STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555445	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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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 0557 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on interview, medical record, and facility P&P review, the facility failed to ensure the personal belongings were properly recorded at discharge for one of three closed record review sampled residents (Resident 76). This failure had the potential for the residents' personal belongings being lost. Findings: Review of the facility's P&P titled Release of a Resident's Personal Belongings revised 3/2017 showed the facility protects the personal belongings of a resident who has been transferred or discharged from our facility. Personal belongings of a resident who is temporarily transferred or discharged from the facility will be inventoried and stored by the facility until the resident has returned or such items have been picked up by the resident's representative. Individuals receiving the resident's personal belongings will be required to sign a release for such items. Review of the facility's P&P titled Discharging Resident revised 12/2016 showed the facility should reassure the resident all his or her personal effects will be taken to his or her place of residence. Closed medical record review for Resident 76 was conducted on 05/31/24 at 1436 hours. Resident 76 was admitted to the facility on [DATE], and transferred to the acute care hospital on 3/12/24. On 05/31/24 at 1436 hours, closed medical record review and concurrent interview was conducted with RN 1 for Resident 76. Review of Resident 76's Resident's Clothing and Possessions Form dated 3/9/24, showed Resident 76 had the following items: two coins, $11.00 in cash, one pink lighter, and one red pocketknife. However, under the Discharge section, the dates and signatures of the resident/responsible party and nurse releasing the belongings were completely blank. The form failed to show Resident 76's personal belongings were returned upon discharge. RN 1 acknowledged and verified Resident 76's Resident's Clothing and Possessions Form was not filled out by the resident/responsible party and nurse prior to Resident 76's discharge from the facility. RN 1 stated Resident 76's belongings were given to Resident 76, but the discharge section of the form should have been filled out and given to the resident for verification.

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the needs of two of 22 final sampled residents (Residents 3 and 115). * The facility failed to ensure Residents 115's call light and remote control for the bed were within resident's reach. * The facility failed to ensure Resident 3's call light was within the resident's reach. These failures had the potential to negatively impact the residents' psychosocial well-being or result in a delay to receive care. Findings: Review of the facility's undated P&P titled Answering Call Light showed to ensure timely responses to the resident's requests and needs and ensure the call light is accessible to the resident when in bed, from toilet, from shower or bathing facility and from the floor. 1. On 5/28/24 at 0843 hours, during the initial tour of the facility, Resident 115's call light and bed remote control were observed to be hanging on the bedside drawer handle that was not within the resident's reach. Resident 115 was observed to be sleeping during the initial tour. Medical record review for Resident 115 was initiated on 5/28/24. Resident 115 was admitted to the facility on [DATE], and readmitted on [DATE]. On 5/28/24 at 0849 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified Resident 115's call light and bed remote control should not have been hanging on the bedside drawer handle and should have been placed on Resident 115's bed within the resident's reach. 48844 2. On 5/28/24 at 0904 hours, during the initial tour of the facility, Resident 3 was observed in bed with eyes closed. Resident 3's call light was observed on the floor. LVN 4 verified the observation and stated Resident 3 would not be able to reach the call light if it was on the floor. On 5/29/24 at 0916 hours, Resident 3 was observed sitting on the bed. Resident 3's call light was observed on the floor. The DON verified the observation and stated Resident 3 will not be able to reach the call light if it was on the floor. Cross reference to F880, example #2.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to notify the resident's representatives of the transfer and reasons for the transfer to the acute care hospital in writing and send a copy of the notice of transfer to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for one of two sampled residents (Resident 19) reviewed for hospitalization . This failure posed the risk of the resident's representatives not being aware of their appeal rights and the Ombudsman not being aware of the circumstances of the resident's transfer/discharge should an appeal be filed or requested by the resident or their representatives regarding the transfer. Findings: Review of the facility's P&P titled Transfer or Discharge, Facility Initiated dated 10/2022 showed the resident and representative are notified in writing of the following information: a. The specific reason for transfer or discharge, including the basis; b. The effective date of transfer or discharge; c. The specific location to which the resident is being transferred or discharged ; d. An explanation of the resident's right to appeal the transfer or discharge to the state, including: 1. the name, address, email, and telephone number of the entity which receives such appeal hearing requests; 2. information about how to obtain an appeal form; and 3. how to get assistance in completing and submitting the appeal hearing request. e. The Notice of Facility Bed Hold and policies; f. The name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. Medical record review for Resident 19 was initiated on 5/30/24. Resident 19 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 19's H&P examination dated 3/19/24, showed Resident 19 had no capacity to understand and make decisions. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 19's Physician Orders showed the orders dated 2/24 and 3/10/24, to transfer the resident to the acute care hospital. Further review of Resident 19's medical record failed to show the written notifications of transfer/discharge for the above dates were provided to the resident's representative. In addition, Resident 19's medical record failed to show the copy of the written notices of transfer/discharge was sent to the LTC Ombudsman. On 5/30/24 at 1151 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 19 was transferred to the acute care hospital on 2/24 and 3/10/24. On 5/31/24 at 0854 hours, an interview and concurrent medical record review was conducted with the MRD. The MRD verified the physician's orders for Resident 19's transfer to the acute care hospital on 2/24 and 3/10/24. The MRD also verified Resident 19's medical record failed to show the written notification of transfer and discharge to the resident's representatives. The MRD stated it was the Medical Records Department's responsibility to send the notice of transfer or discharge to the resident's representatives; however, the MRD was not able to send the written notices for the transfer dates identified.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident or the resident's representative was provided a written bed hold policy upon transfer to the acute care hospital for one of two sampled residents (Resident 19) reviewed for hospitalization . This failure had the potential for the resident or the resident's representative to not be informed of their rights to return to the facility following a hospitalization . Findings: Review of the facility's P&P titled Transfer or Discharge, Facility Initiated dated 10/2022 showed the resident and representative are notified in writing of the following information: a. The specific reason for transfer or discharge, including the basis; b. The effective date of transfer or discharge; c. The specific location to which the resident is being transferred or discharged ; d. An explanation of the resident's right to appeal the transfer or discharge to the state, including: 1. the name, address, email, and telephone number of the entity which receives such appeal hearing requests; 2. information about how to obtain an appeal form; and 3. how to get assistance in completing and submitting the appeal hearing request. e. The Notice of Facility Bed Hold and policies; f. The name, address, and telephone number of the Office of the State Long-Term Care Ombudsman; Review of the facility's P&P titled Bed-Holds and Returns revised on 10/2022 showed the written bed-hold notices provided to the residents or representatives explain in detail: a. The duration of the state bed hold policy, if any, during which the resident is permitted to return and resume residence in the facility; b. The reserve bed payment policy as indicated by the state plan (for Medicaid residents); (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The facility policy regarding bed-hold periods: d. The facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed hold period (for Medicaid residents); and e. The facility return policy. Medical record review for Resident 19 was initiated on 5/30/24. Resident 19 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 19's H&P examination dated 3/19/24, showed the resident had no capacity to understand and make decisions. Review of Resident 19's Physician Orders showed the orders dated 2/24 and 3/10/24, to transfer the resident to the acute care hospital. Further review of Resident 19's medical record failed to show the written bed hold notices were provided to the resident's representative for the transfers of the resident to the acute care hospital on 2/24 and 3/10/24. On 5/30/24 at 1151 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 19 was transferred to the acute care hospital on 2/24 and 3/10/24. On 5/31/24 at 0854 hours, an interview and concurrent medical record review was conducted with the MRD. The MRD verified the physician's orders for Resident 19's transfer to the acute care hospital on 2/24 and 3/10/24. The MRD also verified Resident 19's medical record failed to show the resident's representative was provided with a written bed hold policy upon transfer to the acute care hospital. The MRD stated it was the Medical Records Department's responsibility to send the written bed hold policy upon transfer to the acute care hospital to the resident's representative; however, the MRD was not able to provide the written bed hold policy to the representative for the transfer dates identified.

