STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555333	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Meadows Care Center	1550 Third Street Lincoln, CA 95648

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. 49933 Based on observation, interview, and record review, the facility failed to ensure resident needs were accommodated for one of 25 sampled residents (Resident 63), when the call light was not within reach. This failure had the potential to result in Resident 63 not attaining their highest practicable physical, psychosocial, and emotional well-being. Findings: During a review of Resident 63's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated, Resident 63 was admitted to the facility in September 2023 with multiple diagnosis of muscle weakness, difficulty walking, and history of falling. During a review of Resident 63's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/12/24, the MDS indicated Resident 25 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 3/11/25 at 3:17 p.m. in Resident 63's room, Resident 63 was in bed laying, the call light was observed on the floor behind Resident 63's bed. Resident 63 stated he usually does not have his call light within reach. Resident 63 verbalized in frustration he needed the call light to ask staff to lower the volume of his television (TV). Resident 63 stated his privacy curtain was usually drawn so he cannot see who was walking by. Resident 63 further stated that his roommate had the volume on high so he did not know if anyone could hear him if he yelled out. Licensed Nurse 5 (LN 5) came into the room after being prompted to assist Resident 63. LN 5 confirmed and acknowledged that the call light was on the floor and not within reach. During a concurrent observation and interview on 3/13/25 at 3:27 p.m. in Resident 63's room, Resident 63 was in bed and watching TV. Resident 63's call light was dangling off the side of the bed not within reach. Resident 63 stated he was unable to reach his call light. Certified Nurse Assistant 3 (CNA 3) confirmed that the call light was not within reach. During an interview on 3/14/25 at 9:31 a.m., with Director of Nursing (DON), the DON stated her expectation was to have all call lights within reach of the residents. (continued on next page)

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

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F 0558 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, Answering the Call Light revised October 2024, the P&P indicated .when the resident is in bed or confined to a chair be sure the light is within easy reach of the resident .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50517 Based on observation, interview, and record review, the facility failed to provide timely assistance with incontinence (a condition where a person experiences involuntary loss of urine or stool) care for four of 25 sampled residents (Resident 23, Resident 339, Resident 340, and Resident 60). This failure resulted in residents not attaining their highest practicable physical, psychosocial, and emotional well-being. Findings: During a review of Resident 23's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 23 was admitted [DATE] with diagnoses including fracture (a break or crack) of left femur (thigh bone). Resident 23's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 2/20/25, indicated Resident 23 had moderate cognitive impairment. Resident 23's self-care functional ability indicated, needed maximum assistance for toileting hygiene (helper does all the effort). The MDS indicated, he is always incontinent. During a review of Resident 23's March 2025 bladder continence task records indicated, 1 incontinence episode on night shift, 2 episodes on evening shift, 2 episodes on day shift. During a review of Resident 23's care plan dated, 3/11/25, indicated, resident at risk for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) decline. There was no documented evidence of a care plan for bladder incontinence. During a review of Resident 339's face sheet, indicated Resident 339 was admitted [DATE] with diagnoses including Spinal stenosis (narrowing of the spinal canal) lumbar (lower back) region, and difficulty walking. Resident 339's MDS, dated [DATE], indicated Resident 339 had moderate cognitive impairment. The MDS indicated, Resident 339's self-care functional ability requires maximum assistance for toileting hygiene. The MDS further indicated, Resident 339 was frequently incontinent. During a review of resident 339's March 2025 bladder continence task records indicated, incontinence throughout all shifts. During a review of Resident 339's care plan, dated 2/27/25, indicated Resident 339 had impaired skin integrity as evidenced by surgical wound at lumbar spine. There was no documented evidence of a care plan for bladder incontinence. . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 340's face sheet, indicated Resident 340 was admitted [DATE] with diagnoses including panniculitis (a condition where the fat layer under the skin becomes inflamed, causing painful bumps, sometimes accompanied by fever), and morbid obesity. Resident 340's MDS, dated [DATE], indicated he had intact cognition. Resident 340's self-care functional ability requires partial assistance for toileting hygiene (helper does less than half). The MDS further indicated, occasionally incontinent. During a review of Residents 340's March 2025 bladder continence task records indicated, 1 incontinence episode for night shift, 2 incontinence episodes for day shift. During a review of Resident 60's face sheet, indicated Resident 60 was admitted [DATE] with diagnoses including enterocolitis (inflammation of both the small intestine, and the colon [large intestine]) due to Clostridium Difficile (C. diff- a highly contagious bacteria that causes severe diarrhea). During a review of Resident 60's MDS dated , 2/17/25, indicated she had moderate cognitive impairment. Resident 60's self-care functional ability requires maximal assistance for toileting hygiene. The MDS further indicated, always incontinent with bowel movement. During a review of Resident 