facility's process for handling discontinued medications and new medication orders, the RNS stated the nursing staff should have removed the discontinued medication from the medication cart and replaced it with the new medication from the pharmacy. She stated, the discontinued medication should have been placed aside in the medication cart or taken to the medication room. A review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2023, the P&P indicated .Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility failed to follow the physician's order to hold the administration of the the medication Hydralazine Hydrochloride (medication used to control high blood pressure) for the systolic blood pressure (top number) less than 130 for one resident reviewed (Resident 35). This failure resulted in Resident 35 receiving the medication multiple times below the prescribed parameter as ordered by the physician from May 11, 2024 through June 3, 2024. Findings: On April 3, 2024, at 7:10 a.m., Resident 35 was observed awake, alert and able to verbalize her needs. Resident 35 was observed with oxygen on at two liters (a unit of measurement) of oxygen per minute through nasal cannula (a tube used to deliver oxygen through the nostrils). On April 3, 2024, a review of Resident 35's record indicated, Resident 35 was admitted to the facility on [DATE], with diagnoses which included hypertension (high blood pressure) and Chronic Obstructive Pulmonary Disease (COPD- lung disease). The physician's order dated May 10, 2024, indicated .Hydralazine HCL. Give 25 milligram (mg- a unit of measurement) every 6 hours related to ESSENTIAL (PRIMARY) HYPERTENSION .HOLD FOR SBP (Systolic Blood Pressure - top number) less than 130, HR less than 60 . The Electronic Medication Administration Record (E-MAR) from May 11 through June 3, 2024, was reviewed. The E-MAR indicated Resident 35 was administered Hydralazine on the following dates and times with the following blood pressure readings: May 11, 2024, at 0000 (midnight), BP (Blood Pressure) = 113/64 . May 11, 2024, at 0600 (6 a.m.), BP = 118/67 . May 11, 2024, at 1200 (12 noon), BP = 108/66 . May 12, 2024 at 1200 (12 noon), BP = 122/70 . May 13, 2024, at 0600 (6 a.m.), BP = 124/77 . May 14, 2024, at 0000 (midnight), BP = 128/60 . May 14, 2024, at 1200 (12 noon), BP = 103/70 . May 14, 2024, at 1800 (6 p.m), BP = 116/70 . May 15, 2024, at 0000 (midnight), BP = 124/62 . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 16, 2024, at 0000 (midnight), BP = 123/70 . May 17, 2024, at 0000 (midnight), BP = 121/70 . May 22, 2024, at 1200 (12 noon), BP = 94/65 . May 22, 2024, at 1800 (6 p.m.), BP= 112/63 . May 23, 2024, at 0000 (midnight), BP = 118/74 . May 24, 2024, at 1200 (12 noon), BP = 103/66 . May 25, 2024, at 0000 (midnight), BP = 121/68 . May 26, 2024, at 1800 (6 p.m.), BP = 118/62 . May 27, 2024, at 1800 (6 p.m.), BP = 124/62 . May 28, 2024, at 0600 (6 a.m.), BP = 126/67 . June 1, 2024, at 1200 (12 noon) BP = 113/63 . June 2, 2024, at 0000 (midnight), BP = 113/68 . June 3, 2024, at 0000 (midnight), BP = 123/70 . On June 3, 2024, at 10:56 a.m., a concurrent interview and record review was conducted with Registered Nurse (RN) 2. RN 2 acknowledged the medication Hydralazine HCL was administered to Resident 35 when the systolic blood pressure readings were below 130. RN 2 stated the licensed nurses did not follow the parameter indicated for the administration of high blood pressure medication. The licensed nurses should have contacted the physician regarding Resident 35's blood pressures. The facility's policy and procedure titled, Administering Medications, dated April 2023, was reviewed. The policy indicated, .Medications are administered in accordance with prescriber orders, including any required time frame .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 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. 48870 Based on observation, interview, and record review, the facility failed to ensure dietary staff were able to carry out the functions of food and nutrition services safely and effectively when: 1. Dietary Aide (DA) 3 did not follow the facility cleaning procedure to clean food preparation surface and stationary equipment (Cross referred F 812); 2. Two kitchen staff did not document the cooling process on June 2, 2024 for making boiled eggs (Cook 2) and on June 2, 2024, for making tuna salad (Dietary Aide 1); 3. [NAME] 3 did not know how to calibrate a thermometer; 4. [NAME] 1 did not follow the time length according to manufacturer's guidelines for dipping the test strip in the sanitizer (sanitizing solution used for sanitizing food contact surfaces); and 5. DA 2 did not follow the time length according to manufacturer's guidelines for immersing kitchenware in sanitizer solution in the sanitize sink. These failures had the potential for unsafe food practices which may lead to foodborne illness (stomach illness acquired from ingesting contaminated food), and the potential to not meet the nutritional needs of the residents in a medically vulnerable population of 48 out of 50 residents who received food prepared in the kitchen. Findings: 1. During a concurrent observation and interview on June 4, 2024, at 11:47 a.m., DA 3 was observed using a green bucket with solution inside, followed by using a red bucket with solution inside to wipe down a food preparation surface. DA 3 stated this is the normal process of cleaning and sanitizing work surfaces in the kitchen. The green bucket contains a detergent, and the red bucket contains a sanitizer. During an interview on June 4, 2024, at 3:31 p.m., with [NAME] 3, [NAME] 3 demonstrated how to clean the stationary mixer after each use. [NAME] 3 stated only sanitizer is used to clean the mixer. During an interview on June 4, 2024, at 4:07 p.m., with the DSS, the DSS demonstrated how she cleaned the food preparation surfaces. The DSS stated she used detergent to wash and then sanitizes the area with sanitizer. During an interview on June 5, 2024, at 9:34 a.m., with the Registered Dietician (RD), the RD indicated cross contamination of food can occur if the detergent is not rinsed off after cleaning and before sanitizing. The RD further explained staff are expected to follow the cleaning procedure to wash, rinse, and sanitize work surfaces after each use to prevent cross contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Federal FDA Food Code 2022, Chapter 4: Section 4-603.16, indicated, .Washed UTENSILS and EQUIPMENT shall be rinsed so that abrasives are removed and cleaning chemicals are removed or diluted through the use of water or a detergent-sanitizer solution by using one of the following procedures: . Use of a distinct, separate water rinse after washing and before SANITIZING if using: . A 3-step washing, rinsing, and SANITIZING procedure in a WAREWASHING system for CIP (clean-in-place) EQUIPMENT . A review of the facility policy and procedure titled, SHELVES, COUNTERS, AND OTHER SURFACES INCLUDING SINKS (Handwashing, Food Preparation, Etc.), dated 2023, indicated, CLEANING PROCEDURE .wash surface with a warm detergent solution .rinse with clear water .spray with sanitizer . A review of the facility policy and procedure titled, SANITATION, dated 2023 indicated, .Thoroughly rinse the utensil or surface after cleaning. Remove any detergent residue, which may be toxic. Toxic residue can cause food to develop off-flavors . It is important to thoroughly rinse the utensils or surface prior to applying the sanitizing agent as sanitizers will be ineffective in the presence of some detergents and food particles . 