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview and medical record review, the facility failed to develop and implement the comprehensive person-centered plan of care to reflect the change of condition for one of three closed record review sampled residents (Resident 78) . This failure posed the risk of not providing appropriate, consistent, and individualized care to Resident 78. Findings: Closed medical record review for Resident 78 was initiated on [DATE]. Resident 78 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 78's H&P examination dated [DATE], showed Resident 78 had no capacity to understand and make decisions. Review of Resident 78's licensed nurses progress notes dated [DATE] at 0800 hours, showed Resident 78 had a change of condition, was non responsive and had moderate amount of thick yellowish secretion; and the resdient's oxygen saturation level was 76%. Review of Resident 78's Physician Order Summary Report for [DATE] showed the physician's order dated [DATE] at 1019 hours, to administer Dextrose 5% -Sodium Chloride 45% (a type of IV fluids, provide electrolytes and calories and are a source of water for hydration) solution at 60 ml per hour intravenously for hydration, and to obtain chest x-ray STAT (a common medical abbreviation for urgent or rush, means immediately). Review or Resident 78's plan of care failed to show a care plan was developed for the management of respiratory change of condition. On [DATE] at 1118 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 78's plan of care failed to show a care plan was develop for the resident's change of condition. On [DATE] at 1331 hours, an interview was conducted with the DON. The DON stated a care plan should have been developed for Resident 78's respiratory change of condition. The DON was informed and acknowledged the above findings. Cross reference to F684.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview and medical record review, the facility failed to provide the necessary care and services to ensure one of three closed record review sampled residents (Resident 78) attained and maintained the highest practicable physical well-being. * Resident 78's had an order for stat (a common medical abbreviation for urgent or rush, means immediately) chest x-ray on [DATE] at 1019 hours. Resident 78's chest x-ray result received was dated [DATE] at 1954 hours, more than a day later, when the stat x-ray was ordered. This failure posed the risk for delayed care and intervention to Resident 78. Findings: Review of the facility's P&P titled Lab and Diagnostic Test Results - Clinical protocol revised ,d+[DATE] showed the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic radiology provider, or other source will report test results to the facility. A nurse will identify the urgency of communicating with the attending physician based on physician request, the seriousness of any abnormality, and the individual's current condition. Review of the facility's P&P titled Charting and Documentation revised ,d+[DATE] showed documentation of procedures and treatments should include care-specific details including the following: a. The date and time the procedure was provided; b. The name and title of the individual(s) who provided the care; c. Assessment data/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician, or other staff, if indicated; and g. The signature and title of the individual documenting. Closed medical record review for Resident 78 was initiated on [DATE]. Resident 78 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 78's H&P examination dated [DATE], showed Resident 78 had no capacity to understand and make decisions. Review of Resident 78's licensed nurses' progress notes dated [DATE] at 0800 hours showed Resident 78 had a change of condition, was non responsive, and had moderate amount of thick yellowish secretion; and the resident's oxygen saturation level was 76%. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 78's Physician Order Summary Report for [DATE] showed a physician's order dated [DATE] at 1019 hours, to obtain a chest x-ray stat. Review of Resident 78's medical record showed a chest x-ray was completed on [DATE], with no time indicated when the chest x-ray was done. The chest x-ray result received dated [DATE] at 1954 hours, showed early infiltrative process (an accumulation [in a tissue or cells] of foreign substances in amounts excess of the normal) on the left mid lung fields. Review of the licensed nurses' progress notes failed to show documentation of the time when the x-ray company was contacted to do the chest x-ray stat when the chest x-ray was completed, any documentation of attempts to follow-up with the x-ray company for the stat order to be completed urgently, and documentation of the facility's attempts to follow up on the chest x-ray results for Resident 78. On [DATE] at 1118 hours, an interview and concurrent closed medical record review was conducted with RN 1. RN 1 stated an order for stat x-ray should be completed within four hours. RN 1 further stated sometimes, the mobile x-ray company did not come on time and most of the time, the nurses had to follow up. RN 1 verified the licensed nurses' progress notes documentation failed to show the time the chest x-ray was completed, any documentation of attempts to follow up with the x-ray company for the stat order to be completed urgently, and documentation of the facility's attempts to follow up on the chest x-ray results for Resident 78. On [DATE] at 1331 hours, an interview was conducted with the DON. The DON stated she expected the stat orders to be completed within four hours from the time when the physician had ordered the diagnostic test. The DON was informed and acknowledged the findings. Cross reference to F656.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care was provided for two final sampled residents reviewed for dialysis treatment (Residents 32 and 39). * Resident 39's fluid intake documented in the MAR was inconsistent with the fluid intake documented in the Fluid Intake with Meals form. * The facility failed to ensure dialysis communication forms for Resident 32 were completed and accurate. These failures had the potential for Residents 32 and 39 not being provided with the appropriate care and treatment. Findings: 1. Review of the facility's P&P titled Intake, Measuring and Recording revised 10/10 showed the purpose of the policy is to accurately determine the amount of liquid a resident consumes in a 24-hour period. Medical record review for Resident 39 was initiated on 5/30/24. Resident 39 was admitted to the facility on [DATE]. Resident 39 had diagnoses including end stage renal disease (kidneys no longer function) requiring dialysis three days a week. Review of the Order Summary Report showed the following orders dated 8/23/23: -Fluid restriction 1200 cc/day; -Total dietary 600 cc/day: breakfast = 240 cc, lunch = 120 cc, dinner = 240 cc; -Total nursing 600 cc/day: 7-3 shift = 300 cc, 3-11 shift = 200 cc, 11-7 shift = 100 cc. Review of Resident 39's fluid intakes recorded on the MAR for the month of May 2024 were not consistent with the Fluid intake with Meals on the following dates: - On 5/1, 5/2, and 5/20/24, the MAR showed the resident's fluid intake was 200 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 360 cc; - On 5/2, 5/8, and 5/29/24, the MAR showed the resident's fluid intake was 300 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 720 cc; - On 5/3, 5/13, 5/16, and 5/21/24, the MAR showed the resident's fluid intake was 300 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 480 cc; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/3, 5/10, 5/17, 5/21, and 5/27/24, the MAR showed the resident's fluid intake was 200 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 340 cc; - On 5/4, 5/6, 5/22, 5/24, 5/27, and 5/28/24, the MAR showed the resident's fluid intake was 360 