60's March 2025 bowel continence task records indicated, bowel incontinence throughout all shifts. During a review of Resident 60's care plan dated 2/14/25 indicated, Resident 60 had clostridium difficile. The care plan intervention indicated, keep skin clean and dry, provide incontinence care after each episode of loose stool. During a concurrent observation and interview on 3/11/25 at 9:15 a.m. in Resident 60's room, Resident 60 was observed distraught, restless, and was upset. Resident 60 stated, she was just cleaned up after another accident (diarrhea). Resident 60 stated, It took hours to get some help to be cleaned up. I called for help at 7 in the morning. When asked about her pain and discomfort, the resident stated, the pain was triggered when she had an episode of diarrhea. Resident 60 stated the skin at her buttocks and at her groin area felt raw from frequent stooling and said, It feels raw down there. During a concurrent observation and interview on 3/11/25 at 12 noon in Resident 23's room, Resident 23 was up on his wheelchair and supplied with oxygen through nasal cannula. Resident 23 stated, he had an episode of incontinence last night. Resident 23 stated, I did not have a clear path to go to the restroom .there was a walker, and table on my path and I felt restrained. Resident 23 stated, the nurse answered the call light and said, she will be back but never returned. Resident 23 stated, he felt like a child when he had an accident. Resident 23's complaint was corroborated and confirmed by his roommate Resident 340 who had the same complaint. During an interview on 3/11/25 at 1:00 p.m. with Resident 340, Resident 340 stated, he gets angry when he calls for assistance to the bathroom because the staff takes 45 minutes to help him. Resident 340 stated, there was an instance he ended up getting his shorts dirty because the wait was too long and ended up peeing on himself. Resident 340 stated, I was angry .It shouldn't be that way. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/12/25, at 9:30 a.m. in Resident 339's room, Resident 339 stated, it takes a long time for the staff to come in and help me get up to use the bathroom . She stated, she was wearing a diaper but preferred to get up and use the bedside commode or the toilet. Resident 339 stated, I felt upset and angry because I know when I needed to use the toilet, and they take so long to help me. Resident stated, I feel unvalued. During an interview with LN 3 at 3/12/25, at 9:45 a.m., LN 3 stated, the expectation is that incontinence care was done as soon as possible to keep residents clean and dry. LN 3 stated This will prevent worsening of skin conditions and prevents any skin irritation and infection. During an interview with Physical Therapist 1 (PT 1) at 3/13/25 at 11:25 a.m., PT 1 stated, Resident 339 is improving and should be using bedside commode or toilet. During an interview with LN 4 at 3/13/25, at 11:39 a.m. stated, LN 4 expects that care is provided in a timely manner when residents are incontinent or, responds to their needs to assist them to use the bathroom to prevent any incontinence. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living . dated May 2024, the P&P indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently including appropriate support and assistance with but not limited to . hygiene . mobility . elimination (toileting) .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49933 Based on observation, interview and record review, the facility failed to ensure one out of 25 sampled residents (Resident 58) received appropriate pain management services consistent with professional standards of practice and facility's policy and procedure (P&P) when Resident 58's pain was not managed during wound care treatment. This failure had the potential for Resident 58 not achieve relief from pain and not attain her highest practicable well-being. Findings: During a review of Resident 58's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 58 was admitted to the facility March 2024 with multiple diagnoses which included sacral pressure ulcer stage 3 (full-thickness loss of skin, dead and black tissue may be visible) and chronic pain. During a review of Resident 58's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/5/25, the MDS indicated Resident 58's wound was documented as pressure ulcer Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). During a review of Resident 58's Order Summary Report, (OSR) dated 3/13/25, OSR indicated, Pain-Monitor for Presence of Pain Every Shift Using Scale 0-10 .0=No pain 1-2=Least pain 3-4=Mild Pain 5-6=Moderate Pain 7-8=Severe Pain 9-10 Very Severe/Horrible/Worst pain . Resident 58's OSR also indicated, Morphine (pain medication) .Give 0.5 ml (milliliter, unit of measurement) orally every 1 hour as needed for moderate (4-6) to severe (7-10) pain . Resident 58's OSR dated 3/13/25 further indicated, oxycodone (pain medication) .give 1 tablet by mouth every 4 hours as needed for severe pain . During an interview on 10/11/25 at 11:57 a.m., Resident 58 stated she was on hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) care. Resident 58 stated she had not gotten up that day because she was in pain. During an interview on 10/11/25 at 11:57 a.m., Resident 58 stated she was on hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) care. Resident 58 stated she had not gotten up that day because she was in pain. During a review of Resident 58's care plan intervention for pain, initiated 9/30/24, indicated, pain will be managed to a tolerable level .will express/exhibit pain relief after alternative comfort measures and/or administration of medication as needed . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/13/25 at 11:12 a.m., in Resident 58's room, Licensed Nurse 3 (LN 3) was in the room to provide Resident 58 with wound care. Resident 58 stated to LN 3 that her pain was a lot. LN 3 was observed taking multiple trips back to the treatment cart due to not having enough supplies for the wound treatment. Resident 58 was laying on her right side while LN 3 was providing wound care. Resident 58 stated her legs were hurting during wound treatment. Resident 58 continued to moan in pain and stated it hurts while LN 3 cleaned the wound. LN 3 completed wound treatment and exited Resident 58's room at 11:44 a.m. Resident 58 was heard crying inside the room from outside of the hallway. During a concurrent interview and record review on 3/13/25 at 11:45 a.m. with LN 3, LN 3 confirmed that no pain scale assessment was used for Resident 58's pain, and no documented evidence of pain medication administered prior to wound treatment when Resident 58 stated she was in a lot of pain. LN 3 confirmed and acknowledged that having supplies not within reach prolonged the treatment time, which prolonged Resident 58's pain episode, and stated that Resident 58 could not tolerate laying on her side for very long. During an interview on 3/14/25 at 9:31 a.m. with the Director of Nursing (DON), the DON stated it was the expectation for LNs to pre medicate resident with pain medications to manage pain and if resident is in pain during wound treatment, to administer prn (given as needed or requested) pain medication and come back when the pain has subsided. The DON further stated that a pain scale should be used to assess pain level. During a review of the facility's policy and procedure (P&P), titled, Pain Assessment and Management , revised March 2023, indicated, .Assess pain using a consistent approach and a standardized pain assessment .if pain has not been adequately controlled the multidisciplinary team, including the physician, shall reconsider approaches as indicated . During a review of the facility's P&P, titled Wound Care, revised October 2010, indicated, Review the resident's care plan to assess for any special needs of the resident .a. For example, the resident may have a PRN order for pain medication to be administered .Assemble the equipment and supplies .arrange the supplies so they can be easily reached .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 40830 Based on observation, interview and record review, the facility failed to ensure Dietary Aide (DA) 1 and DA 2 had the appropriate skill set to safely perform the daily operations of the food and nutrition services department when: 1. DA 1 was unable to verbalize the correct process of manual dishwashing with 2-compartment sink (cross refer to F812, #4); 2. DA 2 was unable to perform cleaning and sanitizing procedure correctly for the soiled food contact surface areas (cross refer to F812, #5), and 3. DA 2 was unable to verbalize and demonstrate the correct procedure for testing and proper temperature when preparing the sanitizer solution for the red bucket (red color-coded bucket is used as a standard of practice to contain sanitizer solution) (cross refer to F812, #6). These failures had the potential to place 88 out of 92 highly susceptible residents who consumed food from the facility at risk for food borne illness. Findings: 1. During an interview with DA 1 regarding the process of manual dishwashing by the 2-compartment sink on 3/11/25 at 8:57 a.m., DA 1 stated he would switch to manual dishwashing when the dishwashing machine was not working. He stated the steps were washing, rinsing and air-dried. A concurrent confirmation with Dietary Manager (DM) and stated the correct process were washing, rinsing, sanitizing and air-dried. For the sanitizing step, DA 1 stated the dishes would immerse into the sanitizer solution for 5 to 10 minutes. DA 1 could not state the effective concentration for the sanitizer solution when asked. DM cued DA 1 to read the instruction posted on the wall, and DM stated the concentration should be at the range of 200-400 ppm (parts per million - a measurement unit for the sanitizer solution). A review of facility policy and procedure (P&P) titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, indicated the process involved washing, rinsing, sanitizing, and air-dried, and .sanitizer solution . must read 200-400 ppm .immerse all washed items (in the sanitizer solution) for at least 1 minute (60 seconds) . 2. During a kitchen observation on 3/11/25 at 8:34 a.m., it was noted the storage areas for clean metal pans was not clean with food debris. Observed DA 2 used a towel to wipe the storage areas. DA 2 stated she used the towel from the red bucket (bucket contained sanitizer solution) to clean the storage areas. During an interview with DM on 3/11/25 at 8:45 a.m., DM confirmed and stated DA 2 used the sanitizer to clean the soiled storage areas. DM stated DA 2 did not performed the procedure correctly. He further stated DA 2 should first clean with soap and water, then using the sanitizer to sanitize. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of department document titled, Inservice: Cleaning and Sanitizing Dishes, Utensils, Pots and Pans, dated 3/2022, indicated, .cleaning and sanitizing of .food contact surfaces .food storage areas are vital in keeping food wholesome and safe to consume .Cleaning is the removal of soils, tarnishes, or stains . Sanitizing is the process of reducing the number of microorganisms on the surface to safe levels so that they cannot cause disease or food spoilage .to be effective, cleaning and sanitizing must be a two-step process. Surface must first be (1) cleaned and rinsed before (2) being sanitized .any surface that comes in contact with food much also be cleaned and sanitized . 