STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555463	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village Healthcare Center	2400 West Acacia Avenue Hemet, CA 92545

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate documentation of the residents' wishes regarding their care were maintained, for four of six residents reviewed for Advance Directives (AD - a written instruction relating to the provision of health care when the individual is incapacitated) (Residents 3, 13, 93 , and 26) , when: 1. Resident 3, 13, and 93's ADs were not readily available in their charts; and 2. For Resident 26, there was no documented evidence information was provided to the resident regarding AD formulation. These failures had the potential for the resident's decisions regarding their healthcare and treatment to not be honored. Findings: 1a. A review of Resident 3's record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), mild protein calorie malnutrition, and depression. Resident 3's History and Physical Examination, dated [DATE], indicated Resident 3 did not have the capacity to understand and make decisions. Resident 3's Minimum Data Set (MDS - a clinical assessment tool), dated [DATE], indicated Resident 3 had a Brief Interview for Mental Status (BIMS) score of 2 (severe cognitive impairment). Resident 3's Advance Directive Acknowledgement Form, signed by the resident's representative, dated [DATE], indicated Resident 3 had an AD. Further review of Resident 3's record indicated the AD was not available. 1b. A review of Resident 13's record indicated Resident 13 was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (irregular heart rhythm), hemiplegia (paralysis or loss of voluntary movement on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke, and seizures. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 13's History and Physical Examination, dated [DATE], did not indicate if Resident 93 had or did not have the capacity to understand and make decisions. Resident 13's MDS, dated [DATE], indicated Resident 13 had a BIMS score of 8 (moderate cognitive impairment). Resident 13's Advance Directive Acknowledgement Form, signed by the resident's representative, dated [DATE], indicated Resident 13 had a Durable Power of Attorney for Health Care (DPOA-HC- legal document that allows you to appoint someone to make healthcare decisions for you if you are unable to do so yourself). Further review of Resident 13'2 record indicated the DPOA-HC was not available in Resident 13's physical or electronic record. 1c. A review of Resident 93's record indicated Resident 13 was admitted to the facility on [DATE], with diagnoses which included compression fracture of third lumbar vertebra (a break in the bone of the lower spine due to collapse or compression due to pressure), and acute myeloblastic leukemia (a rapidly progressing cancer of the blood and bone marrow), not having achieved remission (reduction or disappearance of cancer signs and symptoms following treatment). Resident 93's History and Physical Examination, dated [DATE], indicated Resident 93 had the capacity to understand and make decisions. Resident 93's MDS, dated [DATE], indicated Resident 93 had a BIMS score of 15 (cognitively intact). Resident 93's Advance Directive Acknowledgement Form, dated [DATE], indicated Resident 93 had an AD. Further review of Resident 93's record indicated the AD was not available in Resident 13's physical or electronic record. On [DATE], at 2:45 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON confirmed absence of copies of Residents 3 and 93's AD in their physical and electronic records, as well as the absence of Resident 13's DPOA-HC in the physical and electronic record. The DON stated these documents should have been in the resident's chart. The DON further stated, We may not follow what the AD says on there as the resident wishes, if we do not have them in the chart. A review of the facility's policy and procedure titled, Advance Directives, dated [DATE], indicated .Advance directives are honored in accordance with the state law and facility policy .If the resident or residents representative has executed one or more advance directive(s) .copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff .The residents wishes are communicated to the residents direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meetings . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 26's record indicated Resident 26 was admitted on [DATE], with diagnoses which included metabolic encephalopathy (brain function impairment leading to changes in mental status). Resident 26's MDS, dated [DATE], indicated Resident 26 had a BIMS score of 15 (cognitively intact). Resident 26's AD or Advance Directive Acknowledgement Form, was not found in the resident's physical and electronic record. On [DATE], at 2:55 p.m., an interview with the DON was conducted. The DON stated the expectation was if no AD was obtained on admission, a follow up should have been conducted with Resident 26 regarding the AD Acknowledgement Form, and education should be provided to the resident regarding formulation of an AD. If Resident 26 had an AD, a copy should have been obtained and placed in the chart. The DON further stated failure to keep an AD easily available to staff could lead to inappropriate medical actions for the resident such as life saving CPR when not requested. A review of the facility's policy and procedure titled, Advance Directives, dated [DATE], indicated, .The resident has the right to formulate an advance directive, including the right to accept or refuse medical treatment or surgical treatment .The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so .Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative .Written information includes a description of the facility's policies to implement advance directives and applicable state laws .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medical supplies and medication conformed to national standards and the facility policy and procedure when: 1. During medication administration observation, Resident 95's furosemide (medication used to help the body get rid of extra fluid and salt) bubble pack label did not include the blood pressure holding parameters (instructions for when the medication should not be given). This failure had the potential for the medication to be administered outside of holding parameters. 2. During medication storage inspection, the following were observed: a. Three bottles of iron tablets, with expiration dates of April 2025, were stored in the medication cabinet readily available for use; b. One opened container of Metamucil (used to treat constipation), labeled for a discharged resident and with an expiration date of November 2024, was stored in the medication cabinet readily available for use; and c. One open 30-ounce (oz- unit of measurement) bottle of ProStat (a ready-to-drink concentrated liquid protein medical food) was observed stored in the medication cabinet, covered with dried liquid, which had oozed from the top of the bottle. These failures had the potential for the outdated and potentially contaminated medications to be administered to the vulnerable residents of the facility, which could lead to adverse effects from use of these outdated or compromised medications. Findings: 1. On June 12, 2025, at 9:25 a.m., a medication administration observation was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 prepared medications for Resident 95, including the medication Furosemide 20 mg (milligrams- a unit of measurement), which LVN 1 stated was to be given by mouth two times a day, based on the orders on the electronic medication administration record. LVN 1 further stated the medication was to be held if Resident 95's systolic (upper number) blood pressure (SBP) was less than 110 mmHg (millimeters of mercury- unit of measurement for pressure). The LVN did not administer the medication to Resident 95. A review of Resident the medication's label indicated Furosemide 20MG TAB TAKE 1 TABLET BY MOUTH TWICE DAILY. The medication label did not include the holding parameter on the label, and there was no direction change sticker to indicate any change in the administration of the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 95's record indicated Resident 95 was admitted to the facility on [DATE], with diagnoses which included systolic congestive heart failure (heart's left ventricle is too weak to contract effectively, preventing it from pumping enough blood to the body), and atrial fibrillation (irregular heart rhythm). Resident 95's Order Summary Report, included the physician's order, dated June 10, 2025, which indicated, Furosemide Oral Tablet 20 MG .Give 1 tablet by mouth two times a day for CHF (congestive heart failure) HOLD for SBP less than 100. On June 13, 2025, at 9:14 a.m., the Director of Nursing (DON) was interviewed. The DON stated a direction change sticker should have been placed on the Furosemide bubble pack to indicate a change in medication administration instructions. The DON stated she expected the pharmacy to place the correct medication instructions on the label according to the physician's orders. A review of the facility's policy and procedure titled, Medication Labeling and Storage, dated February 2023, indicated, .Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices .The medication label includes, at a minimum .appropriate instructions and precautions .Only the dispensing pharmacy may label or alter the label on a medication container or package . 