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 480 cc; - On 5/5/24, the MAR showed the resident's fluid intake was 360 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 720 cc; - On 5/5, 5/8, and 5/15/24, the MAR showed the resident's fluid intake was 200 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 480 cc; - On 5/6 and 5/29/24, the MAR showed the resident's fluid intake was 200 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 460 cc; - On 5/7/24, the MAR showed the resident's fluid intake was 300 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 360 cc; - On 5/7, 5/13, 5/14, 5/23, 5/24, 5/25, and 5/28/24, the MAR showed the resident's fluid intake was 200 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 240 cc; - On 5/9, 5/16, and 5/22/24, the MAR showed the resident's fluid intake was 200 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 440 cc; - On 5/10/24, the MAR showed the resident's fluid intake was 200 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 480 cc; - On 5/11 and 5/23/24, the MAR showed the resident's fluid intake was 360 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 600 cc; - On 5/11/24, the MAR showed the resident's fluid intake was 200 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 540 cc; - On 5/12/24, the MAR showed the resident's fluid intake was 360 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 540 cc; - On 5/12/24, the MAR showed the resident's fluid intake was 200 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 240 cc; - On 5/14/24, the MAR showed the resident's fluid intake was 300 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 390 cc; - On 5/17/24, the MAR showed resident's fluid intake was 100 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 480 cc; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/18/24, the MAR showed fluid intake was 150 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 240 cc; - On 5/19/24, the MAR showed the resident's fluid intake was 100 cc during the 3-11 shift; however, the Fluid Intake with Meals form showed the intake amount was 240 cc; - On 5/20/24, the MAR showed the resident's fluid intake was 300 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 600 cc; and - On 5/26/24, the MAR showed the resident's fluid intake was 360 cc during the 7-3 shift; however, the Fluid Intake with Meals form showed the intake amount was 600 cc. On 5/30/24 at 1031 hours, an interview and concurrent medical record review for Resident 39 was conducted with RN 1. RN 1 verified the inaccuracy of the fluid restriction intake documentation for Resident 39 who was on dialysis. On 5/31/24 at 0933 hours and 1038 hours, an interview and concurrent medical record review for Resident 39 was conducted with the DON. The DON stated the fluid restriction in the MAR included the intake information from the dietary and nursing. The DON verified the inaccurate information of the resident's total fluid intake. 47474 2. Review of the facility's P&P titled End-Stage Renal Disease, Care of a Resident With undated showed the staff caring for the residents with ESRD (End Stage Renal Disease), including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. The P&P further showed education and training of the staff includes, specifically the following: a. The nature and clinical management of ESRD; b. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis; c. Signs and symptoms of worsening condition and/or complications of ESRD. Medical record review for Resident 32 was initiated on 5/29/24. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 32's medical record showed a physician's order dated 5/4/24, showed Resident 32 had dialysis on Monday, Wednesday, and Friday. Review of Resident 32's Dialysis care plan dated 8/22/20, and revised 3/17/22, showed Resident 32 had the right upper chest (RUC) permanent catheter and intervention included monitoring RUC for tenderness, redness or bleeding every shift. Further review of Resident 32's medical record showed the following dialysis communication forms for post-dialysis assessments were incomplete or inaccurately documented for the following dates: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 5/15 and 5/17/24, the breathing patterns/breath sounds were incomplete and the bruit was marked present. * On 5/20, 5/22, and 5/27/24, the breathing patterns/breath sounds were incomplete. On 5/29/24 at 0841 hours, a concurrent interview and medical record review with RN 1 was conducted. RN 1 verified the above findings. RN 1 stated the bruit and thrill were assessed for the residents with AV fistulas. RN 1 verified Resident 32 has a RUC permanent catheter (not AV fistulas); therefore, the dialysis communication forms dated 5/15 and 5/17/24, were inaccurately completed. RN 1 further stated it was important to assess the residents for breathing patterns and breath sounds post-dialysis to determine if there were any complications. RN 1 stated the dialysis communication forms should have been completed. RN 1 stated the licensed staff would need to be re-educated on the completion of the dialysis communication forms. On 5/31/24 at 1700 hours, an interview with the Administrator and DON was conducted. The Administrator and DON were informed and acknowledged the above findings.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 47474 Based on observation, interview, and facility document review, the facility failed to ensure the DHPPD (Direct Care Services Hours Per Patient Day) nurse staffing form was accurately posted. This failure had the potential to result in inaccurate staffing information provided to the public. Findings: Review of the AFL 18-27 dated 6/29/18, showed beginning 7/1/18, the facility shall either create a census and DHPPD form or use the Census and Direct Care Service Hours per Patient Day (CDPH 612 and instructions) to report daily DHPPD. The DON (or designee) must sign the form verifying the information is true and accurate. The census and DHPPD form must be typed or printed legible. If the facility chooses to create a form, it must contain substantially similar information to the attached CDPH 612 and instructions. The form must include the following: 1. Facility name, address, and license number 2. Patient day date and the patient day start time 3. Total licensed SNF beds 4. Name of administrator and the DON or designee 5. Patient census at start of patient day 6. Scheduled nursing hours and the scheduled DHPPD 7. For the designated census periods: a. Beginning census b. Admissions c. Transfers in d. Other intakes that occurred e. Discharges f. Transfers out g. Deaths, and h. Other decreases that occurred (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	8. Total actual/final nursing hours at the end of each census period 9. Average census 10. The actual/final total nursing hours 11. Actual/Final DHPPD 12. An attestation statement signed by the DON or designee verifying they have reviewed the patient census and nursing hours information and acknowledge the information is true and correct. Review of the facility's document DHPPD nurse staffing hours from 5/28/24 to 5/31/24, showed no documented evidence of the facility address, license number, designated census periods, actual nursing hours worked, actual DHPPD hours, average census, or the DON or designee's signature to acknowledge the information posted were accurate and true. On 5/31/24 at 1346 hours, an observation and concurrent interview with the DON was conducted. The DON verified the above findings for the DHPPD nurse staffing hours untitled dated 5/31/24, posted at Nurse's Station 1. The DON stated she completed the form; however, she did not sign to acknowledge it was completed by her. On 5/31/24 at 1444 hours, a facility document review and concurrent interview with the Administrator was conducted. The Administrator verified the findings. The Administrator stated the facility's DHPPD nurse staffing hours