2. During an observation on June 3, 2024, at 7:07 a.m., in the walk-in refrigerator, a large metal bowl covered with plastic wrap was located on the top shelf containing boiled eggs, labeled with Boiled egg for June 3, 2024. There was also a container labeled tuna salad, dated June 2, 2024. A concurrent follow up interview and June cooling log review on June 3, 2024, at 8:39 a.m., was conducted with the Dietary Services Supervisor (DSS). After review of the June cooling log, there was no cooling process (refers to an essential process used in food production to prevent foodborne illness, and where food is quickly cooled from 135 degrees F (degrees Fahrenheit- a unit of temperature measurement) to 41 degrees F to minimize bacterial growth. If left out to cool, cooked food can become unsafe to eat in a matter of hours) documentation for boiled eggs and tuna salad. The DSS stated [NAME] 1 made the boiled eggs yesterday for use today. The DSS stated she had no idea who made the tuna salad on June 2, 2024. The DSS stated it was very important for kitchen staff to monitor the cooling process and log the cooling process. The DSS explained the cooling process is to ensure prepared food is cooled properly and does not stay in the danger zone (temperatures between 40 - 135 degrees Fahrenheit- a unit of measurement), for too long, which can promote bacterial growth and make residents sick. During an interview on June 3, 2024, at 8:45 a.m. with DA 1, DA 1 stated he made the tuna salad on June 2, 2024, he performed the temperature checks, but did not write the temperatures in the cooling log. DA 1 further stated he was supposed to write the temperatures on the cooling log. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated she expects kitchen staff to log temperatures to monitor the cooling process of prepared foods. A review of facility policy and procedure titled, COOLING AND REHEATING OF POTENTIALLY HAZARDOUS OR TIME/TEMPERATURE CONTROL FOR SAFETY FOOD, dated 2023, indicated, .Cooked potentially hazardous food .shall be cooled or reheated in a method to ensure food safety .cool cooked food from 140 (degrees) F (Fahrenheit) to 70 (degrees) F within two hours. Then cool from 70 degrees Fahrenheit to 41 degrees or less in an additional four hours for a total cooling time of six hours .When cooling down food use the Cool Down Log to document proper procedure .Ambient (room temperature) temperature food shall be cooled within 4 hours to 41 (degrees) F or less . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an interview on June 4, 2024, at 3:27 p.m. with [NAME] 3, [NAME] 3 was asked to demonstrate how to calibrate a thermometer. [NAME] 3 stated the supervisor is the person who calibrates the thermometers for the kitchen and she did not know how to calibrate the digital thermometer because she is not trained to calibrate the thermometers. During an interview on June 4, 2024, at 4:07 p.m. with the DSS, the DSS stated the morning cooks calibrate all the thermometers, not herself, and further explained all the cooks should know how to calibrate the thermometers to ensure the thermometers the used have accurate reading. During an interview on June 5, 2024, at 9:34 am, with the RD, the RD stated all kitchen staff should know how to calibrate the thermometers to ensure accurate temperature reading. A review of the facility policy and procedure titled THERMOMETER USE AND CALIBRATION, dated 2023 indicated, .Food thermometers are to be used properly and calibrated to ensure accurate temperature reading .Food thermometers are to be calibrated each week, after one is dropped, or when a thermometer is new .Follow manufacturer's instructions . 4. A review of a test strip container on June 3, 2024, at 7:42 a.m., indicated, Immerse for 10 seconds. During a concurrent observation and interview on June 3, 2024, at 7:42 a.m. with [NAME] 1, [NAME] 1 was asked to demonstrate how to check the concentration of sanitizer (QUATERNARY AMMONIUM). [NAME] 1 held the paper test strip in the solution for five seconds, then removed the test strip and compared the concentration color on the test strip container. [NAME] 1 stated he needed to dip the test strip into sanitizer for 30 seconds. During an interview on June 5, 2024, at 9:34 a.m. with the RD, the RD stated the test strip needs to be dipped in the sanitizer for 10 seconds per instructions on the test strips. If the instructions are not followed, then it could lead to an incorrect reading. The RD stated the expectation was kitchen staff followed the instructions on the test strip container. A review of the facility policy and procedure, titled QUATERNARY AMMONIUM LOG POLICY, dated 2023 indicated, .The concentration .will be tested to ensure the effectiveness of the solution .per instructions on the test strips .read the instructions on .test strips for proper concentration, length of time the test strip needs to be in contact with the solution . 5. During an interview on June 4, 2024, at 3:45 p.m. with DA 2, DA 2 was asked how long he needed to immerse kitchenware in sanitizer. DA 2 stated he needed to immerse kitchenware in sanitizer for 30 minutes. During an interview on June 4, 2024, at 4:03 p.m. with the DSS, the DSS stated according to the manufacturer guideline, dietary staff need to immerse kitchenware in sanitizer for one minute. During an interview on June 5, 2024, at 9:34 a.m. with the RD, the RD stated she expects the kitchen staff to follow the manufacturer guidelines for immersing kitchenware in sanitizer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 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. 48870 Based on observation, interview, and record review, the facility failed to ensure the nutritional needs for three of eight sample residents (Residents 297, 25, and 26), was met, when the meal was not served in accordance with menu guidance for lunch when: 1. Resident 297, who was on a physician prescribed Fortified diet (diet with added extra nutrients to increase calories and/or protein density to promote improvement in residents' nutritional status), received diet Jello instead regular Jello on June 3, 2024, lunch and received 1 package of dressing instead of 2 packages of dressing on June 4, 2024, lunch; 2. Resident 25, who was on a physician prescribed Controlled Carbohydrate Diet (CCDO: a meal plan for diabetic residents), received regular dessert instead of diet dessert on June 4, 2024; and 3. Resident 26, who was on a physician prescribed large portion diet, did not received large portion on June 4, 2024. These failures had the potential to result in under or over nutrition. When a resident receives foods that are not consistent with their physician ordered diet, it may result in further compromising the resident's medical status. Findings: 1. During an interview on June 3, 2024, at 11:00 am with [NAME] 1, [NAME] 1 stated he made the Jello. [NAME] 1 stated the red Jello is regular, and the green Jello is diet. During a review of Resident 297's meal tray card (a card that consists of the diet menu based on the physician's diet order) indicated Resident 297 was on a Fortified Diet. During a dining room lunch meal observation on June 3, 2024, at 12:10 p.m., with Resident 297, Resident 297 received green Jello on his meal tray. During an interview on June 3, 2024, at 12:14 p.m., with the Treatment Nurse (TN), the TN stated because there was no label on the Jello, he could not tell the difference between the red and green Jello and could not tell if they were regular or diet. The TN verified Resident 297 received green Jello with his meal. During an interview on June 4, 2024, at 12:12 p.m., with the Dietary Services Supervisor (DSS), the DSS stated a fortified diet will also have two packages of salad dressing with the lunch meal. A review of the facility document titled, Cook's Spreadsheet (the document used to guide dietary staff on food items, portions, and therapeutic diets), dated June 3, 2024, indicated .Regular: Providing regular Jello . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on June 3, 2024, at 4:07 p.m., with the DSS, the DSS stated Resident 297 was on a Fortified diet, and needs extra calories. The DSS stated Resident 297 should not receive diet Jello (which does not have calories). During a dining room observation of the lunch meal on June 4, 2024, at 12:17 p.m., Resident 297 received one packet of dressing on the meal tray for salad. During a concurrent observation and interview on June 4, 2024, at 12:21 p.m., with Resident 297, Resident 297 opened a package of dressing and put it on the salad. Resident 297 stated he only had one packet of salad dressing. During an interview on June 5, 2024, at 9:39 a.m., with the Registered Dietician (RD), the RD explained a Fortified diet is a diet with added extra nutrients to boost the calories and/or protein density to help residents improve weight, wounds, and low protein status in the body.The RD stated it was inappropriate for Resident 297 to receive diet Jello and not receive two packages of salad dressing.The RD stated Resident 297 did not receive extra calories per physician ordered diet. The RD stated she expects the kitchen staff to follow the spreadsheet and menu to serve meals. A review of the medical record titled, Physician Orders, dated May 27, 2024, indicated, .Fortified Diet . A review of the facility policy and procedure titled, FORTIFIED DIET, dated 2020, indicated, .The Fortified Diet is designed for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status .the goal is to increase the calorie density of the foods commonly consumed by the resident . A review of the facility document titled, Diet Spread Sheet, dated 2024, indicated, .Fortified Lunch on Tuesday, 1-2 tsp (teaspoon- a unit of measurement) extra dressing . A review of the facility policy and procedure titled, DIET ORDERS, dated 2023, indicated, .Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department . A review of the facility 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, physicians' orders and, to extent medically possible . A review of the facility 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 . 2. A review of the meal tray card on June 4, 2024, at 12:50 p.m. for Resident 25 indicated, CCHO diet. During an observation of the lunch meal on June 4, 2024, at 12:50 p.m., in Resident 25's room, Resident 25 received a portion of chocolate cake with frosting. During a follow up observation and interview on June 4, 2024, at 1:08 p.m. with the DSS, in Resident 25's room, the DSS stated Resident 25 received a regular portion of chocolate cake with frosting in error and should have received a 1/2 portion of cake without frosting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on June 5, 2024, at 9:39 am, with the RD, the RD stated kitchen staff should follow the spreadsheet for serving CCHO dessert for Resident 25. A review of the medical record titled, Physician's Orders, dated, May 11, 2024, indicated, .CCHO diet . A review of the facility document titled, Cook's Spreadsheet, dated 2024, indicated, .CCHO .chocolate cake 1/2 portion-no icing . A review of the facility policy and procedure titled, CONTROLLED CARBOHYDRATE DIET (CCHO), dated 2020, indicated, .A controlled carbohydrate diet .is a meal plan without specific calorie levels for diabetic residents .Residents will see a regular dessert approximately 3 (three) times per week, although they may be a smaller portion depending on their total carbohydrate count for the day . A review of the facility policy and procedure titled, DIET ORDERS, dated 2023, indicated, .Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department . A review of the facility 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, physicians' orders and, to extent medically possible . A review of the facility policy and procedure titled, MEAL SERVICE, dated 2023, indicated, .Meals that meet the nutritional needs of the resident will be served in an accurate . 3. On June 4, 2024, at 12:52 p.m. a review of Resident 26's meal tray card indicated Large Portions. During a concurrent lunch observation and interview of the lunch meal on June 4, 2024, at 12:52 p.m., with the DSS, in Resident 26's room, the DSS stated the portion of pasta Resident 26 received was not a large portion, it was a regular portion of 1/2 cup. During an interview on June 5, 2024, at 9:39 a.m., with the Registered Dietician (RD), the RD stated kitchen staff should follow the spreadsheet to serve large portions for Resident 26 per physician order. A review of the medical record titled, Physician's Orders, dated February 7, 2024, indicated, .Large portions . A review of the facility policy and procedure titled PORTION SIZES, dated 2023 indicated, .large portion servings will be served as printed on the cook's spreadsheets for every meal . A review of the facility policy and procedure titled, DIET ORDERS, dated 2023, indicated, .Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department . A review of the facility 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 orders and, to the extent medically possible . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure titled MEAL SERVICE, dated 2023, indicated, .Meals that meet the nutritional needs of the resident will be served in an accurate .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 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. 48870 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when: 1. Food service workers did not follow the facility cleaning procedure to clean food preparation surfaces; 2. Dust found in several areas in kitchen, ice machine room and dry storage room; 3. Poor quality produce found in walk-in refrigerator; 4. Can opener and base had buildup; 5. Blender had buildup; 6. Floor in the kitchen and dry storage room found dust and food particles; 7. The hot water spout on the coffee maker had hard water buildup; 8. One food container stacked wet in dry storage room; 9. Bottom of small oven found black particles; 10. Two opened food items exposed to air in reach-in freezer; 11. A container which stored Margarine did not have an identification label and date; and 12. Microwave had buildup/splatter dried inside. These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) in a medically vulnerable population of 48 out of 50 residents who received food prepared in the kitchen. Findings: 1. A review of the facility policy and procedure titled, SHELVES, COUNTERS, AND OTHER SURFACES INCLUDING SINKS (Handwashing and Food Preparation, Etc.), dated 2023, indicated, CLEANING PROCEDURE .wash surface with a warm detergent solution .rinse with clear water .spray with sanitizer . During a concurrent observation and interview on June 3, 2024, at 7:30 a.m., with [NAME] 1 in the kitchen, [NAME] 1 was observed using a solution in a red bucket to wipe down surfaces where food is prepared. [NAME] 1 stated he was cleaning the work surfaces as he finished food preparation tasks. [NAME] 1 explained the red bucket had sanitizing solution in it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on June 4, 2024, at 10:41 a.m., [NAME] 2 was observed preparing lunch. [NAME] 2 prepared food on a surface that had not been cleaned after previous use and did not clean and sanitize the food preparation area after completing the task. During an observation on June 4, 2024, at 10:48 a.m., Dietary Aide (DA) 2 was making a peanut butter and jelly sandwich. After DA 2 completed the task, the surface was not cleaned and disinfected. During a concurrent observation and interview on June 4, 2024, at 11:47 a.m., DA 3 was observed using a green bucket with solution inside, followed by using a red bucket with solution inside to wipe down a food preparation surface. DA 3 stated this is the normal process of cleaning and sanitizing work surfaces in the kitchen. DA 3 stated the green bucket contains a detergent, and the red bucket contains a sanitizer. During an interview on June 5, 2024, at 9:34 a.m., with the Registered Dietician (RD), the RD indicated cross contamination of food can occur if the kitchen staff do not follow the facility's cleaning procedure to sanitize the working surfaces. The RD further explained staff are expected to clean the working surfaces by following facility cleaning procedures. A review of the facility policy and procedure titled, SANITATION, dated 2023, indicated, .Thoroughly rinse the utensil or surface after cleaning. Remove any detergent residue, which may be toxic. Toxic residue can cause food to develop off-flavors .It is important to thoroughly rinse the utensils or surface prior to applying the sanitizing agent as sanitizers will be ineffective in the presence of some detergents and food particles . 