STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555371	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Care Center	1405 Teresa Dr Morro Bay, CA 93442

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 46000 Based on interview and record review, the facility failed to ensure language assistance services were provided for one of 18 sampled residents (Resident 36), whose primary language is Farsi. This failure had the potential to violate Resident 36's right to be fully informed, in a language he could understand, and make decisions about his medical condition. Findings: During a review of Resident 36's admission Minimum Data Set (MDS - a standardized assessment tool that measures health status in nursing home residents) the MDS Section A dated 8/20/24 indicated Language, Farsi. During an interview on 11/13/24 at 10:33 a.m. with Licensed Nurse (LN) 2, LN 2 acknowledged Resident 36's primary language is Farsi. LN 2 indicated the facility does not have language assistance services for staff to use to communicate with Resident 36. During a review of Resident 36's care plan (CP- a document that summarizes how a patient's needs will be met, and their care will be managed)) titled Communication dated 8/13/24, the CP indicated Sometimes understood in ability to express ideas and wants. Farsi is his primary language. During an interview on 11/13/24 at 10:35 a.m. with the facility's Director of Nursing (DON), the DON acknowledged Resident 36's primary language is Farsi. DON confirmed the facility does not have language interpretation or translation services for nursing staff to use to communicate with Resident 36 in Farsi. DON stated, We don't have a translation service. The facility was not able to provide a policy & procedure (P&P) to indicate a process was in place for staff to communicate with residents who have limited English proficiency.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48380 Based on observation, interview, and record review the facility failed to ensure two of 18 sampled residents (Resident 39 and Resident 40) had their call light within reach. These failures had the potential to result in residents not being assisted timely and had the potential to affect their psychosocial and personal hygiene needs. Findings: During an observation on 11/12/24 at 11:19 a.m. in Resident 39's room, Resident 39's call light was found on the floor. Resident 39 was not able to reach or see the call light. During an observation on 11/12/24 at 2:10 p.m. in Resident 40's room, Resident 40's call light was not placed within reach and was observed over the nightstand. During an observation on 11/12/24 at 3:30 p.m. Resident 40's call light was still over the nightstand and not placed within Resident 40's reach. During an observation on 11/13/24 at 10:04 a.m. in Resident 39's room, Resident 39's call light was found dangling from Residents 39's bed and was not within reach. During a concurrent observation and interview on 11/13/24 at 10:10 a.m. with a Certified Nursing Assistant (CNA 2), at Resident 39's bedside, CNA 2 stated, the call light should be within resident's reach, not on the floor and not dangling from the bed. During a concurrent interview and record review on 11/14/24 at 11:00 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Emergency Electrical Power System undated, was reviewed. The P&P indicated in part .The nurse's station is equipped to receive resident calls through a communication system from resident rooms .The system is in operating order . shall be readily accessible to residents at all times. The system is accessible to residents while in their bed. The DON agreed call lights should not be on the floor, dangling from the bed or out of resident's reach.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46000 Based on observation and interview the facility failed to ensure expired medications were not stored and available for use. This failure had the potential for unsafe and ineffective medication administration to residents. Findings: During a concurrent observation and interview with Licensed Nurse (LN1) on 11/12/24 at 11:15 a.m., in the B-Hall Nurse Station 1 there was a meedication storage room refrigerator. A box containing five vials of Engerix-B(R) Hepatitis B (a liver infection) Vaccine (safe and effective way to protecting people from harmful diseases) (protects against hepatitis B, a liver infection caused by the hepatitis B virus), 20 mcg/mL (microgram/milliliter - unit of measure) with was observed with an expiration date of 8/24/24. LN 1 acknowledged the expiration date and stated, It should be discarded. During an interview on 11/12/24 at 12:15 p.m. with Director of Nursing (DON), the DON confirmed the five vials of Engerix-B(R) Hepatitis B Vaccine were expired and should be discarded. During a review of the facility's policy and procedure (P&P) titled, Disposal of Medications, undated, the P&P indicated, Outdated medications, contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50132 Based on observation, interview, and record review the facility failed to ensure pureed food was prepared by methods that conserved nutritive value, flavor, and was palatable. This failure resulted in lack of flavor and palatability in pureed foods and has the potential for the eight residents on a pureed diet to have a decreased food intake which can further compromise the nutrition and medical status. Findings: During a concurrent observation and interview on 11/13/2024 at 10:13 a.m. in the kitchen, [NAME] (CK) 1 was observed making pureed chicken for eight residents. CK 1 stated that chicken had been cooked with tarragon and