form was updated two weeks ago. The Administrator further stated the form did not show the actual nursing hours worked; however, the form only showed the projected nursing hours. On 5/31/24 at 1700 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications and biologicals were stored and disposed of properly. * The facility failed to ensure the medication for the discharged resident (Resident 684) was disposed of. * The facility failed to ensure two medication carts (Medication Carts 1 and 3) and the supplies were maintained in a sanitary condition. * The facility failed to ensure proper storage of the IV medication for Resident 75 in Medication room [ROOM NUMBER]. * The facility failed to ensure safe storage of ibuprofen (used to treat mild to moderate pain) and hydrogen peroxide (used to treat minor cuts and scrapes) spray bottle found at Resident 21's bedside. These failures had the potential to result in the unsafe medication administration, cross-contamination of the medications and posed the risk for other residents to have access to the medications. Findings: Review of the facility's P&P titled Disposal of Medications and Medication- related supplies, Discharge Medications revised 4/08 showed medications are sent with the resident upon discharge only under conditions that protect the resident and assure compliance with the applicable laws. Review of the facility's P&P titled Medication Storage in the Facility revised 4/2008 showed medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and recorded from the pharmacy if a current order exists. 1. On 05/29/24 at 0750 hours, an inspection of Medication room [ROOM NUMBER] and concurrent interview was conducted with RN 1. A box of hydrocortisone AC (used to relieve rectal pain, itching and bleeding) 25 mg suppository for Resident 684 was observed stored together with the facility's house supply rectal medications. RN 1 acknowledged and verified the above finding. RN 1 stated Resident 684 was discharged from the facility and the medication should have been disposed of. 2.a. On 05/29/24 at 1149 hours, an inspection of Medication Cart 3 and concurrent interview was conducted with RN 1. The following was observed: - A bottle of Povidine -Iodine Solution 10% Solution (a solution to disinfecting skin, cleans abrasions, cuts, or lacerations) was observed with brown, dried solution on the top of the bottle. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The first and second drawers of Medication Cart 3 were observed with sticky brown residue. RN 1 acknowledged and verified the above findings. RN 1 stated the medication cart and medication bottle should be maintained clean, neat, and not have any liquid sticky residue. b. On 05/29/24 at 0210 hour, an inspection of Medication Cart 1 and concurrent interview was conducted with LVN 6. A bottle of ProStat (liquid protein) was observed with sticky reddish residue on top of the bottle. LVN 6 verified the above finding and stated the ProStat should not have any sticky liquid residue on the outside of the bottle. 3. On 05/29/24 at 0750 hours, an inspection of Medication room [ROOM NUMBER] and concurrent interview was conducted with RN 1. An uncovered IV normal saline (used to restore fluid balance and hydrate tissues) bag with an attached vial of cefepime (antibiotic) that was partly constituted for Resident 75 was observed inside the medication room refrigerator. The manufacturer's label on the cefepime vial showed for IV use after constitution and to protect from light. RN 1 verified the above finding and stated the IV medication should have not been prepared in advance and should have been protected from the light. 41941 4. Review of the facility's P&P titled Self-Administration of Medications revised 2/2021 showed when the IDT evaluates if self-administration of medications is safe and clinically appropriate for a resident, the IDT considers if the resident is able to store the medications safely and securely. The P&P also showed self-administered medications should be stored in a safe and secure place which was not accessible to other residents. On 5/28/24 at 0848 hours, during an initial tour of the facility, an observation and concurrent interview was conducted with Resident 21. Resident 21 was observed with a bottle of ibuprofen in a large plastic bin on the bedside table and a spray bottle of hydrogen peroxide on a table next to Resident 21. Resident 21 stated he took the ibuprofen for his leg pain. Resident 21 was observed picking up the bottle of hydrogen peroxide and sprayed it on his head. Medical record review for Resident 21 was initiated on 5/28/24. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's H&P examination dated 5/12/23, showed Resident 21 had the capacity to understand and make medical decisions. Review of Resident 21's Order Summary Report showed the following physician's orders: - dated 12/26/23, indicating Resident 21 could self-administer his medication. - dated 4/3/24, to apply hydrogen peroxide solution to the superior scalp daily, per the resident's request. - dated 12/28/22, to administer ibuprofen 200 mg two tablets by mouth every six hours as needed for moderate pain, and to administer with food. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/24 at 0905 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 21 had the bottle of ibuprofen and spray bottle of hydrogen peroxide at the bedside. On 5/29/24 at 1453 hours, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated Resident 21 refused to store the above medications in a locked box. The MDS Coordinator stated the purpose for the medication to be stored securely was to prevent the other residents from taking the medications. On 5/30/24 at 1549 hours, an interview was conducted with the DON. The DON stated the medications should be stored in a safe and secure place where it was not visible.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of 22 final sampled resident (Resident 52) was provided with the prescribed therapeutic diet. * Resident 52 was prescribed with fortified/high protein diet pureed/level 4 texture, thin consistency. Resident 52 was served with fortified/high protein diet pureed/level 4 texture double portions. This failure posed the risk of resident's nutritional needs not being met. Findings: Review of the facility's P&P titled Therapeutic Diets revised 10/2017 showed the therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. Medical record review for Resident 52 was initiated on 5/29/24. Resident 52 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 52's Order Summary Report dated 5/30/24, showed the physician's order dated 5/27/24, for fortified/high protein diet pureed/level 4 texture, thin consistency. Review of the Diet Type Report dated 5/28/24, showed Resident 52 was on a fortified/high protein pureed/level 4 thin with no additional directions. On 5/28/24 at 1247 hours, CNA 3 was observed feeding Resident 52 in his room. Review of Resident 52's meal ticket (used to identify the resident's diet and food preferences for meal service) showed Resident 52 had thin pureed/level 4 fortified/high protein double portions. CNA 3 verified Resident 52 had double portions listed on the meal ticket and was given two trays. On 5/30/24 at 1004 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 stated the license nurses checked the trays given to the residents. RN 1 confirmed there was no order for double portions for Resident 52. On 5/30/24 at 1126 hours, a concurrent interview and medical record review was conducted with the IP and DON. The IP stated the tray ticket was checked by the licensed nurses before the trays were passed to the residents. Furthermore, the IP stated Resident 52 had double portions. The DON checked the physician's order and verified there was no physician's order for a double portions serving. Both the DON and IP confirmed Resident 52 had no physician's order for double portions serving.