2. During an observation on June 3, 2024, at 6:44 a.m. in the dry storage room in the kitchen, the vent on the ceiling and the wall near the vent was covered with a black debris. During an observation on June 3, 2024, at 7:01 a.m., in the kitchen, the juice machine, tubing, and motor had a thick coat of brown debris. The wall and vent above the juice machine had black colored debris on them. During an observation on June 3, 2024, at 7:07 a.m., inside the walk-in refrigerator, the wire temperature censor was covered in black debris and the door had brown/dark debris on it. During an observation on June 3, 2024, at 7:36 a.m., in the kitchen, the chains holding a utensil rack over the steam table had brown/black debris on all four corners, and the post next to the rack had dark gray debris covering it. During an observation on June 3, 2024, at 7:40 a.m., a door leading out of the kitchen to the physical therapy department had black debris around the door jamb/frame inside the kitchen. During an observation on June 3, 2024, at 7:46 a.m., the hood and vents above the stove were covered with greasy, black debris, and the fire suppression unit had grease and black debris on it. During an interview on June 3, 2024, at 7:58 a.m., with the Dietary Services Supervisor (DSS) in the kitchen, the DSS confirmed the brown/gray/black debris as dust in the above-mentioned areas. The DSS stated the kitchen should not have dust in it because it can get in the food and cause cross contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on June 3, 2024, at 9:20 a.m., with the DSS, a thick coating of dust was present on the gas line to the stove. The DSS stated the dust should not be there and the area needs to be kept clean. During a concurrent observation and interview on June 3, 2024, at 9:27 a.m., with the DSS, in the large dry storage room, the vent on the ceiling was dusty. The DSS stated the dust should not be there. During a concurrent observation and interview on June 3, 2024, at 10:20 a.m., with a Certified Nurse Aide (CNA) in the ice machine room, white/brown debris was observed on the outside of the ice machine. The CNA confirmed the white/brown debris was dust and stated that dust can get in the ice if it is not cleaned. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated dust in the kitchen is not sanitary, and means the kitchen is not being properly cleaned. The RD explained that dust can fall into food and cause cross contamination. The RD stated the expectation is to keep the kitchen clean. A review of the facility policy and procedure titled, SANITATION, dated 2023, indicated, .The kitchen staff is responsible for all the cleaning with the exception of ceiling vents, light fixtures, and the hood over the stove, which will be cleaned by the maintenance staff. A review of the facility policy and procedure titled, HOODS, FILTERS, AND VENTS, dated 2023, indicated, . Hoods must be cleaned every two weeks and must be free of dust and grease .Vents must be free of dust and dirt . A review of the facility policy and procedure titled, STORAGE OF FOOD AND SUPPLIES, dated 2023, indicated, .The storeroom should be .clean at all times .routine cleaning .procedures should be developed and followed . A review of the facility policy and procedure titled, PROCEDURE FOR REFRIGERATED STORAGE, dated 2023, indicated, .Refrigeration equipment should be routinely cleaned . 3. During an observation on June 3, 2023, at 7:07 a.m., in the walk-in refrigerator, the produce bins were inspected. There were two discolored, mushy tomatoes which had white fuzzy spots on them, and two discolored, soft bell peppers, one of which was cracking open. During an interview on June 3, 2024, at 8:15 a.m., with the DSS in the walk-in refrigerator, the DSS identified four poor quality tomatoes and two bell peppers that had moldy spots and other discoloration on them. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated she expects the kitchen staff to monitor the quality of the produce as they use it and to throw away products that do not look good. A review of the facility policy and procedure titled, PROCEDURE FOR REFRIGERATED STORAGE, dated 2023, indicated, .Produce will be delivered frequently and rotated in the order it is delivered to assure that a fresh product is used, free of any wilting or spoilage . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure titled, GENERAL RECEIVING OF DELIVERY OF FOOD AND SUPPLIES, dated 2023, indicated, .Produce is to be fresh and free of any wilting or spoilage . A review of the facility policy and procedure titled, STORING PRODUCE, dated 2023, indicated, .Check boxes of fruit and vegetable for rotten, spoiled items .Remove the wilted or spoiled portions of lettuce, celery, and other fresh vegetables in the refrigerator often so they don't cause the rest of the vegetable to spoil . 4. During an observation on June 3, 2024, at 7:47 a.m., in the kitchen, the can opener had a black, sticky grime on the blade and base. During an interview on June 3, 2024, at 9:09 a.m., with the DSS, the DSS stated the can opener is supposed to be washed and sanitized after each use. The DSS explained the black grime may be from juice and syrup but was not sure. The DSS stated she expects kitchen staff to clean it after every use. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated that the can opener should be cleaned and run through the dishwasher after each use. The RD explained the dirty can opener can cause cross contamination. A review of the facility policy and procedure titled, CAN OPENER AND BASE, dated 2023, indicated, .Proper sanitation and maintenance of the can opener and base is important to sanitary food preparation . 5. During an observation on June 3, 2024, at 6:57 a.m., in the kitchen, the blender container had an orange/brown color in the base. During an interview on June 3, 2024, at 9:08 a.m., with the DSS, the DSS stated the brown grime should not be there and the blender should not be used because of the risk for cross contamination. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated the blender should be kept clean, even on the outside part because of the risk of cross contamination. A review of the facility policy and procedure titled, SANITATION, dated 2023, indicated, .Each employee shall know how to operate and clean all equipment in his specific work area .The kitchen staff is responsible for all the cleaning . 6. A review of the U.S. Food and Drug Administration (FDA) Food Code 2022, section 4-602.13 Nonfood-Contact Surfaces, 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 . During an observation on June 3, 2024, at 7:01 a.m., in the kitchen, the floor behind juice machine had one sprouted potato, brown/black grime, and dust. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on June 3, 2024, at 7:58 a.m., with the DSS, the DSS stated the floor needed to be swept and mopped under the juice machine. DSS expects kitchen staff to keep the floor clean to prevent attracting pests. During a concurrent observation and interview on June 3, 2024, at 9:27 am, with the DSS in the large dry storage room, on the floor were found hair/fibers, dust, dead cockroaches, and food particles. Under the reach in freezer, on the floor, were plastic lids and food particles. The DSS stated the floor needs to be swept and mopped. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated the floor should be swept and mopped on a regular basis to keep it clean. The RD explained there is a risk for cross contamination, physical hazards, and creates the potential to attract more pests when the floors are not kept clean. A review of the facility policy and procedure titled, GENERAL CLEANING OF FOOD & NUTRITION SERVICES DEPARTMENT, dated 2023, indicated, .Floors must be mopped at least once per day .Mop under and around equipment, along the walls and in corners . 7. During an observation on June 3, 2024, at 7:01 a.m., in the kitchen, the coffee maker hot water spout had a build up of white crust around the opening. During an interview on June 3, 2024, at 7:58 am, with the DSS, the DSS stated the build up was from hard water and it should be cleaned so it does not fall into hot water and cause cross contamination. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated the spout of coffee maker had hard water scaling and it should be cleaned/descaled regularly because it can cause cross contamination. A review of the facility policy and procedure titled, SANITATION, dated 2023, indicated, .Each employee shall know how to operate and clean all equipment in his specific work area .All .equipment shall be kept clean . 8. During an observation on June 3, 2024, at 6:44 a.m., in the small dry storage room, one plastic container was stacked wet on top of a dry container. During an interview on June 3, 2024, at 8:04 a.m., with the DSS, the DSS stated all containers are supposed to be air dried before being put away. The DSS explained the moisture on the container has the potential to promote bacterial growth. During an interview on June 5, 2023, at 9:34 a.m., with the RD, the RD stated dishes are not supposed to be stacked wet because it could cause cross contamination due to mold build up. When dishes are stacked wet, they do not dry properly. A review of the FDA Food Code 2022, Annex 3, section 4-901.11, indicated, .Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. During a concurrent observation and interview on June 3, 2024, at 9:17 a.m., with the DSS in the kitchen, burnt, black particles were found inside the small oven. The DSS stated it appeared to be spilled juice from prepared foods. The DSS explained that the oven should be cleaned after the cooks are done with meal preparation. The DSS explained the burnt material could affect food quality. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated the burnt material is a safety issue and could result in a fire. The RD stated she expects the cooks to clean the oven after use. A review of the facility policy and procedure titled, RANGES AND OVENS, dated 2023, indicated, . CLEANING PROCEDURE .Weekly, and as often as necessary .remove encrusted material from oven surface . 10. During a concurrent observation and interview on June 3, 2024, at 9:27 a.m., with the DSS in the reach-in freezer, there were two items stored in the freezer that were open and exposed to air: beef patties and pie shells. The DSS stated the food items need to be sealed because it will cause freezer burn. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated open items in the freezer need to be sealed to prevent ice build up and freezer burn. RD explained freezer burn affects the quality of the food. The RD stated she expects kitchen staff to store the food correctly. A review of the facility policy and procedure titled, PROCEDURE FOR FREEZER STORAGE, dated 2023, indicated, .Store frozen foods in airtight moisture-resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn . 11. A review of the FDA Food Code 2022, section 3-302.12 Food Storage Containers, Identified with Common Name of Food, indicated, .Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT .shall be identified with the common name of the FOOD . During a concurrent observation and interview on June 3, 2024, at 9:12 a.m., with the DSS in the kitchen, an unlabeled and undated clear plastic container with a green lid and yellow contents was sitting on the food preparation table next to the stove. The DSS opened the container and identified the contents as margarine. The DSS explained there is no way to tell when the margarine was put in the container or when the margarine expires. The DSS stated she expects kitchen staff to label and date everything that is not kept in its original container. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated unlabeled foods are unable to be identified and determine when the best by date is. The RD stated she expects everything to be properly labeled and dated. A review of the facility policy and procedure titled, LABELING AND DATING OF FOODS, dated 2023, indicated, .Newly opened food items will need to be closed and labeled with an open date and a use by date . 12. During an observation on June 3, 2024, at 7:42 a.m., in the kitchen the microwave had dried yellow/brown splatter inside on the top. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on June 3, 2024, at 9:05 a.m., with the DSS, the DSS stated the microwave is supposed to be cleaned after every use because it could cause cross contamination. During an interview on June 5, 2024, at 9:34 a.m., with the RD, the RD stated microwave splashes are expected to be cleaned after each use and daily. Build up can cause a fire and cross contamination. A review of the facility policy and procedure titled, SANITATION, dated 2023, indicated, .All .equipment shall be kept clean, maintained in good repair .The kitchen staff is responsible for all the cleaning .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 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** 44173 Based on observation, interview and record review, the facility failed to ensure infection control and prevention practices were observed when: 1. For Resident 147, there was no enhanced barrier precaution (EBP - an infection control method that use personal protective equipment [PPE - medical equipment for protection] to reduce the spread of infection) sign posted and there was no container found in the room to dispose the used cloth gowns and linens to care for the resident who had a urinary catheter (a flexible tube used to empty the bladder [body organ that stores urine]) in place; 2. Nursing staff failed to properly clean and disinfect a shared automatic blood pressure (BP - pressure of blood in blood vessels) cuff machine after use according to the facility's policy for Resident 101; 3. Nursing staff failed to properly clean and disinfect the resident's prefilled insulin (medication for diabetes) pen before use according to manufacturer's specifications for Residents 27 and 37; and 4. Nursing staff failed to properly clean and disinfect a shared glucometer (blood glucose meter to measure and display the amount of sugar (glucose) in your blood) after use according to manufacturer's instructions and accepted professional standards for five of five randomly sampled residents (Residents 18, 25, 27,32, amd 97). These failures had the potential for Residents 147, 101, 27, 37, 18, 25, 27, 32, and 97 to be exposed to infection from cross contamination. Findings: 1. On June 3, 2024, at 7:05 a.m., a concurrent observation and interview was conducted with Resident 147. Resident 147 was lying in bed, awake and alert. Resident 147 was observed with a urinary catheter draining to clear yellow urine attached to a drainage bag. There was no EBP sign posted in Resident 147's room. There was no container available in the room to dispose of the used coth gowns and linens. On June 3, 2024, at 8:21 a.m., the Restorative Nursing Assistant (RNA) was interviewed. The RNA stated she used gloves when she emptied the urinary catheter. The RNA did not mention the use of the isolation gown when emptying the urinary catheter. On June 3, 2024, at 3:54 p.m., Licensed Vocational Nurse (LVN) 4 and Registered Nurse 3 (RN) 3 were interviewed. LVN 4 and RN 3 both stated Resident 147 had a urinary catheter and should be placed