3. A concurrent observation and interview with DA 2 and DM regarding the preparation and testing of the sanitizer solution for the red bucket was conducted on 3/11/25 at 8:34 a.m. DA 2 stated the sanitizer solution was pre-mixed and she got the solution from the dispenser. She stated she would test the effective concentration of the solution by using the test strip and the concentration range should be 200-400 ppm. DA 2 demonstrated how to test the effectiveness of the sanitizer solution. She used the test strip by dipping the sanitizer solution for more than 15 seconds and took it out to compare the color chart (different colors from the chart corresponds to different concentration (ppm) range includes: 0, 150, 200, 400 and 500) on the test strip container. Then she used the same test strip to dip into the solution again. DM confirmed and stated DA 2 should not dip in the solution again and test strip should dip in the solution for 10 seconds. DA 2 stated when she prepared the solution, she usually dipped the test strip in the solution more than 10 seconds because the color would not change. She further stated the solution should be cold. The solution was cold when touch and took the temperature with thermometer with the result was 59.7 degrees Fahrenheit (F). DM verified and stated the solution was fine because it was cold. A concurrent review of the instruction of the test strip container, it stated, .dip paper (test strip) in quat (sanitizer) solution, not from surface, for 10 seconds .testing solution should be between 65-75 degrees F . DM stated he was not aware of the temperature range and would contact the sanitizer vendor to adjust the temperature. A review of facility P&P titled, Quaternary Ammonium Log Policy, dated 2023, indicated, .Read instructions on quaternary container and the test strip for proper concentration length of time the strip needs to be in contact with the solution, and if temperature of the solution is to be considered when testing for concentration .Follow container and test strip instructions. A high concentration may potentially hazardous and may be a chemical contaminate of food. A review of DA 1's employee file, it indicated his date of hire was on 2/28/23 for dietary aide position. Review the job description for dietary aide, it stated the position required food handler's certificate. DA 1's file did not have any certificate. An interview with DM on 3/13/25 at 10:38 a.m., DM confirmed and stated DA 1 did not have any food handler's certificate. A review of DA 2's employee file, it indicated her date of hire was on 2/14/23 for a position as a cook. A review of the job description for a cook, it stated the position required ServSafe (set of training courses for food safety) food handler certificate. DA 2's file did not have any certificate. An interview with DM on 3/13/25 at 10:38 a.m., DM stated D2 should be hired as dietary aide position and not sure why her position changed to be a cook. DM confirmed and stated DA 2 did not have any food handler's certificate. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility documents titled, Verification of Job Competency Demonstration - Diet Aides, for DA 1 and DA 2, both completed for the year of 2024 by DM, indicated DA 1 was competent on Emergency dish washing procedure and when to use it, and DA 2 was competent on How to clean and sanitize equipment, counter top and Sanitizing solution; preparation, test concentration and record results; when to replace solution by demonstration and verbalization. A review of departmental document titled, Food & Nutrition Service In-Service, Topic: Competency Checks Update and Inspection List, completed on 10/28/24 and added on dates of 11/21/24, 12,20/24 and 1/22/25 and given by DM. The document showed DA 1 and DA 2 attended the in-services. There was no individual lesson plans referred to the different competency topics. A concurrent interview with DM on 3/13/25 at 9:22 a. m., DM stated the topic Competency Checks Update and Inspection List was to review everything for the competency subjects to prepare the staff for survey. A review of facility job description titled, Director of Food and Nutrition (DM), dated 2/2018, it stated, . Essential Job Functions .provide .training .oversee that proper levels of cleanliness and sanitation within the department .plan and conduct staff meetings and in-service education programs on dietary policies and procedures .Practice and ensure compliance of infection control policies and procedures of the department and facility .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 40830 Based on observation, interviews, and record review, the facility failed to ensure the planned menu was followed for the therapeutic diets (modified diets from regular diet, tailored to fit the nutritional needs of a particular person - may be part of a treatment or medical condition and usually prescribed by a physician) during lunch on 3/12/25 when: 1. 19 Residents (Resident (3, 4, 5, 7, 22, 29, 33, 35, 47, 52, 56, 63, 66, 68, 75, 79, 82, 291, and 341) with regular portion with regular texture diets got 6 ounces (oz.) (3/4 cup) of pasta instead of 4 oz. (1/2 cup) 2. 11 residents (Resident 19, 23, 24, 30, 32, 36, 44, 57, 60, 72, and 85) with CCHO (Consistent Carbohydrate) diet (a therapeutic diet to manage diabetic disease and/or to stabilize blood sugar level) and CCHO Renal (kidney) diet (a diet to manage chronic kidney disease and diabetic disease) got one serving of dessert (lemon snow bar) and 6 oz. of pasta instead of half (1/2) serving of dessert and 4 oz. of pasta 3. Four residents (Resident 9, 34, 76, and 340) with small portion with diets received one serving of dessert, 6 oz. of pasta and 6 oz. chicken instead of 1/2 serving of dessert, 4 oz. of chicken and 2 oz. (1/4 cup) of pasta 4. Two residents (Resident 17 and 58) with fortified (add extra calories and nutrients) diet (diet designs for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status) did not receive 1/2 oz. of melted margarine on the vegetables 5. Three residents (Resident 14, 65 and 73) with finger food diet did not receive the dessert cut in half 6. 88 out of 88 residents who received meals form the facility kitchen did not receive garnish (food decor to enhance the presentation of meals to help increase appetite) with their lunch meals. These deficient practices had the potential to result in residents having meals which did not meet their nutritional needs and compromising the medical and nutrition status of the 88 residents who consumed meals from the facility kitchen. Findings: During the lunch meal distribution on 3/12/25 beginning at 11:52 a.m., it was noted as followed: Observed there were one kind of serving utensils (6 oz.) for serving chicken and pasta, and a concurrent interview with [NAME] (CK) to confirm both serving sizes were 6 oz. For the dessert (lemon snow bar, one serving measurement: 2 inches long x 2 inches wide x 1/2 inch height), CK stated she prepared only one serving size for all the residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. 