2. On June 12, 2025, at 1:27 p.m., an inspection of the Medication Room was conducted with the DON. The following were found: a. One 30-oz bottle of Prostat was observed in the upper shelf of a five-tier wooden medicine cabinet. Brownish-orange liquid, which had oozed from the top of the bottle, had dried and crusted along one side of the bottle from top to bottom. In a concurrent interview, the DON stated it should not have been in the medication cabinet. Inspection of the medication room was continued with the Infection Preventionist (IP). b. One bottle of Metamucil, which was labeled for Resident 96, had an expiration date of November 2024, was observed in the upper shelf of the five-tier wooden medicine cabinet. A review of Resident 96's record indicated Resident 96 was admitted to the facility on [DATE], and was discharged from the facility on July 4, 2024. c. A built in cabinet was against the back wall of the medication room. On the bottom shelf of the upper cabinets were three bottles of Gericare Iron 27 mg (100 tablets per bottle), with expiration dates of April 2025. On June 12, 2025, at 2:45 p.m., a concurrent observation and interview was conducted with the DON. The DON confirmed the expired status of the Metamucil and iron tablets. The DON stated the medications should not have been kept stored in the medication cabinet. The DON further stated the expired medications could be given to the residents in error and cause adverse reactions. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Medication Labeling and Storage, dated February 2023, indicated .If the facility has discontinued, outdated or deteriorated medications or biologicals (drugs made from living organisms or their components, like proteins or cells), the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review the facility failed to ensure Food and Nutrition Services associates were trained and competent to carry out the functions of the department safely and effectively when: 1. Food Service (FS) staff did not use three separate steps (wash, rinse and sanitize) to clean and sanitize work surfaces and soiled equipment, according to the facility's policy and procedure; and 2. FS staff did not follow the manufacturer's guidelines for the length of time required for dipping the test strip into the sanitizer (sanitizing solution used for sanitizing food contact surfaces) when testing the concentration of the sanitizer. These failures had the potential for food utensils and dishes to be improperly sanitized, and may result in food-borne illnesses in the vulnerable resident population. Findings: 1. On June 10, 2025, at 2:11 p.m., during a concurrent observation and interview with FS 1, FS 1 was observed cleaning a dirty meal cart. FS 1 stated she used a blue bucket with soap and water solution to clean the work surfaces of the kitchen or soiled equipment, and then used a red bucket to sanitize them. FS1 further stated she already washed and sanitized them. FS 1 did not mention rinsing the soap and water solution before sanitizing. On June 10, 2025, at 2:16 p.m., during an interview with FS 2, FS 2 stated she cleaned the soiled counter top surfaces using soap and water solution, then the sanitizer solution would be used. FS 2 did not mention rinsing the soap and water solution before sanitizing. On June 10, 2025, at 3:34 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated the proper steps for dishwashing were: removal of food debris, wash with detergent solution, rinse with water, and lastly, sanitize with sanitizer. The RD further stated if staff did not follow the proper dish cleaning and disinfecting procedures, kitchen equipment surfaces would not be cleaned properly. A review of the facility's policy and procedure titled, Tools for Effective Cleaning, dated 2023, indicated, . Cleaning involves the removal of soil. Water is the main cleaning agent .chemical cleaning compound .The purpose of detergents is to loosen the soil or dirt .The soil must be rinsed off .and sanitized . A review of the U.S. FDA (Food and Drug Administration) Food Code 2022, Annex 3 Section 4-501.18 Warewashing Equipment, Clean Solutions, the Food Code indicated, Failure to maintain clean wash, rinse, and sanitizing solutions adversely affects the warewashing operation. Equipment and utensils may not be sanitized, resulting in subsequent contamination of food .Warewashing means the cleaning and SANITIZING of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On June 10, 2025, at 10:11 a.m., during a concurrent observation and interview with Kitchen Supervisor (KS), KS was asked to demonstrate how to check the concentration of the sanitizer. KS was observed dipping the test strip into the sanitizer for 10 seconds. KS stated he needed to dip the test strip for 10 seconds to check the concentration of sanitizer. On June 10, 2025, at 2:11 p.m., during a concurrent observation and interview with FS 1, FS 1 was observed dipping the test strip into the sanitizer for 15 seconds to check the concentration of the sanitizer. FS 1 stated she needed to dip the test strip into the sanitizer for 15-20 seconds, and confirmed she dipped the test strip into sanitizer for 15 seconds to check the concentration of sanitizer. A review of the sanitizer manufacturer's guidelines, dated January 2025, indicated, .Procedure .Immerse the strip in sample for 5 (five) seconds . On June 10, 2025, at 3:34 p.m., an interview was conducted with the RD. The RD stated the staff should have followed the manufacturer's guideline for the length of time required for dipping of the test strip into the sanitizer solution. The RD further stated if the test strip was dipped for too long, it would lead to False reading result. A review of the facility's policy and procedure titled, Cleaning and Sanitizing - Basics, dated 2023, indicated, . When cleaning and sanitizing any food contact surface, it is extremely important that: Always refer to manufacturer's recommendation of dilution strength and current Federal/ or a State Food code (using stricter of the two standards) .