on EBP. LVN 4 and RN 3 both stated staff should use gloves and cloth gown when conducting direct patient care such as bathing and emptying the urinary catheter. LVN 4 and RN 3 both stated there was no EBP sign posted and there was no container for used cloth gowns and linens found in Resident 147's room. LVN 4 and RN 3 both stated there should be a sign posted for EBP and a container for used isolation gowns and linens in Resident 147's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 6, 2024, at at 12:40 p.m., the Director of Staff Development/Infection Preventionist (DSD/IP) was interviewed. The DSD/IP stated the facility staff were aware residents with urinary catheter, enteral feeding, wounds and central lines should be placed on EBP. He stated a sign for EBP should be placed as soon as the resident was identified to meet the criteria. The IP stated staff should follow the EBP procedure as indicated in the EBP sign. He stated the EBP sign should be posted in the resident's room and a container should be available inside the resident's room for used cloth gowns and linens. The DSD/IP stated the staff should wear gloves and isolation gown when performing tasks such as changing diapers, toileting, emptying urinary catheters, wound care, caring for medical devices like central lines, and assisting residents in and out of the bed, as well as cleaning the resident's room. Resident 147's record was reviewed. Resident 147 was admitted to the facility on [DATE], with diagnoses which included urinary tract infection (UTI - a condition that occurs when bacteria invade and grow in the urinary tract [the tube through which the urine passes]) and chronic kidney disease (CKD - a longstanding disease of the kidneys). During a review of Resident 147's history and physical (H&P), dated May 29, 2024, the H&P indicated Resident 147 had the capacity to understand and make decisions. The physician's order dated May 28, 2024, indicated .Foley catheter (medical device that helps drain urine from the body) .to gravity drainage for retention . The facility policy and procedure titled Enhanced Barrier Precaution, revised May 28, 2024, indicated, . Enhanced Barrier Precautions will be in place for residents that meet the criteria .Residents that have the following will be on EBP .urinary catheter .The facility will make Personal Protective Equipment (PPE) available for staff use .EBP will be implemented when the staff provides prolonged long contact care for residents. Examples include but are not limited to .Device care or use .urinary catheter . 46393 2. During a medication pass observation on June 3, 2024, at 8:01 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 was observed removing an automatic blood pressure (BP-pressure of blood in blood vessels) cuff machine from inside the medication cart and then proceeded into Resident 101's room. LVN 3 applied the automatic BP cuff on Resident 101's left arm. After obtaining Resident 101's BP reading, LVN 3 removed the automatic BP cuff from Resident 101's arm, returned to the medication cart, and placed the automatic BP cuff machine back inside the medication cart. LVN 3 was not observed to have disinfected the automatic BP cuff machine after it was used on Resident 101. During an interview on June 3, 2024 at 1:06 p.m. with LVN 3, LVN 3 acknowledged he did not disinfect the automatic BP cuff machine after use and acknowledged he should have. During an interview on June 3, 2024 at 1:13 p.m. with LVN 2, LVN 2 stated shared equipment such as a BP machine and glucometers should be cleaned after each use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on June 6, 2024 at 10:45 a.m. with the Registered Nurse Supervisor (RNS), the RNS stated the BP machine should have been cleaned after use between residents. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated September 2023, the P&P indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to the current CDC (Centers for Disease Control and Prevention- a nationally recognized disease control and prevention organization) recommendations for disinfection .Non-critical items are those that come in contact with intact skin but not mucous membrane .Non-critical resident-care items include .blood pressure cuffs .Reusable items are cleaned and disinfected or sterilized between residents. According to the CDC article titled, Disinfection and Sterilization Guideline for Disinfection and Sterilization in Healthcare Facilities, updated May 2019, .non-critical patient-care devices are disinfected when visibly soiled and on a regular basis .such as after use on each patient . 3. a. During a medication pass observation on June 3, 2024 at 8:34 a.m., LVN 2 was observed preparing 11 medications for Resident 37. The medications included a prefilled insulin glargine (a type of insulin) 100 units/milliliter (ml, unit of measurement) pen. He removed the cap from the prefilled insulin pen and attached the new needle to the pen without wiping the rubber seal on the pen tip with alcohol first. On June 3, 2024 at 8:50 a.m., LVN 2 was observed administering 10 units from the prefilled insulin pen as a subcutaneous (under the skin) injection in Resident 37's lower right abdomen. A review of Resident 37's medical record indicated a physician's order, dated May 22, 2024, for insulin glargine solution 100 units/ml, inject 10 units subcutaneously one time a day. During an interview on June 3, 2024 at 3:11 p.m. with LVN 2, he confirmed he did not wipe the rubber seal on the prefilled insulin pen tip with alcohol before he attached the needle and acknowledged he should have. During an interview on June 3, 2024 at 3:34 p.m. with the DSD/IP, regarding the process for prefilled insulin pen administration, the IP stated, nursing staff were expected to open the cap, clean the rubber seal, and then attach the needle to the insulin pen. Additionally, the DSD/IP stated, the expectation would be the same as an insulin vial, nursing staff were expected to wipe the rubber top with an alcohol wipe before use. During a concurrent interview and record review on June 6, 2024 at 10:36 a.m. with the RNS, the RNS downloaded and reviewed the prefilled insulin pen manufacturer's instructions from the manufacturer's website. The RNS read verbatim from the manufacturer's instructions: Wipe the pen tip (rubber seal) with an alcohol swab. b. During a medication pass observation on June 3, 2024 at 12:32 p.m. with LVN 3, LVN 3 was observed preparing a prefilled Humalog (a type of insulin, medication for diabetes) 100 units/ml pen for Resident 27. LVN 3 removed the cap from the prefilled insulin pen and attached the new needle to the pen without wiping the rubber seal on the pen tip with alcohol first. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 3, 2024 at 12:33 p.m. LVN 3 was observed administering 4 units from the prefilled insulin pen as a subcutaneous injection in Resident 27's lower left abdomen. A review of Resident 27's medical record indicated a physician's order, dated May 6, 2024, for Humalog Injection Solution 100 units/ml (Insulin Lispro), inject 4 units subcutaneously before meals. During an interview on June 3, 2024 at 12:57 p.m. with LVN 3, he confirmed he did not wipe the rubber seal on the prefilled insulin pen tip with alcohol before he attached the needle and acknowledged he should have. During a concurrent interview and record review on June 6, 2024 at 10:32 a.m. with the RNS, the RNS downloaded and reviewed the prefilled insulin pen manufacturer's instructions from the manufacturer's website. The RNS read verbatim from the manufacturer's instructions: Wipe the rubber seal with an alcohol swab. During an interview on June 6, 2024 at 10:44 a.m. with the RNS, regarding the use of insulin pens, the RNS stated, nursing staff were expected to follow manufacturer instructions. During a review of the facility's P&P, titled Insulin Administration, dated March 2023, indicated, Steps