19 residents (Resident 3, 4, 5, 7, 22, 29, 33, 35, 47, 52, 56, 63, 66, 68, 75, 79, 82, 291 and 341) with regular portion with regular texture received 6 oz. of pasta. A concurrent review of facility spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) titled, Spring Cycle Menus, Week 2 Wednesday, indicated regular portion with regular texture should receive 1/2 cup (4 oz.) of pasta. 2. 11 residents (Resident 19, 23, 24, 30, 32, 36, 44, 57, 60, 72 and 85) with CCHO and CCHO Renal diet received one serving of dessert and 6 oz. of pasta. A concurrent review of facility spreadsheet titled, Spring Cycle Menus, Week 2 Wednesday, indicated CCHO and CCHO Renal diet should receive 1/2 serving of dessert and 4 oz. of pasta. 3. Four residents (Resident 9, 34, 76 and 340) with small portion with diets got one serving of dessert, 6 oz. of pasta and 6 oz. of chicken. A concurrent review of facility spreadsheet titled, Spring Cycle Menus, Week 2 Wednesday, indicated small portion with diets should receive 1/2 serving of dessert, 2 oz. of pasta and 4 oz. of chicken. 4. Two residents (Resident 17 and 58) with fortified diets did not receive extra 1/2 oz. of melted margarine on the vegetables as fortified food. A concurrent review of facility document titled, Spring 2025 - Week 2, Fortified Breakfast, Fortified Lunch, Fortified Dinner, indicated fortified diet should give extra 1/2 oz. of melted margarine on the vegetables for lunch 3/12/25. 5. Three residents (Resident 14, 65 and 73) with Finger Food diet receive one whole piece of dessert. A concurrent review of facility spreadsheet titled, Spring Cycle Menus, Week 2 Wednesday, indicated finger food diet should receive one serving of dessert cut in half. 6. 88 out of 88 residents who received lunch meals from facility kitchen did not get parsley garnish. A concurrent review of facility spreadsheet titled, Spring Cycle Menus, Week 2 Wednesday, indicated all diets should have received parsley garnish. An interview with Dietary Manager (DM) and a concurrent review of the spreadsheet on 3/12/25 at 1:19 p.m. was conducted. DM acknowledged and confirmed the issues found during the meal distribution. He stated his expectation for the staff should be accurate for the portion measurement of the food, and they should follow the menu or spreadsheet according to the therapeutic diets. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Registered Dietitian (RD) on 3/13/25 at 12:27 p.m., RD acknowledged issues that were found during the meal distribution on 3/12/25. RD stated the staff should follow the menu and spreadsheet because it would provide the correct portions for the according therapeutics diets. She further explained especially for CCHO diet, the portion sizes were to control blood sugar level. RD stated if the portion sizes are not being followed would lead to over- or under- nutrition. She explained the fortified foods provided extra calories for the residents had weight loss or to stabilize weight. RD further stated the finger foods were given for the residents with mobility issues and helped them to maintain independence during eating. A review of the facility's policy and procedure titled, Menu Planning dated 2023, it indicated, .menus are planned to meet nutritional needs of residents in accordance with established national guidelines .the facility's diet manual and diets are ordered by the physician should mirror the nutritional care provided by the facility .menus are written for regular and therapeutic diets in compliance with the diet manual . A review of facility document titled, Job description, Cook, dated 10/2016, indicated the cook was to follow prepared menus and portion control guides .prepare special diets accurately .make the presentation of the food appealing to the residents .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40830 Based on observation, interview and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food serve in a safety manner when: 1. Various sizes of metal pans were found having issues stored in the clean and ready-to-use storage areas: - Stacked wet - Were not clean with food particles 2. The storage areas for storing the clean and ready-to-use metal pans were not clean 3. The blade of the can opener was not well maintained 4. Dietary Aide (DA) 1 was not able to verbalize the process of manual dishwashing by 2-compartment sink 5. DA 2 was not able to perform cleaning and sanitizing procedure correctly for the soiled food contact surface areas 6. DA 2 was not able to verbalize and demonstrate the correct procedure to prepare and test the sanitizer solution for the red bucket (red color-coded bucket is used as a standard of practice to contain sanitizer solution) 7. DA 3 did not have the hair restraint fully cover the hair 8. There were issues found for the resident's refrigerator: - Residents' food did not label and date properly - Outdated food did not discard in the freezer - The interior of the refrigerator was not clean These failures had potential to cause food-borne illness in a highly susceptible population of 88 out of 88 residents who received food from the facility kitchen. Findings: 1. During a concurrent observation and interview on [DATE] at 8:23 a.m. with Dietary Manager (DM), DM confirmed the following items were stack wet and had food particles stored in the clean and ready-to-use storage areas: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- five of full sheet metal pans (stacked wet; 4 out of 5 had red and white particles) - one of ,d+[DATE] sheet metal pan (had red particles) - 10 of ,d+[DATE] sheet metal pans (stacked wet) - 11 of ,d+[DATE] sheet metal pans (stacked wet) DM stated the dishes, pans and pots should be completely dried and clean before stored away. He further stated the staff who put away the dishes should check if they were clean and dried before stored away. During an interview with Registered Dietitian (RD) on [DATE] at 12:27 p.m., RD stated the dishes, pans and pots should be clean and air-dried before stored away. A review of facility policy and procedure (P&P) titled, Dishwashing, dated 2023, indicated, .Dishes are to be air dried in racks before stacking and storing . A review of facility P&P titled, Sanitation, dated 2023, indicated, .all utensils .shall be kept clean, maintained in good repair . 