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Food and Nutrition Services staff followed the Cook's spreadsheet when: 1. For Residents 14 and Resident 25, the appropriate dessert was not served during lunch on June 9, 2025; and 2. For Residents 14, 18, and 25, the pot roast meat was not served with gravy during lunch on June 9, 2025. These failures had the potential for residents on oral diets to not receive the adequate nutrition which can further compromise their medical status. Findings: 1. On June 9, 2025, at 12:33 p.m., a concurrent observation of the lunch meal trays of Residents 14 and 25 was conducted with the Director of Staff Development (DSD) in the dining room. The food trays were observed to each contain a cup of cherry crisp. In a concurrent interview, the DSD stated Residents 14 and 25 received a cherry crisp each as dessert. The DSD further stated both Residents 14 and 25 were on CCHO (controlled carbohydrate- less sugar) diet because they were diabetics (with abnormal blood sugar). a. During lunch meal observation on June 9, 2025, Resident 14's tray contained the following: - egg salad sandwich; - chopped/soft fried potatoes; - chopped seasoned red cabbage; - minestrone soup; - soft chopped cherry crisp; - decaf hot tea; - iced tea; and - whole milk/beverage. On June 9, 2025, Resident 14's record was reviewed. Resident 14 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus type 2 (DM2 - abnormal blood sugar). A review of Resident 14's Physicians Order, dated June 6, 2025, indicated Resident 14 was on a CCHO diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a lunch meal observation on June 9, 2025, Resident 25's tray contained the following: - pureed Honey Pot roast with gravy; - applesauce; - pureed fried potatoes; -pureed seasoned red cabbage; - pureed seasoned red; - pureed cherry crisp; - diet lemonade-honey thick; and - whole milk. On June 9, 2025, Resident 25's record was reviewed. Resident 25 was admitted to the facility on [DATE], with diagnoses which included DM2. A review of Resident 25's Physicians Order, dated June 6, 2025, indicated Resident 25 was on a CCHO diet. A review of the facility's Diet Spreadsheet, dated Week 2, Day 9-Monday, indicated CCHO residents would receive fruit in place of cherry crisp. The facility was not able to provide a documentation or a logbook regarding changes in the diet menu. There was no posting on the menu board or consumer board regarding the changes in the planned menu for the day. On June 10, 2025, at 3:54 p.m., during an interview with the RD, the RD stated the meal diets of Residents 14 and 25 should have coincided with the cook's spreadsheet. The RD stated Residents 14 and 25 should have received fruits for dessert, according to the cook's spreadsheet. The RD further stated Residents 14 and 15 would be at risk for uncontrolled sugar levels, which could lead to kidney failure and possible hospitalization. 2. On June 9, 2025, at 12:33 p.m., a concurrent dining observation was conducted with the DSD in the dining room. The food items for Residents 14, 18, and 25 were observed to not have gravy on their pot roast meat. In a concurrent interview, the DSD stated there was no gravy on pot roast meats served to Residents 14, 18, and 25. The DSD further stated kitchen did not follow the order listed on the meal tickets, and the list should have been followed. A review of facility's Diet Spreadsheet, dated Week 2, Day 9-Monday, indicated mechanical soft diet residents would receive ground honey pot roast with gravy, and residents receiving pureed texture would receive pureed honey pot roast with gravy. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 10, 2025, at 3:54 p.m., during an interview with the RD, the RD stated the meal diets of Residents 14, 18, and 25 should have coincided with the cook's spreadsheet. The RD stated the pot roast meats should have been served with gravy. The RD further stated, the gravy would help moisten to the food, thereby preventing choking and aspiration. The RD further stated the absence of gravy could lead to undernourishment and weight loss. A review of the facility's policy and procedure titled, Menu Diet Spreadsheets/Portion Serving Communication Tool, dated 2020, indicated, .Diet spreadsheets are based on the planned menu and reflect serving .for regular and therapeutic diet orders .Therapeutic diets reflected on the spreadsheet correspond to the diet guidelines found in the community's approved diet manual .