paprika. CK1 was observed placing approximately 5 cups of cooked chicken into a blender then added hot water to the fill the contents to the top of the blender to total 8 cups. CK1 then blended the chicken and poured contents into a large bowl. CK1 added an unmeasured amount of thickener three times to reach a mashed potato like consistency. CK1 then placed pureed food into oven to keep warm until tray line. During an observation on 11/13/2024 at 10:31 a.m. in the kitchen, CK1 was observed making pureed orzo by adding 4.5 cups of orzo to blender then adding 8 cups of water. CK1 then blended the mixture, poured mixture into a large bowl and added an unmeasured amount of thickener three times to reach a mashed potato like consistency. During an interview on 11/13/2024 at 12:26 p.m. in Hall D/C a regular diet and pureed diet test tray was tasted with Dietary Manager (DM). Food temperature was adequate. DM acknowledged that the pureed diet was not as flavorful as the regular foods. DM stated that orzo in the pureed diet did not have the green herbs that the regular food tray did. DM stated that maybe the seasoning was added later to the regular food that were not added to the pureed food. The pureed spinach was more gelatin like. DM acknowledged and confirmed the pureed spinach was more gelatin-like, pasty, and very thick. During a review of the recipes titled Spinach Sauteed with Garlic (fresh), Orzo Lemon Herb, and Chicken Greek [3] (thigh), dated 11/13/2024, the menu indicated in part, IDDSI Level 4 -Pureed: Measure desired # of servings into a food processor. Blend until smooth. Use the Fork Drip Test and the Spoon Tilt Test to confirm texture is within IDDSI Level 4 specifications. It also showed for any of the modified texture diets to, Add small amounts of gravy, sauce, vegetable juice, cooking water, fruit juice, milk or half and half to meet desired consistency and to add commercial thickener if product needs thickening. During an interview with the Dietary Manager (DM) on 11/13/2024 at 4:24 p.m., in the kitchen, the DM stated that the cooks do not usually do the fork drip or spoon tilt test to check or determine if the recipe consistency was prepared properly. DM stated that they usually do visual observation because they have been doing it for so long. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Registered Dietitian (RD) on 11/14/24 at 9:24 a.m., RD stated when foods are pureed, and the cook uses that much water then can dilute food and that would change flavor with so much water and food thickener. RD stated food for puree menu items should be prepared and seasoned like the regular food items. RD acknowledged that less water and thickener is better and would taste better. RD stated expect staff to follow recipes and recipes for puree. RD stated residents on puree already can have more concerns or not able to speak for themselves. RD stated she does not do any of the fork or spoon tests for puree foods on any of the audits that she does. RD stated puree foods can be looked more closely on how they are preparing the puree foods.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 50132 Based on observation, interview, and record review the facility failed to ensure resident preferences were accommodated on meal trays for three of 18 sampled residents (Resident 18, 27, and 63). This failure has the potential to result in residents not having their food preferences met. Findings: During a lunch meal observation and a concurrent review of Resident 18's lunch meal tray ticket, and concurrent interview with a Dietary Aide (DA3) on 11/12/24 at 12:21 p.m. in the kitchen, the try ticket showed, **NO SOUP SPOONS ON TRAY***. Upon observation one soup spoon and one regular tablespoon were located on Resident 18's meal tray. When the cart was ready to leave the kitchen, DA3 was asked about the spoon and stated, Oh no and took it off the tray. During a lunch meal observation on 11/12/24 at 12:35 p.m. in the kitchen, the lunch tray ticket showed Resident 63 had requeseted a Peanut Butter (Packet)*. There was no peanut butter packet on the lunch tray. During a lunch meal observation on 11/12/24 at 12:37 p.m. in the kitchen, Resident 27's lunch meal tray ticket showed a request for three packets of salt. An observation of the lunch tray showed only one packet of salt was located on the lunch tray. During an interview on 11/12/24 at 12:39 p.m. in the kitchen with DA3, DA3 reviewed the lunch tray cart and the meal tickets and confirmed the peanut butter was missing on Resident 63's meal tray that should be there and there needed to be two more salt packets added to Resident 27's meal tray. During an interview on 11/14/24 at 9:23 a.m. with the Registered Dietitian (RD), RD stated that she would expect kitchen staff to read the meal tickets and if preferences listed on the meal ticket, then it is important to have it done correctly. RD stated she expects kitchen staff to follow what is written on the meal tickets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50132 Based on observation, interview, and review of facility documents, the facility failed to ensure food and ice were stored, prepared, and served in accordance with professional standards for food service safety when: 1. Facial hair coverings were not worn during food preparation; 2. One ice machine contained a brownish pink substance on the censor on the metal grate where ice is formed; and 3. There was lack of an air gap for one of the ice machines located in central supply room. This failure has the potential to result in the growth of microorganisms that can cause foodborne illness to