2. During an inspection of the condition of the metal sheet pans stored at the storage areas at [DATE] at 8:46 a.m., it was noted the storage areas (the areas used for storing clean and ready-to-use metal sheet pans) were not clean with particles on them. A concurrent interview with DM, DM confirmed and stated the particles were food debris. He further stated the storage areas should be clean, and the staff usually clean them daily. During an interview with RD on [DATE] at 12:27 p.m., RD stated the storage areas for storing dishes, pans and pots should be clean. A review of facility P&P titled, Sanitation, dated 2023, indicated, .all .counters, shelves .shall be kept clean, maintained in good repair . 3. During a kitchen inspection and a concurrent interview of DM on [DATE] at 10:45 a.m., it was noted the blade of can opener with discoloration and the blade surface was chipped. DM confirmed and stated the blade was chipping away and needed replacement. He further stated it was one of the findings during the facility internal inspection. A review of facility P&P titled, Can Opener and Base, dated 2023, indicated, Proper sanitation and maintenance of the can opener .is important to sanitary food preparation. Metal shavings and shredding can result from a dull cutting blade or worn out cogwheel .Replace blade on can opener, as needed . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During an interview on [DATE] at 8:57 a.m. with Dietary Aide (DA) 1, DA 1 stated if the dishwashing machine was not functioning, he would switch to manual dishwashing with 2-compartment sink. DA 1 stated the steps were washing, rinsing and air-dried. He stated No when asked if he was missing a step. A concurrent interview with DM, DM verified and stated the correct process were washing, rinsing, sanitizing and air-dried. DM stated they had a big tub worked as third compartment filled with sanitizer solution for sanitizing step. Asked DA 1 how long the dishes should immerse in the sanitizer after the rinsing step, and he stated 5 to 10 minutes. DA 1 stated he did not know the effective concentration for the sanitizer was when asked. DM cued DA 1 to read the instruction posted on the wall and DM stated the concentration should be at the range of ,d+[DATE] ppm (parts per million - a measurement unit for the sanitizer solution). During an interview with RD on [DATE] at 12:27 p.m., RD stated the dietary staff should have a good knowledge about the manual dishwashing process especially there was an emergency like out of power. A review of facility P&P titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, indicated the process involved washing, rinsing, sanitizing, and air-dried, and .sanitizer solution .must read ,d+[DATE] ppm .immerse all washed items (in the sanitizer solution) for at least 1 minute (60 seconds) . 5. During a confirmation with DM regarding the storage areas for clean metal pans was not clean with food debris on [DATE] at 8:34 a.m., observed DA 2 used a towel to wipe the storage areas. DA 2 stated she used the towel from the red bucket (bucket contained sanitizer solution) to clean the storage areas. During an interview with DM on [DATE] at 8:45 a.m., DM confirmed DA 2 used the sanitizer to clean the dirty storage areas. He stated the procedure was to sanitize and clean when the food contact surfaces were soiled. Then he switched answer to the correct procedure should be first to clean with soap and water, and then using the sanitizer to sanitize. DM further stated DA 2 did not performed the procedure correctly. A review of department document titled, Inservice: Cleaning and Sanitizing Dishes, Utensils, Pots and Pans, dated ,d+[DATE], indicated, .cleaning and sanitizing of .food contact surfaces .food storage areas are vital in keeping food wholesome and safe to consume .Cleaning is the removal of soils, tarnishes, or stains . Sanitizing is the process of reducing the number of microorganisms on the surface to safe levels so that they cannot cause disease or food spoilage .to be effective, cleaning and sanitizing must be a two-step process. Surface must first be (1) cleaned and rinsed before (2) being sanitized .any surface that comes in contact with food much also be cleaned and sanitized . 6. During an interview with DA 2 on [DATE] at 8:34 a.m., DA 2 verbalized the process to prepare and test the sanitizer solution for the red bucket. DA 2 stated she got the pre-mixed sanitizer solution from the dispenser and then used the test strip to test the effective concentration and stated it should be at ,d+[DATE] ppm. DA 2 demonstrated to use the test strip by dipping the sanitizer solution for more than 15 seconds and took it out to compare the color chart (different colors from the chart corresponds to different concentration (ppm) range includes: 0, 150, 200, 400 and 500) on the test strip container. Then she used the same test strip to dip in the sanitizer solution again. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A concurrent confirmation with DM and he stated DA 2 should not dip in the solution again and the test strip should dip in the solution for 10 seconds. DA 2 stated when preparing the sanitizer solution, she usually dipped the test strip for more than 10 seconds because the color would not change. She stated the solution should be cold. The solution was cold when touched and then took the temperature with thermometer and it read 59.7 degrees Fahrenheit (F). DM verified and stated the sanitizer solution should be cold and stated 59.7 degrees F was fine. A concurrent review of the instruction on the test strip container, and it stated, .dip paper (test strip) in quat (sanitizer) solution, not from surface, for 10 seconds .testing solution should be between ,d+[DATE] degrees F . DM stated he was not aware of the temperature range of the sanitizer solution, and he would