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure the appropriate food texture was provided, for nine of nine residents reviewed (Residents 14, 142, 2, 3, 93, 20, 241, 18, and 17), when: 1. Residents on mechanical soft diet did not receive ground pork and chopped vegetables according to the cook's spreadsheet during lunch on June 9, 2025; and 2. Residents on mechanical soft diet were served with potatoes skin during lunch on June 9, 2025. These failures had the potential for the residents to choke on the food. Findings: 1. A review of the facility's menu spreadsheet for lunch on June 9, 2025, indicated residents on mechanical soft diet were to receive ground pork and chopped vegetables as the main entrée. On June 9, 2025, at 12:18 p.m., during meal tray distribution observation, the pot roast meat was observed to have whole coarse strands of meat which measured approximately one inch in size. There was no ground meat for the pot roast in the trayline. The vegetables were observed to have large chunks similar to vegetables intended for residents on regular diets. In a concurrent interview with the Registered Dietician (RD), the RD confirmed the pot roast meat for the residents on mechanical soft diet was not ground, and was the same texture as the meat for those with regular diet. The RD stated the texture and consistency of meat for mechanical soft diet should be chopped or bite size, and should be smaller than half an inch. The RD stated the vegetables should be in small chunks. The RD further stated if the texture for mechanical soft diet was not followed, residents could choke, which could potentially lead to death. A review of the facility's Diet Type Report, dated June 9, 2025, indicated Residents 14, 142, 2, 3, 93, 20, 241, 18, and 17, had a diet order of mechanical soft ground. A review of the facility's undated diet manual section titled, Dental Soft (Mechanical Soft) Diet, indicated, . Meat is ground or chopped into bite-size pieces (1/2 inch or smaller) .Vegetables are cooked soft .with no large chunks or pieces . 2. A review of the facility's menu spreadsheet for lunch on June 9, 2025, indicated residents on mechanical soft diet were to receive chopped potatoes. On June 9, 2025, at 12:18 p.m., during meal tray distribution observation, residents on mechanical soft texture diet received potatoes with skin. In a concurrent interview with the RD, the RD confirmed the potatoes that were served for residents on mechanical soft diet had potatoes with skin. The RD stated there was no other type of potatoes prepared for lunch and the potatoes should have been served without the skin on. The RD further stated potato skins could cause residents to choke or aspirate (inhale food or liquid in to the lungs), which could potentially lead to death. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village Healthcare Center	2400 West Acacia Avenue Hemet, CA 92545

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated facility diet manual section titled, LIST OF DIETS AVAILABLE IN THE COMMUNITY, indicated, .MECHANICAL SOFT-GROUND .Cannot have potato skins .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen were observed, when: 1. Dust was found in multiple areas of the kitchen and on several kitchen equipment; 2. Grime buildup was found on the bottom of the cold storage shelves and on the walk in Refrigerator's (Ref) # (number) 1 inner door; and 3. Multiple residents' food items were stored in the nurses' station refrigerator undated and out of date. These failures had the potential to place residents at risk for food-borne diseases (illness that result from ingestion of contaminated food) that can cause sickness and/or death. Findings: 1. On June 9, 2025, at 9:05 a.m., a concurrent observation and interview was conducted with the Food Server Director (FSD) in the kitchen area. The FSD confirmed Ref #4's fan surface was dusty. On June 9, 2025, at 9:07 a.m., a concurrent observation and interview was conducted with the FSD in the kitchen area. The FSD confirmed the black debris on the fan surface of Ref #3 was dust. On June 9, 2025, at 9:08 a.m., a concurrent observation and interview was conducted with Food Server (FS) 2 in the work server area. FS 2 stated the wall above Ref #2 was dusty, and maintenance should have cleaned it. On June 9, 2025, at 9:17 a.m., a concurrent observation and interview with the Dietary Supervisor (DS) was conducted in the kitchen. The DS confirmed the black material in the door frame leading to the assisted living dining room was dusty. On June 9, 2025, at 9:26 a.m., a concurrent observation and interview with the DS was conducted in the kitchen. The DS confirmed the walk in Ref #1s' fan cover was dusty and needed to be cleaned. On June 9, 2025, at 9:29 a.m., a concurrent observation and interview with the DS was conducted in the kitchen. The DS confirmed the inner wall of walk in Ref #1's wall above the door was dusty. On June 10, 2025, at 4:10 p.m., during an interview with the Registered Dietitian (RD), the RD stated the kitchen area should have been cleaned and free from dust, because dust would potentially cause cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the U.S. Food and Drug Administration's (FDA) Food Code 2022, Section 4-602.13 Nonfood-Contact Surfaces, the Food Code indicated, .The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests . 2. On June 9, 2025, at 8:15 a.m., during a concurrent walk-through observation and interview inside the kitchen with the DS, white grime build up was found on the bottom cold storage shelf inside walk in Ref #1. In addition, there was black grime build up along the rubber gasket in the left upper corner (L-shaped) of the inner surface of the door. In a concurrent interview with the DS, the DS stated the white grime build up was food residue, and the black grime build up in the walk in Ref #1's inner door was dirt and was missed during cleaning by the staff. The DS stated the grime build up found on the bottom shelves, as well as the dirt on walk in Ref #1's inner door should have been cleaned. The DS further stated the grime could cross-contaminate food and cause food-borne illness in the residents. On June 10, 2025, at 4:10 p.m., during an interview with the RD, the RD stated the kitchen area and storage equipment should been cleaned and free from grime, because dirt and grime could potentially could cause cross-contamination and illness. A review of Food code 2022. Annex 3: 4-402.12 Fixed Equipment, Elevation or Sealing indicated, .The inability to adequately or effectively clean areas under equipment could create a situation that may attract insects and rodents and accumulate pathogenic (disease causing) microorganisms that are transmissible through food . A review of the facility's undated policy and procedure titled, What is Food Sanitation? indicated, .The term sanitation means sound and health or clean and whole. It is largely concerned with the removal and effective control of micro-organisms (germs, bacteria, yeasts, mold, etc.) in food and everything that touches food . Sanitation is therefore a way of life and must be practiced around the clock, every day and all year round . 3. On June 10, 2025, beginning at 3 p.m., the nurse's station refrigerator, which contained residents' food, was inspected with the Infection Preventionist (IP). The following were observed: a. One unopened Stringles Organic string cheese seven g (grams-unit of measurement) serving was labeled with room [ROOM NUMBER]A, undated, and with best-by date of February 9, 2025. In a concurrent interview, the IP stated the food item should have been dated when it was received, should not have been in the fridge anymore, and should have been taken out; b. One opened 20-oz (ounce-unit of measurement) plastic bottle of strawberry fruit spread, and with a date of March 6, 2025. In a concurrent interview, the IP stated the strawberry fruit spread was past its storage date and should have been taken out of the fridge; c. One unopened 1.6 oz plastic container of celery sticks was unlabeled and had a best used by date of May 1, 2025. In a concurrent interview, the IP stated the pack of celery sticks was past its storage date, should have been labeled, and should have been taken out of the fridge; and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d. One open 16-oz plastic bottle of salad dressing was unlabeled with a best used by date of January 16, 2024. In a concurrent interview, the IP stated the plastic bottle of salad dressing was open, unlabeled, and should have been taken out of the fridge. The IP further stated that for open food items, they could be stored in the fridge for 72 hours, after which they were supposed to be discarded. On June 10, 2025, at 4:10 p.m., during an interview with the RD, the RD stated expired food that were found in the residents' refrigerator should have been tossed to maintain the sanitary condition of the fridge. The RD further stated if food was expired and not monitored, it could cause food-borne illness in the residents. A review of the facility's undated policy and procedure titled, Food from Family, Visitors, Community, indicated, .Food stored for resident should be labeled and dated appropriately and discarded per safe food storage guidelines .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were implemented, when Licensed Vocational Nurse (LVN) 1 was observed removing one tablet of Metoprolol (a blood pressure medication) from the medicine cup using bare forefinger, during medication administration observation. In addition, LVN 1 was observed not disinfecting the blood pressure (BP) apparatus before and after resident use. These failures had the potential to spread infection among the vulnerable residents of the facility. Findings: On June 12, 2025, at 9:16 a.m., a medication administration observation was conducted with LVN 1. The following were observed: - LVN 1 poured Resident 94's medications, including one tablet Metoprolol 25 mg (milligram- unit of measurement) into one medicine cup on top of the medication cart (med cart). LVN 1 stated the medication was not to be