residents. Findings: 1. During an observation on 11/12/2024 at 12:28 p.m. in the kitchen, Diet Aid (DA) 2 was seen putting cold items from the reach in refrigerator onto lunch trays. DA2 was wearing a blue surgical mask. Facial hair was seen outside of the surgical mask on both sides of the face that was uncovered. During an observation on 11/12/2024 at 3:54 p.m. in the kitchen, DA2 was preparing dinner trays. DA2 was placing silverware, condiments, and desserts on meal trays. DA2 had facial hair uncovered. During a concurrent observation and interview on 11/13/2024 at 2:55 p.m. in the kitchen, DA 1 was making salad. DA1 had facial hair uncovered. During an observation on 11/14/2024 at 9:22 a.m. in the kitchen, [NAME] (CK) 1 was at stove cooking food with no facial hair covering. During an observation on 11/14/2024 at 10:44 a.m. in the kitchen, CK1 was preparing food. [NAME] restraint was noted around chin. Hair above upper lip was exposed and not covered. During an observation on 11/14/2024 at 10:58 a.m. in the kitchen, DA1 was pouring tomato juice into cups and facial hair was uncovered. During an interview on 11/14/2024 at 11:49 a.m. with RD, RD stated her expectation is that any and all facial hair should be covered while in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facilities policy and procedure (P&P) titled, Employee Sanitary Practices, dated 2022, the P&P indicated in part, All food and nutrition services employees will practice good personal hygiene and safe food handling procedures. All employees will: Wear hair restraints (hairnet, hat, and/or beard restraints) to prevent hair from contacting exposed food. This does not apply to employees who have a totally shaved or bald head. If face coverings or mask are required to be worn during work hours, nose and mouth must be securely covered. Hands are to be washed before putting on a mask and after disposing of it. If masks are touched or adjusted during the shift, hands must be washed immediately after. 2. During a concurrent observation and interview on 11/13/2024 at 2:37 p.m., Certified Nurse Assistant (CNA) 4 was filling a water pitcher with ice from the ice machine in the central supply room for two resident's. CNA4 confirmed she was using the ice for the residents. During a concurrent observation and interview on 11/13/2024 at 2:46 p.m. in the central supply room with the Maintenance Supervisor (MS) and Maintenance Worker (MW) the ice machine cleaning process was reviewed. MW stated that the ice machine was cleaned three weeks prior. MW removed the upper cover. On the metal grate was a censor that had brownish pink substance around sides. When wiped with a white paper towel the substance came off. MS acknowledged that there was substance located on the censor. 3. During a concurrent observation and interview starting at 11/13/2024 at 2:46 p.m. with MS, the floor sink/drain next to the ice machine where there were pipes going into it and there was no air gap present. MS acknowledged the pipes were down in the floor drain/sink and no air gap was present. During a review of FDA's (Food and Drug Administration), Food Code 2022, Section 5-202.13 Backflow Prevention, Air Gap, The FDA Food Code indicated, An air gap between the water supply inlet and the flood level rim of the plumbing, fixture, equipment or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). In, Section 5-203.14 Backflow Prevention Device, the FDA Food Code indicated, A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT, including on a hose [NAME] if a hose is attached or on a hose [NAME] if a hose is not attached and backflow prevention is required by LAW, by: (A) Providing an air gap .; or (B) Installing an APPROVED backflow prevention device. (Air gap: An air gap refers to a fixture that provides back-flow prevention. When installed and maintained properly, the air gap works to prevents drain water from backing up into the equipment and possibly contaminating the area used. An air gap is a way to make certain wastewater and contaminants never re-enter the clean water supply.)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49405 Based on observation, interview, and record review the facility failed to implement transmission-based precautions (actions to control how infection is spread) for one of 18 sampled residents (Resident 446) when the facility staff did not implement their Policy and Procedure (P&P) titled, Enhanced Barrier Precautions. This failure placed Resident 18 at an increased risk of acquiring an infection due to their medical condition. Findings: During a tour of facility on 11/13/24 at 10:30 a.m. it was observed that there was no Personal Protective Equipment outside of room [ROOM NUMBER] and there was no sign stating Enhanced Barrier Precautions (EBP) on the wall or door to Patient 446's room. During a concurrent interview and record review on 11/13/24 at 10:42 a.m., with Licensed Nurse (LN4), Patient 446's medical record was reviewed. The medical record indicated Resident 446 was ordered for EBP. LN4 confirmed that Resident 446 had an order for EBP due to an indwelling medical device and acknowledged that Resident 446 should be on EBP precautions. LN4 confirmed that there was not an EBP sign on the wall or door of Resident 466's room. LN4 stated there should be a sign alerting staff to EBP per facility policy. During a review of the facility policy and procedure (P&P) titled, Enhanced Barrier Precautions dated 08/2022, the P&P indicated, 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization . 10. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. 11. PPE is available outside of the resident rooms.