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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. 48882 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen when: * The facility failed to monitor for Time/Temperature Control for Safety (TCS) foods (food that require time and temperature controls to limit the growth of illness causing bacteria) to ensure proper cool down process was followed. * The facility failed to ensure the proper hand hygiene was practiced by dietary staff in the kitchen. * The facility failed to ensure the food past the use-by date was discarded. * The facility failed to ensure the items in the refrigerator were labeled correctly. * The facility failed to properly air-dry the kitchen equipment. * The facility failed to ensure the vendors donned their hair restraints or beard restraints in the kitchen. * The facility failed to ensure the kitchen utensils and equipment were stored or kept in sanitary conditions. * The facility failed to ensure the kitchen utensils were in good condition. * The facility failed to ensure the cutting boards were kept in sanitary condition and with cleanable surfaces. * The facility failed to ensure the proper sanitation of surfaces as per the manufacturer instructions. These failures had the potential to cause foodborne illnesses in a highly susceptible resident population of 72 facility residents who consumed food prepared in the kitchen. Findings: Review of the facility's matrix showed 72 of 74 residents consumed food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 3-501.14 Cooling, showed (A) Cooked time/temperature control for safety food shall be cooled: (1) within two hours from 135 degrees Fahrenheit (F) to 70 degrees F; and (2) within a total of six hours from 135 degrees F to 41 degrees F or less, (B) Time/temperature control for safety food shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature, such as reconstituted foods and canned tuna. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Policy for Safe Cooling Process undated showed food will be cooled in a safe manner that avoids the risk of food borne illnesses. Any food cooked or prepared hot and placed in the refrigerator or freezer to cool will be monitored to assure that it reaches an internal temperature of 41 degrees F within six hours. This is a two-step process as follows: - The food will be cooled rapidly from 140 degrees F to 70 degrees F within two hours, the time for cooling begins when the temperature drops below 140 degrees F. - The temperature will drop from 70 degrees to 41 degrees F within the next four hours, - To check and record temperatures on the cooling log. On 5/28/24 at 0807 hours, during the initial tour of the kitchen, an observation of Refrigerator 2 was conducted. A covered metal container containing multiple hot dogs was observed. The hot dogs were observed with spotted and uneven areas of pink and light brown discoloration. The container of the hot dogs was labeled with a use-by date of 5/27/24. On 5/28/24 at 0823 hours, an observation and concurrent interview was conducted with the DSS. The DSS confirmed the above findings. The DSS stated the hot dogs should be pink in color and should not be served with the brownish color. The DSS was observed throwing the hot dogs away. Review of the facility's Menu titled Cambridge Anaheim Crest Cycle 2 2024 showed on Sunday, 5/26/24, hot dog/cheese was the main dinner entree served. Review of the Cooling Log for May 2024 showed no documented evidence of the cool down process for the hot dogs served on 5/26/24. The Cooling Log for May 2024 failed to show the initial date, time, and temperature, and final temperature for the hot dogs. On 5/30/24 at 1015 hours, an interview and concurrent facility document review was conducted with the DSS. The DSS verified the residents were served hot dogs for dinner on 5/26/24. The DSS stated if the hot dogs were refrigerated after that meal, it should have been documented and monitored on the Cooling Log to determine if it was cooled properly after it was heated for dinner. Concurrent review of the Cooling Log for May 2024 was conducted with the DSS. The DSS verified the hot dogs was not on the Cooling Log. On 5/30/24 at 1115 hours, a follow-up interview was conducted with the DSS. The DSS stated the purpose of the cooling process was to prevent food-borne illnesses by ensuring food are served safely to residents to consume. The DSS stated food should be cooled appropriately within a specific time to prevent bacteria growth. On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. According to the USDA Food Code 2022, 2-301, When to Wash, showed food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment, and utensils, and unwrapped single-service and single use articles; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. Review of the facility's P&P titled Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices revised 11/2022 showed the food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Employees must wash their hands after handling soiled equipment or utensils, during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or after engaging in other activities that contaminate the hands. Further review of the P&P showed gloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed, and gloves are replaced between handling raw meats and ready-to-eat foods, and between handling soiled and clean dishes. Review of the facility's P&P titled Food Preparation and Service revised 11/2022 showed gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use. On 5/29/24 at 0825 hours, [NAME] 2 was observed removing her gloves after preparing sandwiches. [NAME] 2 was observed donning a new pair of gloves without washing her hands. [NAME] 2 was then observed unloading clean dishes and kitchen utensils from the clean rack. On 5/29/24 at 0826 hours, [NAME] 2 was then observed grabbing the red sanitation bucket, and grabbed a towel from the red sanitation bucket to wipe down the surface of a cart. [NAME] 2 was observed placing the bucket under the counter and returned to the clean dishwashing area. [NAME] 2 was not observed removing her gloves and washing her hands. On 5/29/24 at 0827 hours, [NAME] 2 was then observed picking up a metal pan containing clean scoops and placed the pan on the surface of the cart. [NAME] 2 was not observed performing hand hygiene and donning a new pair of gloves between tasks. The surface of the cart was observed still wet. [NAME] 2 was then observed placing multiple stacked metal pans on the cart, beside the container of the scoops. On 5/29/24 at 0837 hours, an interview was conducted with [NAME] 2. When asked about the policy for hand hygiene in the kitchen, [NAME] 2 stated she was supposed to wash her hands before applying the gloves and when switching between tasks. [NAME] 2 verified she did not wash her hands between tasks. On 5/29/24 at 1442 hours, an interview was conducted with the DSS. The DSS stated to prevent food borne illnesses through cross contamination, she expected the kitchen staff to wash their hands before starting tasks, after removing gloves and before donning new gloves, and when moving from one task to another. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings. 3. Review of the facility's P&P titled Food Receiving and Storage revised 11/2022 showed all foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded. Review of the facility's P&P titled Labeling and Dating of Food undated showed all the food will be dated, labeled, and prepared for storage to prevent contamination, deterioration, and dehydration. Opened products can be stored in original containers if the container can be closed properly. All products must clearly be labeled with the date when the product was opened. Opened products that cannot be stored in their original containers must be transferred to a plastic re-usable container and covered. The product should be clearly labeled and dated. a. On 5/28/24 at 0800 hours, during the initial tour of the kitchen, an observation of Refrigerator 1 was conducted. The following items were observed in Refrigerator 1: - a container of roasted sesame oil was not labeled with the open date or use-by date; - a bottle of oyster sauce was not labeled with the open date or use-by date; - a gallon container of teriyaki sauce was not labeled with the open date or use-by date; and - a container of sesame seeds was not labeled with the open date or use-by date. On 5/30/24 at 0826 hours, an interview and concurrent observation of Refrigerator 1 was conducted with the DSS. The DSS verified the above findings. The DSS stated all the items placed in the refrigerator should be labeled with an open date. The DSS further stated the above items should have been labeled prior to being placed in the refrigerator. On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings. b. On 5/28/24 at 0807 hours, during the initial tour of the kitchen, an observation of Refrigerator 2 was conducted. A container of sour cream was observed with a use-by date of 5/27/24. On 5/28/24 at 0823 hours, an interview and concurrent observation was conducted with the DSS. The DSS verified the above findings. The DSS stated the container of the sour cream should be discarded. On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings. 4. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air- Drying Required showed 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 microorganism can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. a. On 5/28/24 at 0823 hours, during the initial kitchen tour with the DSS, two white cutting boards were observed stored wet. The DSS verified the findings. On 5/28/24 at 0900 hours, a concurrent observation and interview was conducted with the DSS. A scooper was observed stored wet inside a steam pan with clean utensils. The DSS verified the findings and stated the kitchen items should have been air dried properly before storing. b. On 5/28/24 at 0850 hours, during the initial kitchen tour, an interview and concurrent observation was conducted with the DSS. Three blenders were observed stored on blender bases. When asked the DSS stated the blenders were clean and ready for usage. Upon inspection, the following were observed: - Blender 1 was observed visibly wet inside, with white food residue on the blender walls; - Blender 2 (with a white base) was observed visibly wet inside, with a whitish liquid residue on the top inner walls of the blender; and - A black blender lid was observed with yellowish colored food particle under the lid. The DSS verified the findings and stated all kitchen equipment should be washed and completely air dried before being put back for use. The DSS was observed taking the equipment to the dishwashing station to be rewashed. On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings. 5. According to the USDA Food Code 2022 Section 2-402.11 Hair Restraints, Effectiveness, showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens. Review of the facility's P&P titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices revised 11/2022 showed hair nets or caps and/or beard restraints are worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens. On 5/29/24 at 0848 hours, Vendor 1 was observed entering the kitchen through the staff lounge with shipments. Vendor 1 was observed with noticeable hair, wearing a mask, and no hair restraint. The DSS verified the findings and stated Vendor 1 should be wearing a hair net. The DSS was observed providing Vendor 1 with a hair net. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/29/24 at 0910 hours, Vendor 2 was observed entering the kitchen through the staff lounge. Vendor 2 was observed with a mustache. Vendor 2 was not wearing any beard restraints. The DSS verified this finding. The DSS stated the vendors with beards and mustaches should don beard restraints prior to entering the kitchen. The DSS was observed providing Vendor 2 with beard restraints. On 5/29/24 at 0915 hours, Vendor 2 was observed entering the kitchen with a facemask covering his mustache. On 5/30/24 at 0834 hours, an interview was conducted with the DSS. The DSS stated all personnel including the vendors entering the kitchen should wear a hair net and personnel with a beard or mustache should have beard restraints. On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings. 6. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surfaces, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Non-Contact Surfaces, 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 insect, rodents, and other pests. Review of the facility's P&P titled Sanitization revised 11/2022 showed all utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. Cutting boards are washed and sanitized between uses. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. When cleaning fixed equipment, the removable parts are washed and sanitized and non-removable parts cleaned with detergent and hot water, rinsed, air-dried and sprayed with a sanitizing solution (at effective concentration) and the equipment is reassembled and any food contact surfaces that may have been contaminated during the process are re-sanitized. Review of the facility's P&P titled Cleaning Instructions Cleaning Can Openers dated 2005 showed can openers will be cleaned after each use. Guidelines for cleaning hand held can openers: remove can opener shaft from base, wash in sink filled with soapy water, rinse, sanitize, air dry, wash base thoroughly with hot detergent water- be sure to remove all food particles from blade and base, sanitize, air dry, reassemble, and repeat guidelines after each use. a. On 5/28/24 at 0900 hours, during the initial tour of the kitchen, a concurrent interview and observation was conducted with the DSS. The following was observed: - a white silicone basting brush with black and brown particles was stored in a steam pan with clean cooking utensils; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- a metal spatula with a brownish residue was stored inside a steam pan with clean cooking utensils; - a metal ladle with dry food particles was stored inside a steam pan with clean cooking utensils; - two steam pans holding clean cooking utensils were observed with food particles at the bottom of the pans; - a hand-held can opener with sticky brown residue on the blade was stored inside a steam pan with clean cooking utensils; and - a counter mounted can opener was observed with brownish sticky residue on the blade. The DSS verified the above findings. The DSS stated the can openers should be cleaned and the steam pans should be washed. The DSS was observed removing the above items to be rewashed and removed all utensils from the dirty steam pans. b. On 5/28/24 at 0807 hours, during the initial tour of the kitchen, the heated plate dispenser was observed with brownish stains or residue on the bottom metal panel and the top surface of the plate dispenser was observed with food particles. On 5/28/24 at 0823 hours, the DSS verified the above findings. The DSS was observed using her fingers to touch the brownish residue or stain, and stated the heated plate dispenser could be cleaned more. c. On 5/28/24 at 0823 hours, during the initial tour of the kitchen, an interview and concurrent observation was conducted with the DSS. The following was observed: - a yellow cutting board observed with black particles; and - multiple cutting boards were observed on a rack, stored vertically, under the counter. The area directly below the cutting board rack was observed dusty, with food particles and small plastic particles. The DSS verified the above findings and stated the dirty cutting board should be rewashed. The DSS was observed running her fingers under the cutting board rack with noticeable dust and plastic particles on her finger. The DSS was observed throwing the food particle away and washing her hands. The DSS stated the kitchen staff should be cleaning all areas of the kitchen on a daily basis including under the cutting board rack. On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings. 7. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for 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 the foods that are prepared on such surfaces. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. Review of the facility's P&P titled Sanitization revised 11/2022 showed all utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. a. On 5/28/24 at 0823 hours, during the initial tour of the kitchen, an interview and concurrent observation was conducted with the DSS. A green, brown, yellow, red, and blue cutting boards were observed discolored, heavily marred, and fuzzy. The DSS verified the findings and stated the cutting boards should be replaced when noticeable marred to prevent bacterial growth. b. On 5/28/24 at 0900 hours, a concurrent observation and interview was conducted with the DSS. The following was observed: - one white rubber spatula with a red handle was cracked, chipped, and discolored; and - two portion servers observed with partially melted handles. The DSS verified the above findings and stated the spatula and servers should be replaced. On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings. 8. Review of the facility's P&P titled Food Preparation and Service revised 11/2022 showed appropriate measures are used to prevent cross contamination. These include sanitizing towels and cloths used for wiping surfaces in containers filled with approved sanitizing solution (at concentrations specified by the manufacturers of the solution used) and cleaning and sanitizing work surfaces (including cutting boards) and food contact-equipment between uses, following food code guidelines. Review of the Sani Tech Directions for Use, undated, showed to disinfect food service establishment or restaurant food contact surfaces: countertops, outside appliances, tables, add three ounces of this product per five gallons of water. To apply the solution with a cloth, sponge, or hand pump trigger sprayer so as to wet all surfaces thoroughly. To allow the surface to remain visibly wet for 10 minutes, then remove excess liquid and rinse with potable water. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/29/24 at 0826 hours, [NAME] 2 was observed grabbing a towel from a red sanitation bucket to wipe down the surface of a cart. The label on the red sanitation bucket showed, contact time: 10 minutes. [NAME] 2 was observed putting the towel back into the red bucket and returned the bucket under the counter. [NAME] 2 was then observed going to the clean dishwashing area. On 5/29/24 at 0827 hours, [NAME] 2 was observed picking up a metal pan containing clean scoops and placed the metal pan on the cart that [NAME] 2 just wiped. The surface of the cart was observed still wet. [NAME] 2 was then observed placing multiple stacked metal pans on the cart, beside the container of scoops. On 5/29/24 at 0837 hours, an interview was conducted with [NAME] 2. [NAME] 2 was asked about the process for sanitation. [NAME] 2 stated she used the towels in the red sanitation buckets to wipe down surfaces. [NAME] 2 stated she should wait for 10 minutes after wiping. [NAME] 2 verified she did not wait for 10 minutes after sanitizing the cart before placing the metal containers on the cart. On 5/29/24 at 1442 hours, an interview was conducted with the DSS. The DSS stated to prevent food borne illnesses through cross contamination, she expected the kitchen staff to wash their hands before starting tasks, after removing gloves and before donning new gloves, and when moving from one task to another. When asked about the process for sanitation of the surfaces in the kitchen, the DSS stated she expected the staff to clean surfaces with soap and water and wipe down with the sanitizer solution. The DSS further stated the staff should wait for 10 minutes after wiping to use the surface and if surfaces were not allowed the full contact time, the surface may not be fully sanitized. On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observations, interview, and facility P&P review, the facility failed to ensure the facility's P&P for foods brought by family or visitors was followed when: * The facility failed to ensure the food items in the residents' refrigerator were labeled and dated as per the P&P. * The facility failed to discard foods by the use-by date. These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food brought from outside sources. Findings: Review of the facility's P&P titled Foods Brought by Family/Visitors revised 3/2022 showed food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility prepared food. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. The nursing staff will discard perishable foods on or before the use-by date. The nursing staff and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). 1. On 5/28/24 at 0917 hours, an observation of the refrigerator used to store the residents' food brought in by the visitors and concurrent interview was conducted with the DSS. Upon inspection of the refrigerator for the residents' food brought in by the visitors, the following items were observed: - a brown Kentucky Fried Chicken bag was marked 125 B and resident's last name, undated; - a clear plastic container labeled Rebanada 3 leches (translated to slice of three milks, slice of tres leches cake) was not labeled with the resident's name and date; - one El [NAME] Loco container with food content inside was not labeled with the resident's name and date; - one bag containing tortilla wrapped inside an aluminum foil was not labeled with the resident's name and undated; - a white plastic bag with multiple food containers inside dated 5/20/24, was not labeled with the resident's name; - a container with dried brown noodles dated 5/20/24, was marked 101 B with the resident's name; - a black plastic container dated 5/21, was marked 125 B, unlabeled with the resident's name; and (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- a thawed bag of Totino's pizza bites marked with the resident's name, undated. The instructions on the bag showed for food safety and quality follow cooking instructions: cook thoroughly to internal temperatures of at least 160 degrees F, keep frozen until ready to cook, and best if used by 5/22/24. The DSS verified the above findings. The DSS stated items in the refrigerator for the residents' foods should be labeled with the resident's name, room number, and the date the item entered the fridge. The DSS further stated the resident refrigerator was checked and cleaned daily by the DSS or the cooks. On 5/29/24 at 0900 hours, an interview was conducted with CNA 4. CNA 4 stated when the resident's family/visitors bring in food for the residents, she labeled the items with the room number and resident's name. When asked, CNA 4 stated she did not label the items with any other information. CNA 4 verified she did not label the food items with the date and further stated she would start now. On 5/29/24 at 1627 hours, an interview was conducted with the DON. The DON stated the food brought in for the residents by the visitors were stored in the resident refrigerator, in the employee breakroom. The food items were labeled with the resident's name and the date when the food was brought in. The DON further stated the items were good for 72 hours, before it should be discarded; and the staff checked the resident refrigerator daily. On 5/30/24 at 1140 hours, the DSS and Administrator were informed and acknowledged the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview and medical record review, the facility failed to ensure the medical records for two of two sampled residents (Residents 18 and 78) were accurate. * The facility failed to ensure Resident 78's closed record was complete and accurate. This failure had the potential to negatively impact the delivery of services as the medical information was inaccurate. * The facility failed to ensure a physician's signature was obtained on the POLST (Physician Orders for Life-Sustaining Treatment) for Resident 18. This failure had the potential to result in the residents' health wishes and directive not being honored. Findings: 1. Review of the facility's P&P titled Death of a Resident, Documenting revised ,d+[DATE] showed appropriate documentation shall be made in the clinical record concerning the death of a resident. The name of the mortician and person removing the deceased resident must be entered in the resident's medical record. The person removing the deceased resident from the facility must sign the release for the body, and the release must be filed in the resident's medical record. All records must be completed and forwarded to the medical records for disposition. Closed medical record review for Resident 78 was initiated on [DATE]. Resident 78 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 78's Physician's Order Summary Report showed a physician's order dated [DATE], to release the body to mortuary of choice. Review of Transfer Discharge Report dated [DATE], showed the miscellaneous information was incompletely filled out as follows: - Date and time of transfer and discharge was blank. - The mortician did not write the date and time of the pick-up of the deceased . - Personal effects sent was blank. On [DATE] at 1331 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated the Transfer Discharge Report dated [DATE], was used as the mortician receipt. The DON verified the Transfer Discharge Report was incompletely filled out. 47474 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's document titled Physician Orders for Life Sustaining (POLST) - Directions for Health Care Provider effective ,d+[DATE] showed for the POLST to be valid, the form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice, authorized by law and (2) the patient or decision maker. Medical record review for Resident 18 was initiated on [DATE]. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's H&P examination dated [DATE], showed Resident 18 had the capacity to understand and make decisions. Review of Resident 18's POLST dated [DATE], showed Resident 18 selected for CPR (Cardiopulmonary Resuscitation). The POLST showed a copy of the signed POLST form was a legal valid physician's order and the physician, nurse practitioner, or physician assistant's signature indicated the order was consistent with the resident's medical condition and preferences. Further review of Resident 18's POLST showed no documented evidence the resident's physician signed and dated the POLST form. On [DATE] at 0817 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 18 was admitted to the facility on [DATE]. RN 1 further verified Resident 18's POLST was not signed and dated by the physician. RN 1 stated the physician's signature acknowledged the resident's preference for life-sustaining treatment and Resident 18's POLST should have been signed by the physician. On [DATE] at 1700 hours, an interview with the Administrator and DON was conducted. The Administrator and DON were informed and acknowledged the above findings.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the coordination of care between the facility and hospice provider for one of one final sampled resident reviewed for hospice services (Resident 28). * Resident 28's hospice monthly personalized visit schedules were incomplete. * Resident 28's hospice aide visit summaries were not completed and the facility failed to show the hospice aide had showered the resident twice per week. * The plan of care was not available or reviewed by the hospice staff. These failures posed the risk of the resident not receiving the care and services required to meet the resident's needs. Findings: Review of the facility's P&P titled Hospice Program revised 7/2017 showed it is the facilities responsibility to ensure the facility and the hospice collaborate on the coordination of care provided to the residents, to ensure quality of care for the residents receiving hospice services. The P&P also showed the most recent hospice plan of care should be available. Medical record review for Resident 28 was initiated on 5/30/24. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P examination dated 7/20/23, showed Resident 28 had no capacity to understand and make medical decisions. Review of Residents 28's MDS dated [DATE], showed Resident 28 had severe cognitive impairment. Review of Resident 28's Order Summary Report showed a physician's order dated 12/12/19, to admit Resident 28 to hospice services with a terminal diagnosis of end-stage Alzheimer's disease (progressive disease that destroys memory and other mental functions). On 5/30/28 at 0858 hours, an interview and concurrent medical record and facility document review was conducted with the DON, SSD, and RN 1. Review of Resident 28's hospice binder showed the following: - Personalized visits schedules dated December 2023 through May 2024 were in complete. - Personalized visits schedule for April 2024 showed the last week in April was blank and did not show any staff from Hospice 1 were scheduled to visit Resident 28. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Personalized visit schedule for May 2024 did not show the hospice aide was scheduled to visit during the whole month. In addition, the last week of May 2024 did not show any staff from Hospice 1 were scheduled to visit Resident 28. -Hospice aide sign-in sheets for May 2024 showed the hospice aide signed in five times. The SSD stated Hospice 1 was supposed to fill out the monthly schedule for the nurse and hospice aide visits. The SSD stated the RN supervisor or charge nurse on duty that day was supposed to check the hospice schedule. When RN 1 was asked how the care was coordinated between Hospice 1 and the facility, RN 1 stated the staff from Hospice 1 would sign something indicating they were here. The DON stated the hospice aide from Hospice 1 was supposed to visit Resident 28 two times per week to provide showers to the resident. RN 1 stated the care manager from Hospice 1 was supposed to make sure the hospice aides visited Resident 28 as scheduled. The DON verified the facility staff were not checking the hospice records. On 5/30/24 at 0937 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. When the MDS Coordinator was asked how Resident 28's care plan was coordinated between Hospice 1 and the facility, the MDS Coordinator stated there was no confirmation Hospice 1 reviewed and approved Resident 28's plan of care. The MDS Coordinator stated Hospice 1 did not have access to Resident 28's care plans because they were kept in the electronic record keeping system, which Hospice 1 did not have access to. The MDS Coordinator verified the care plans were not accessible in Resident 28's hospice binder. On 5/30/24 at 0959 hours, an interview and concurrent facility document review was conducted with Hospice RN 1 and the DON for Resident 28. Hospice RN 1 stated the calendar was the visit schedule for Resident 28 and it was supposed to be filled out before the first of the month. Hospice RN 1 stated the hospice aide was supposed to be visit Resident 28 twice per week. The DON stated the hospice aide from Hospice 1 was supposed to provide the showers for Resident 28 twice per week. Hospice RN 1 stated the hospice aides were supposed to document the care provided on the hospice aide plan of care file. Hospice RN 1 verified there was no hospice aide care forms filled out for Resident 28. The DON stated the facility was supposed to check the hospice aide plan of care forms for completion. Hospice RN 1 verified the hospice aide from Hospice 1 did not sign-in twice per week during the month of May 2024 and she could not verify whether the hospice aide provided the showers twice per week during the month of May 2024. Review of Resident 28's case sheet inside the hospice binder, which listed the staff from Hospice 1, showed it was last updated on 7/21/22. Hospice RN 1 stated the case sheet was outdated and it did not have the current staff listed. The DON stated there should have been a current list of the Hospice 1 staff in the hospice binder. On 5/30/24 at 1047 hours, an interview was conducted with CNA 1. CNA 1 stated the hospice aide from Hospice 1 came on Mondays and Fridays to give Resident 28 a shower. On the days the hospice aide from Hospice 1 was not in the facility, Resident 28 got a bed bath. CNA 1 stated when the aide from Hospice 1 was not in the facility by 1000 hours, on Mondays and Fridays, then she would give Resident 28 a bed bath. (continued on next page)

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	555445	A. Building B. Wing	05/31/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 1108 hours, an interview and concurrent facility document review was conducted with LVN 2. LVN 2 stated she, the DON, DSD, and RN supervisors were responsible for maintaining the facility's shower schedules. Review of the facility's shower schedule showed Resident 28's assigned shower days were Mondays and Fridays with Hospice 1. LVN 2 stated Hospice 1 told her that the hospice aide would shower Resident 28 on Mondays and Fridays and the shower schedule had been in place for a year.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 48844 Based on interview, facility document review, and facility P&P review, the facility failed to implement their Quality Assessment and Assurance plan of action. There was no documentation to show an evaluation of the facility's action plan to identify if the facility had achieved and sustained the improvement for the repeated deficient practices cited at F578, F684, F812, and F880 in accordance with their POC for the Recertification survey completed on 8/13/21. This failure had the potential to affect the quality of care for all the residents in the facility. Findings: Review of the facility's P&P titled Quality Assurance and Performance Improvement (QAPI) Program revised 2/20 showed on implementation, the QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process includes among others: developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. On 5/31/24 at 1323 hours, a concurrent interview and facility document review was conducted with the Administrator and AIT. The Administrator was asked on how the facility monitored, reevaluated, and trended the previous survey findings. The Administrator stated the facility's 2021 QAPI binder had already been placed in the storage. The Administrator failed to show documented evidence the facility had monitored, reevaluated, and trended the repeated deficient practices.

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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. 47474 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the infection control practices were maintained as evidenced by: * The facility failed to ensure two of two laundry dryers were free of noticeable buildup of lint. * The facility failed to ensure the staff performed the infection control practice before placing back the contaminated call light to Resident 3's bed. * The facility failed to ensure LVN 7 performed hand hygiene after picking up the black permanent marker on the floor. These failures had the potential to cause safety hazards and the spread infection to staff and residents. Findings: 1. Review of the facility's P&P titled Laundry Room Procedures (undated) showed drying clean linen includes keeping machines and lint traps clean. Review of the facility's P&P titled Laundry and Linen (undated) showed to maintain a clean and safe environment. On 5/29/24 at 1435 hours, a concurrent observation and interview was conducted with the Maintenance Director. Two of two Speed Queen Dryer machines were observed with noticeable amount of lint in both lint receptacle. The Maintenance Director verified the findings and stated the lint should be cleaned out every hour. The Maintenance Director further stated a safety concern with too much lint that it could cause a fire. On 5/31/24 at 1700 hours, an interview with the Administrator and DON was conducted. The Administrator and DON were informed and acknowledged the above findings. 48844 2. On 5/28/24 at 0904 hours, initial tour of the facility was conducted with LVN 4. Resident 3's call light was observed on the floor. LVN 4 placed the call light on Resident's 3 bed without disinfecting or cleaning it. LVN 4 verified the findings and stated the call light should have been cleaned to avoid contamination. On 5/29/24 at 0916 hours, Resident 3's call light was observed on the floor. The DON placed the call light on Resident 3's bed without disinfecting or cleaning. The DON confirmed the call light should have been disinfected before placing to Resident 3's bed to avoid contamination. Cross reference to F558, example #2. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49324 3. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 8/2019 showed the facility considers hand hygiene the primary means to prevent spread of infection, Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before preparing or handling medications; after contact with objects in the immediate vicinity of the resident. On 5/30/24 at 0954 hours, medication administration observation of LVN 7 for Resident 75 was conducted. After LVN 7 prepared all the medications for Resident 75, LVN 7 accidentally dropped her black permanent marker on the floor. LVN 7 picked up the black permanent marker from the floor, placed it on top of the medication cart then proceeded to type on the medication cart's laptop keyboard without performing hand hygiene. After using the laptop, LVN 7 was observed to disinfect her blank permanent marker with alcohol swab then performed hand hygiene before entering Resident 75's room. On 5/30/24 at 1620 hours, an interview was conducted with LVN 7. LVN 7 verified she should have performed hand hygiene before proceeding to use her laptop and should have disinfected her black permanent marker before laying on the medication cart.