administered if Resident 94's systolic (upper number) blood pressure was less than 110 mmHg (millimeters mercury- unit of measurement for pressure). LVN 1 stated Resident 94's blood pressure, which was taken earlier, was 110/60 mmHg, so he would recheck Resident 94's blood pressure when in the room and before administering the medication; - LVN 1 brought out the BP apparatus from the bottom drawer of the med cart and placed it on top of the med cart. LVN 1 then picked up the medicine cup, picked up the BP apparatus, and proceeded to Resident 94's room. LVN 1 obtained Resident 94's blood pressure using the BP apparatus and a stethoscope which he removed from around his neck. After obtaining Resident 94's blood pressure, the LVN looped the stethoscope back around his neck without disinfecting the stethoscope; - LVN 1 stated Resident 94's BP was 100/59 and the Metoprolol was not going to be administered. LVN 1 returned to the medication cart with the medicine cup and the BP apparatus. LVN 1 identified the Metoprolol tablet and proceeded to remove the medication from inside the medicine cup using his bare right forefinger. The BP apparatus was left on top of the medication cart; and - After administering the medications to Resident 94, LVN 1 was observed to return the BP apparatus to the bottom drawer of the med cart without disinfecting the medical equipment. In a concurrent interview with LVN 1, LVN 1 stated he should not have used his bare forefinger in removing the medication from the medicine cup, and he should have disinfected the stethoscope and BP apparatus before and after use on Resident 94. On June 13, 2025, at 9:03 a.m., the Infection Preventionist (IP) was interviewed. The IP stated LVN 1 should not have removed the medication from the medicine cup using his bare forefinger, and should have disinfected the stethoscope and BP apparatus after use on Resident 94, to avoid the risk of contamination or cross-contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 13, 2025, at 9:14 a.m., the Director of Nursing (DON) was interviewed. The DON stated LVN 1 should not have used bare hands in handling the medication, and should have sanitized the medical equipment before and after use. A review of the facility's policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated September 2022, indicated .Resident-Care equipment, including reusable items .will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection .Non-critical items are those that come in contact with intact skin .items include bedpans, blood pressure cuffs .items require cleaning followed by either low- or intermediate-level disinfection following manufacturers' instructions .performed with an EPA (Environmental Protection Agency)-registered disinfectant labeled for use in healthcare settings .Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment) .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure the proper maintenance of essential equipment, when water was found dripping from the condenser unit (removes heat from the refrigerator and cooling it down to a liquid state) of Refrigerator (Ref) #3 . This failure had the potential to place residents at risk for food-borne diseases (illness that result from ingestion of contaminated food) that can cause sickness and/or death. Findings: On June 9, 2025, at 10:10 a.m., during the initial kitchen tour, an observation of Ref #3 was conducted. Inside Ref#3, the condenser unit was located at the top back wall of Ref#3. Water was observed dripping down from the condenser unit into a 1/8 6-inch deep metal pan, which was below the condenser unit and resting on the top shelf of the refrigerator. The metal pan was full to the brim with water, with water overflowing and dripping onto some food items on the lower shelves. In a concurrent interview with the Food Server Director (FSD), the FSD stated the water leak came from the condenser unit, and maintenance should have fixed it. The FSD further stated the water was leaking down towards the shelves and dripped onto the food, so it was not safe due to possible cross-contamination of the food. On June 9, 2025, at 10:14 a.m., during a concurrent observation and interview with the Maintenance Supervisor (MS) inside the kitchen, the MS stated Ref #3's condenser unit had a leak, so the water dripped down to the shelves. The MS further stated, It should have been fixed as soon as possible. On June 10, 2025, at 4 p.m., during an interview with the Registered Dietician (RD), the RD stated any damaged kitchen equipment should have been prioritized and repaired for safe and operable use. The RD further stated water that leaked and dripped on to the food would cause cross-contamination, which could cause residents to have food-borne illnesses. A review of the facility's policy and procedure titled, Maintenance Service, dated December 2009, indicated, . Maintenance service shall be provided to all areas of the building, grounds, and equipment .The maintenance department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times .