contact the sanitizer vendor to adjust the temperature. A review of facility P&P titled, Quaternary Ammonium Log Policy, dated 2023, indicated, .Read instructions on quaternary container and the test strip for proper concentration length of time the strip needs to be in contact with the solution, and if temperature of the solution is to be considered when testing for concentration .Follow container and test strip instructions. A high concentration may potentially hazardous and may be a chemical contaminate of food. 7. During a kitchen inspection tour on [DATE] at 10:55 a.m., it was noted DA 3 had a cap on (without any hairnet under the cap) but did not completely cover all his hair. Observed the back of his hair and the side burns on both sides extending outside the cap. A concurrent confirmation with DM and he agreed DA 3's cap did not cover all his hair. DM stated DA 3 should put the hairnet on to completely cover his hair before putting his cap on. A review of facility P&P titled, Dress Code, dated 2023, indicated, .Hat for hair, if hair is short, which completely covers the hair .Hair net for hair, if hair is long (over the ears or longer) . 8. An observation and a concurrent interview with Licensed Vocation Nurse (LVN) 1 regarding the resident's food refrigerator located at nurse station on [DATE] at 2:41 p.m. was conducted. It was noted there were issues found as followed: - The interior of the refrigerator was not clean with dry liquid spills on the bottom of shelf (confirmed with LVN 1 and stated it was dirty) - An opened bag of individual wrapped ice cream cups in the freezer (confirmed with LVN 1 and stated it had no name and received date and should discard) - An opened box of individual wrapped ice cream sandwiches in the freezer (confirmed with LVN 1 and stated it had no resident's name and the manufacture's expired date of [DATE] and should discard) - A tub of chocolate ice cream in the freezer (confirmed with LVN 1 and stated it had resident's name but no received date, stated should discard) - A bag with a popsicle in the freezer (confirmed with LVN 1 and stated it had name but no received date, should discard) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A half-drank drink in paper cup in the freezer (confirmed with LVN 1 and stated it had name but no received date, and needed to be discarded) LVN 1 stated the nurses were responsible to monitor temperature and food of the refrigerator. She further stated the nurses who monitor the refrigerator also responsible to clean the refrigerator. She stated there was no set schedule for the refrigerator to be clean. LVN 1 explained the process of when they received food from the residents' families or visitors, the nurses should label the food with resident's name and received date, and the food would be discarded on the third day from the received date and it also applied to the frozen food. During an interview with LVN 2 on [DATE] at 2:29 p.m., LVN 2 stated the process of receiving food from the family or visitor. He stated the nurses usually put the label on the food with resident's name, room number and received date. LVN 2 stated the food could keep in the refrigerator for three days. He stated he was the PM (post meridiem-after midday) nurse and responsible to monitor the refrigerator at PM shift. He further stated the nurses who monitor the refrigerator also responsible to clean the refrigerator. He stated the housekeeping sometimes would clean the refrigerator too but not sure how often. During an interview with housekeeping (HK) on [DATE] at 3:05 p.m., HK stated housekeeping was not responsible to clean the resident's food refrigerator. During an interview with Director of Nursing (DON) on [DATE] at 3:15 p.m., DON acknowledged the issues found in the resident's food refrigerator. DON stated she was not sure how often the resident's food refrigerator getting clean by the nurses. She further stated may be once a week and deep clean every three months. A review of facility P&P titled, Foods Brought by Family/Visitors, revised ,d+[DATE], indicated, .Perishable foods are stored in re-sealed containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the room number and the use by date .Perishable foods .may be refrigerated for up to 3 days, then will be discarded by staff . A review of facility P&P titled, Refrigerators and Freezers, revised ,d+[DATE], indicated, .Supervisors are responsible for ensuring food items in .refrigerators, and freezers are not past use by or expiration dates . Refrigerators and freezers are kept clean, free of debris, and disinfected with sanitizing by designated staff .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44946 Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were implemented when: 1. Oxygen tubing was on the floor for Resident 18, Resident 12 and Resident 36. 2. Resident 10's urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) tubing was dragging on the floor while on the wheelchair. 3. Tube feeding formula was left uncapped and open to air while disconnected from Resident 45. These failures had the potential to compromise resident's health and safety, and potentially lead to the spread of communicable illnesses. Findings: 1. During a review of Resident 18's Admission Record (AR), the AR indicated, Resident 18 was admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease with acute exacerbation (COPD-a chronic lung disease causing difficulty in breathing), acute respiratory failure with hypoxia (when lungs suddenly can't get enough oxygen into the blood) and asthma (condition in which airways narrow and swell). During a review of Resident 18's Order Summary Report (OSR), printed on 3/12/25, the OSR indicated, Resident 18 had an order for oxygen at 2 liters (unit of measurement) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) every 8 hours as needed for SOB (shortness of breath), chest pain, O2 sat (oxygen saturation-measurement of how much oxygen the blood is carrying as a percentage); Notify MD if O2 sat <90%. During a review of Resident 12's AR, the AR indicated, Resident 12 was admitted on [DATE] with diagnoses which included acute respiratory failure with hypercapnia (condition that occurs when the lungs can't get rid of enough carbon dioxide from the blood) and COPD. During a review of Resident 12's OSR, printed on 3/12/25, the OSR indicated, Resident 12 had an order for continuous O2 (oxygen) at 4 LPM (liters per minute) via nasal cannula to maintain O2 sat >90%. During a review of Resident 36's AR, the AR indicated, Resident 36 was admitted on [DATE] with diagnoses which included acute and chronic respiratory failure with hypoxia and pleural effusion (buildup of fluid between the tissues that line the lungs and the chest). During a review of Resident 36's OSR, printed on 3/14/25, the OSR indicated, Resident 36 had an order oxygen at 2 L/Min via nasal cannula routine/continuous. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/11/25 at 8:41 a.m. with Licensed Nurse (LN) 1 in Resident 36's room, Resident 36 was lying on the bed with oxygen in use, and the oxygen tubing was touching the floor. LN 1 confirmed that the oxygen tubing was on the floor and stated it should not be touching the floor due to infection control and safety concerns. During a concurrent observation and interview on 3/11/25 at 9:08 a.m. with LN 6 in Resident 12's room, Resident 12 was lying on the bed with oxygen in use, LN 6 confirmed that the oxygen tubing was on the floor. During a concurrent observation and interview on 3/11/24 at 9:40 a.m. with Director of Nursing (DON) in Resident 18's room, Resident 18 was sitting up on bed with oxygen in use, DON confirmed the oxygen tubing was on the floor and should not be touching the floor due to infection control concerns. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items, Surfaces and Equipment, dated October 2021, the P&P indicated, Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g. respiratory therapy equipment) . such devices should be free from all microorganisms . 2. During a review of Resident 10's AR, the AR indicated, Resident 10 was admitted on [DATE] with diagnoses which included acute pyelonephritis (bacterial infection causing inflammation of kidneys, a complication of an ascending urinary tract infection), uterovaginal prolapse (the womb or other pelvic organs dropping down and pressing into the vaginal area), neuromuscular dysfunction of the bladder (the nerves and muscles that control urination aren't working properly), acute cystitis without hematuria (sudden bladder infection that's not causing blood in urine). During a review of Resident 10's OSR, printed on 3/12/25, the OSR indicated Resident 10 had an order for Foley catheter (a type of urinary catheter) Fr 16 (French 16-size of catheter) vol (volume) 10. During a concurrent observation and interview on 3/11/25 at 12:26 p.m., with LN 3 in the dining room, Resident 10 was wheeling herself in the wheelchair. LN 3 confirmed the catheter tubing was dragging on the floor and stated that it should not be touching the floor due to infection control concerns. During a concurrent observation and interview on 3/11/25 at 12:28 p.m., with DON in the nursing station, Resident 10 was in front of the nursing station when the DON checked the catheter tubing and confirmed it was touching the floor. The DON stated that the expectation is for the catheter tubing not to drag on the floor. During an interview on 3/12/25 at 1:00 p.m., with DON, DON stated the expectation is for oxygen tubing and catheter tubing not to touch the floor and that they follow standard nursing practices for infection control. During an interview on 3/13/25 at 10:57 a.m., with Infection Preventionist (IP), IP stated that oxygen and catheter tubing should be kept off the floor because touching the floor increases the risk of contamination and the floor can be a source of bacteria. (continued on next page)

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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 concurrent interview and record review on 3/14/25 at 8:49 a.m., with IP, the facility's P&P titled, Indwelling Catheters, dated September 2021 was reviewed. The P&P indicated, Be sure catheter tubing and drainage bag are kept off the floor. IP confirmed that this is the policy in her infection control binder and is the policy she uses to teach staff about infection control practices for urinary catheters. 50517 3. During a review of Resident 45's AR, the AR indicated, Resident 45 was admitted [DATE] with diagnoses including malignant neoplasm (cancerous/ abnormal growth tissue) lower third of esophagus (muscular tube through which food passes from the throat to the stomach), artificial opening of gastrointestinal tract (feeding tube placement). During a review of Resident 45's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated, 1/16/25 indicated Resident 45 had mild cognition impairment. Resident 45's Physician Orders indicated, NPO (nothing by mouth), and Enteral feeding (tube feeding), continuous. During a review of Resident 45's care plan, dated 1/9/25 indicated, resident will not have any complications with feeding tube. The care plan interventions indicated, observe signs and symptoms of infection. During a concurrent observation and interview on, 3/11/25 at 12:30 p.m., in Resident 45's room, Resident 45 arrived from physical therapy with tube feeding disconnected. Feeding formula (liquified food) was observed hanging on feeding tube pole, with tubing left hanging from pole uncapped and was open to air. LN 4 confirmed that the tubing was left uncapped and stated, leaving a tube feeding formula open to air can lead to a potential infection and contamination especially for residents who are vulnerable. During a review of the facility's P&P titled, Enteral Feedings, reviewed August 2024, indicated, .preventing contamination maintain aseptic technique use closed enteral nutrition systems when possible. During a review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care items, Surfaces and Equipment, revised October 2021 indicated, Critical items consist of items that carry a high risk of infection if contaminated with any microorganism . Objects that enter sterile tissue or vascular system are considered critical items .