in the Procedure (Insulin Injections via Syringe) .Disinfect the top of the vial with an alcohol wipe. 4. a. During a concurrent observation and interview on June 3, 2024 at 11:52 a.m. with LVN 3 at Medication Cart 1, LVN 3 was observed obtaining Resident 32's blood sugar (BS) at the bedside. LVN 3 pricked the resident's finger with the lancet (a cutting device), then collected a small blood sample on a testing strip that was connected to the glucometer. After completing reading the BS, LVN 3 disposed of the testing strip, went back to the medication cart, and was observed wiping the glucometer with a PDI Sani-Hands wipe from a container with a blue colored lid (blue top). When asked what type of wipes he used to clean the glucometer, LVN 3 read from the back of the blue top container and stated, Alcohol wipes. b. During an observation on June 3, 2024 at 12:03 p.m., LVN 3 was observed obtaining Resident 18's BS at the bedside with the same glucometer as above. LVN 3 pricked the resident's finger with the lancet, then collected a small blood sample on a testing strip that was connected to the glucometer. After completing reading the BS, LVN 3 disposed of the testing strip, went back to the medication cart, and was observed wiping the glucometer with a wipe from the same PDI Sani-Hands blue top container as above. c. During an observation on June 3, 2024 at 12:09 p.m., LVN 3 was observed obtaining Resident 25's BS at the bedside with the same glucometer as above. LVN 3 pricked the resident's finger with the lancet, then collected a small blood sample on a testing strip that was connected to the glucometer. After completing reading the BS, LVN 3 disposed of the testing strip, went back to the medication cart, and was observed wiping the glucometer with a wipe from the same PDI Sani-Hands blue top container as above. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During an observation on June 3, 2024 at 12:20 p.m., LVN 3 was observed obtaining Resident 97's BS at the bedside with the same glucometer as above. LVN 3 pricked the resident's finger with the lancet, then collected a small blood sample on a testing strip that was connected to the glucometer. After completing reading the BS, LVN 3 disposed of the testing strip, went back to the medication cart, and was observed wiping the glucometer with a wipe from the same PDI Sani-Hands blue top container as above. e. During an observation on June 3, 2024 at 12:27 p.m., LVN 3 was observed obtaining Resident 27's BS at the bedside with the same glucometer as above. LVN 3 pricked the resident's finger with the lancet, then collected a small blood sample on a testing strip that was connected to the glucometer. After completing reading the BS, LVN 3 disposed of the testing strip, went back to the medication cart, and was observed wiping the glucometer with a wipe from the same PDI Sani-Hands blue top container as above. During an interview on June 3, 2023 at 12:57 p.m. with LVN 3, LVN 3 stated he started employment at the facility two weeks ago. When asked if he had been trained on how to clean and disinfect shared glucometers, LVN 3 stated, he was trained to clean the glucometer after each time it was used. When asked if he was trained regarding which type of wipe to use, LVN 3 stated, No. LVN 3 stated, he would ask the IP regarding the wipes that should have been used to clean the shared glucometer. During an interview on June 3, 2024 at 1:01 p.m. with the IP, when asked to describe the facility's process for cleaning and disinfecting shared glucometers, the IP stated, nurses should clean the glucometer between each resident with wipes from the Red Top or Purple Top container. The IP confirmed the blue top alcohol wipes should have only been used for hands and should not have been used to disinfect shared glucometers or other shared devices such as BP machines. When asked if nursing staff were trained regarding the process for cleaning and disinfection of shared devices, the IP stated an in-service training was provided around February 2024. The IP stated he will look for the in-service training lesson provided to nursing staff and follow-up with the surveyor. During an interview on June 3, 2024 at 1:13 p.m. with LVN 2, LVN 2 stated nursing staff were instructed to use wipes from the Red or Purple top container or bleach wipes to clean and disinfect shared equipment such as BP machines and glucometers. LVN 2 stated the blue top wipe should have only be used on hands and should not have been used to disinfect shared equipment. During a follow-up interview on June 4, 2024 at 4:20 p.m. with the IP, he confirmed nursing staff had not been trained on how to clean and disinfect shared devices. During an interview on June 6, 2024 at 10:48 a.m. with the RNS, regarding the expectations of nursing staff regarding the cleaning and disinfecting of shared devices such as glucometers, the RNS stated nursing staff should not have used alcohol wipes to clean the glucometer. Further review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated September 2023, the P&P indicated, .Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions . During a review of the manufacturer's instructions for cleaning and disinfecting of the glucometer provided by the facility, it indicated, .The meter MUST be cleaned and disinfected after use on each patient . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Food and Drug Administration's (FDA) Letter to Manufacturers of Blood Glucose Monitoring Systems Listed With the FDA, dated December 12, 2017, it indicated, .The disinfection solvent you choose should be effective against HIV, Hepatitis C, and Hepatitis B virus. Outbreak episodes have been largely due to transmission of Hepatitis B and C viruses .Please note that 70% ethanol solutions are not effective against viral bloodborne pathogens . According to the online publication titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration by the Centers for Disease Control and Prevention (CDC), dated March 2, 2011, it indicated, . An underappreciated risk of blood glucose testing is the opportunity for exposure to bloodborne viruses (HBV [hepatitis B virus], hepatitis C virus, and HIV) through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g., blood glucose meters, fingerstick devices, insulin pens) are shared .If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 48870 Based on observation, interview, and record review the facility failed to ensure equipment in the kitchen was clean and maintained in a safe operating condition when: 1. There was ice buildup in reach-in freezer; 2. Three out of three cracked white shelves in reach-in freezer; 3. The bottom shelf of the prep table corrosion; 4. Two out of two silver storage shelves found had rust in dry storage room at kitchen; 5. One blue cutting board a rough surface; and 6. The drying dome rack had cracked coating with exposed rusting metal. These failures had the potential for equipment not functioning in the way they were intended and in turn cause contamination of food which could lead to food borne illnesses for 48 out of 50 residents. Findings: 1. During a review of the U.S. Food and Drug Administration's (FDA) Food Code 2022, Annex 3: 4-501.11 Good Repair and Proper Adjustment, the Food Code indicated, .Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk . During a concurrent observation and interview on June 3, 2024, at 9:27 a.m., with the the Dietary Services Supervisor (DSS), the reach-in freezer had ice accumulated at the top of the freezer and ice drips forming under the top shelf. The DSS confirmed the ice accumulated at the top of the freezer and ice drips forming under the top shelf. During an interview on June 5, 2024, at 9:34 a.m. with the Registered Dietician (RD) and the Administrator, the Administrator agreed the reach-in was not properly functioning with ice build up at the top of the freezer and ice drips forming under the top shelf. 2. During a concurrent observation and interview on June 3, 2024, at 9:30 a.m., with the DSS, three of three storage shelves in the reach-in freezer had cracked coating. The DSS stated when the coating cracks, the shelves need to be replaced. During an interview June 5, 2024, at 9:34 a.m., with the RD, the RD stated once the shelves start showing wear and tear, they should be replaced. She stated the cracked coating could cause physical contamination of food because cracks are an area for bacterial growth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure titled, SANITATION, dated 2023 indicated, .All equipment shall be maintained as necessary and kept in working order . A review of the facility policy and procedure titled, Maintenance Service, dated August 2022, indicated, . Periodically inspect shelves and replace if coating is chipped away exposing metal shelves . 3. During an observation on June 4, 2024, at 10:44 a.m., in the kitchen, on the food preparation table bottom shelf had a white mat laid over the metal shelf, with cleaned pans and bowls stored on top of it. The white mat was lifted, and the shelf was rusty, and contained dust and food particles. During an interview on June 4, 2024, at 4:06 p.m., with the DSS, the DSS stated the preparation table had corrosion (the gradual deterioration of metals caused by the action of air, moisture, or a chemical reaction on their surface causing rust). During an interview on June 5, 2024, at 9:43 a.m., with the RD, the RD stated rust in the kitchen is not appropriate due to the risk of cross contamination. The RD stated she expects the kitchen to not have rusty equipment. A review of the facility policy and procedure titled, STORAGE OF FOOD AND SUPPLIES, dated 2023, indicated, .All shelves and storage racks or platforms should be in accordance with state and federal regulations to facilitate air circulation and promote easy and regular cleaning. Shelves and cupboards will not be lined with shelf paper or other liners . A review of the facility policy and procedure titled, SANITATION, dated 2023, indicated, .All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas . 4. During an observation on June 3, 2024, at 6:44 a.m., in the dry storage room, two of two storage racks for dry foods had reddish/brown spotting and rough surfaces. During an interview on June 3, 2024, at 8:04 a.m., with the DSS, the DSS stated reddish/brown spotting was rust and rusty shelves are not supposed to be used in the kitchen because it can cause cross contamination. During an interview on June 5, 2024, at 9:43 a.m., with the RD, the RD stated rust in the kitchen is not appropriate due to the risk of cross contamination. The RD stated she expects the kitchen not to have rusted items. A review of the facility policy and procedure titled, SANITATION, dated 2023, indicated .All equipment shall be maintained as necessary and kept in working order .All .shelves .shall be kept clean, maintained in good repair and shall be free from .corrosions . 5. During a concurrent observation and interview on June 3, 2024, at 8:58 a.m., with the DSS, a blue cutting board had a rough surface with deep cutting marks. The DSS stated the cutting board needed to be replaced and explained the rough surface can trap bacteria. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on June 5, 2024, at 9:43 a.m., with the RD, the RD stated the blue chopping board needs to be replaced when worn out because of the risk for bacterial growth and cross contamination of food. During a review of the U.S FDA (Food and Drug Administration) Food Code 2022, Section 4-501.12 Cutting Surfaces, the FDA Food Code indicated, .Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces . 6. During a concurrent observation and interview on June 3, 2024, at 9:01 a.m., with the DSS in the kitchen. There was a dome drying rack observed had cracked gray plastic coating with exposed rusting metal. The DSS stated the dome drying rack needed to replace otherwise it potentially could cause cross contamination. During an interview on June 5, 2024, at 9:43 a.m., with the RD, the RD stated rust in the kitchen is not appropriate due to the risk of cross contamination. The RD stated she expects the kitchen not to have rusted equipment. A review of the facility policy and procedure titled, SANITATION, dated 2023, indicated .All equipment shall be maintained as necessary and kept in working order .All .shelves .shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000 Based on observation, interview, and record review, the facility failed to provide the required bedroom space, measuring at least 80 square feet per resident, in 12 resident rooms (Rooms 16, 17, 19, 21, 23, 24, 27, 29, 30, 32, 33, and 34). Findings: On June 3, 2024, at 9:06 a.m., during the entrance conference, the Administrator was interviewed regarding the room sizes for resident Rooms 16, 17, 19, 21, 23, 24, 27, 29, 30, 32, 33, and 34. The Administrator agreed the rooms did not meet the space requirement of at least 80 square feet per resident in the above-mentioned resident rooms. The Administrator stated the facility had a waiver for the rooms and would be requesting for the renewal of the waiver. On June 5, 2024, at 1:54 p.m., a concurrent observation and interview was conducted with Resident 24 in room [ROOM NUMBER]. Resident 24 was observed in bed and was awake. Resident 24 stated the room size did not interfere with his care and there was enough space for him to move about in the room. During the survey dates of June 3, 4, 5, and 6, 2024, the above-listed rooms were observed at different times of the day. There were no adverse effects that impacted the quality of life of the residents who resided in the rooms as observed during the survey dates. On June 3, 2024, the Administrator submitted the requirements for the request to continue room waivers for Rooms 16, 17, 19, 21, 23, 24, 27, 29, 30, 32, 33, and 34. The survey team recommends the room variance to continue, provided the health and safety of the residents who resided in the above-mentioned rooms, are not adversely affected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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. 48870 Based on observation, interview, and facility document review, the facility failed to ensure an effective pest control program was in place for the kitchen, when a gnat was observed in a storage room on June 3, 2024, and four house flies were observed flying and landing in the kitchen on June 4, 2024. This failure had the potential to lead to food borne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) in the facility residents who eat food prepared in the kitchen. Findings: During an observation on June 3, 2024, at 6:44 a.m., in the kitchen dry storage room, there was a plastic bin with four brown bananas in it, with a gnat/fruit fly flying around the fruit. During an interview on June 3, 2024, at 8:04 a.m., with Dietary Services Supervisor (DSS), DSS stated the ripe bananas attract gnats and the kitchen cannot have pests because it can cause cross contamination of the foods served. During a concurrent observation and interview on June 4, 2024, at 4:16 p.m., with [NAME] 3, there were four flies seen in the kitchen, flying around and landing in different areas of the kitchen. [NAME] 3 stated that it is difficult to keep flies out of the kitchen because every time someone opens the door to the kitchen, more flies come in and further explained the fan on the ceiling does not blow hard enough to prevent the flies from coming into the kitchen. During an interview on June 5, 2024, at 9:34 am, with Registered Dietician (RD), RD stated that flies should not be in the kitchen because they can get into the food and cause cross contamination. A review of the facility policy and procedure titled, Pest Control, dated August 2022, indicated .This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents .