STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555466	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashby Care Center	2270 Ashby Avenue Berkeley, CA 94705

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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, for six of six sampled residents (Residents 119, 118, 116, 112, 113 and 111), the facility failed to offer or ensure an advance directive (a written instruction for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated) was on file, when the facility did not offer or help the residents/representatives to locate or complete the advance directive. This failure had the potential for Residents 119, 118, 116 112, 113 and 111's wishes regarding provision of health care to not be honored. Findings: 1. During a review of Resident 119's admission record, dated 11/1/24, indicated, Resident 119 was admitted to the facility on [DATE] with multiple diagnoses that included epilepsy (neurological conditions characterized by sudden, uncontrolled burst of electrical activity in the brain). During a review of Resident 119's clinical record titled, ADVANCE DIRECTIVE ACKNOWLEDGMENT, dated 6/27/22, indicated Resident 119 have executed an advance directive. 2. During a review of Resident 118's admission record, dated 11/1/24, indicated Resident 118 was admitted to the facility on [DATE] with multiple diagnoses that included Schizophrenia (a severe mental illness that affects a person's ability to distinguish between what is real and what is not). 3. During a review of Resident 116's admission record, dated 4/24/25, indicated Resident 116 was admitted to the facility on [DATE] with multiple diagnoses that included cerebral infarction (stroke), atherosclerosis of aorta (buildup of mix of fat and other substances on the inner walls of the body's largest artery). During a review of Resident 116's clinical record titled, ADVANCE DIRECTIVE ACKNOWLEDGMENT, dated 4/18/25, indicated Resident 116 have executed an advance directive. 4. During a review of Resident 112's admission record, dated 11/1/24, indicated, Resident 112 was admitted to the facility on [DATE] with multiple diagnoses that included, Traumatic subdural hemorrhage with loss of consciousness (a serious condition where blood collects between the brain and its outer covering after a head injury). (continued on next page)

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	During a review of Resident 112's clinical record titled, ADVANCE DIRECTIVE ACKNOWLEDGMENT, dated 10/1/21, indicated Resident 112 wished to execute an Advance Directive. 5. During a review of Resident 113's admission record dated, 11/1/24, indicated Resident was admitted to the facility on [DATE] with multiple diagnoses that included Venous insufficiency (a condition where veins have trouble returning blood from the legs back to the heart). 6. During a review of Resident 111's admission record dated 11/1/24, indicated Resident 111 was admitted to the facility on [DATE] with multiple diagnoses that included adult failure to thrive (syndrome characterized by a decline in health and function in older adults, often involving weight loss, decreased appetite, and reduced activity). During a review of Resident 111's Physician Orders for Life-Sustaining Treatment (POLST, medical order that provide clear instructions to healthcare providers about the medical treatments a patient wants or does not want to receive in the event of a serious illness or medical emergency), dated 10/20/21, the POLST indicated Resident 111 had an advance directive. During a review of Resident 111's clinical record titled, ADVANCE DIRECTIVE ACKNOWLEDGMENT, dated 10/20/21, indicated Resident 111 have executed an advance directive. During a concurrent interview and record review on 5/20/25, at 12:08 p.m., with Administrator/Minimum Data Set Coordinator (ADM/MDSC), ADM/MDSC revealed, 119, 118, 116, 113 and 111 did not have advance directive in each paper chart or electronic health medical record nor were the Residents offered it. ADM/MDSC stated it was important to have advance directive on file in case of emergency situation and resident became incapacitated so we can carry out resident wish, it's their rights. During a record review of the facility's policy and procedure (P&P) titled, ASHBY CARE CENTER POLICY ON ADVANCE DIRECTIVES AND RESIDENT RIGHT TO ACCEPT OR REFUSE MEDICAL TREATMENT undated, indicated .2. The facility shall document in the individual's medical record whether or not the individual has executed an advance directive .Under procedure 3. Inquire about advance directive. During the admission process or as reasonably possible thereafter, the person who documents a resident's admission will ask the resident whether he/she has completed an advance directive. If an advance directive has been completed, the person who documents the resident's admission will ask for a copy of the advance directive so that it may be placed in the resident's medical record. If a copy of the resident's advance directive is not immediately available, the resident will be informed that it is his or her responsibility to provide a valid copy of the advance directive to the facility as soon as possible. 4. If an advance directive has not been completed, or if the resident is unfamiliar with advance directives, the person who documents the resident's admission will ask the resident whether he or she would like to receive further information on advance directives . Under Documentation .B. Whether the resident has an advance directive. A copy of the advance directive (if it is available) will be included in the medical record .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of 13 sampled residents was free from physical restraints when the facility staff placed Resident 167 in a Geri chair with a hard table cover over the Geri chair (a large, padded chair that is designed to help seniors with limited mobility), preventing Resident 167's freedom of movement (change in place or position for the body or any part of the body that the person is physically able to control) and from getting in and out of the Geri chair at his own will. This failure placed Resident 167 at risk of self-injury, of not attaining and maintaining their highest practicable well-being or good quality of life. Findings: During a record review of Resident 167's Facesheet (FC), the FC indicated Resident 167 was admitted to the facility on [DATE]. FC also indicated Resident 167 had diagnoses of essential primary hypertension (a chronic condition of persistent high blood pressure with no identifiable cause), nontraumatic intracerebral hemorrhage (bleeding within the brain tissue without any direct trauma or injury), and mild cognitive impairment (brain condition in which people have more memory and thinking problems than other people their age. During a concurrent interview and record review on 5/19/25, at 1:27 p.m., with Administrator/Minimum Data Set Coordinator (ADM/MDSC), the Facility Matrix was reviewed. The Facility Matrix indicated facility had one Resident on physical restraints, Resident 167. ADM/MDSC stated Resident 167 was on physical restraints, which is the Geri chair, and the Geri chair was used to prevent falls, as Resident 167 had generalized weakness. ADM/MDSC further stated if Resident 167 was not placed in the Geri chair, Resident 167 would constantly try to get up and stand, which could result in a fall. ADM/MDCS also stated once Resident 167 was placed in the Geri chair, Resident 167 could not get himself in and out of the Geri chair, unless staff got him out. During a review of Resident 167's care plan, start date 3/17/25, the care plan only indicated, geri chair in place for safety, comfort, and mobility support, due to muscle weakness high fall risk. The care plan did not include other interventions for fall risk and muscle weakness. During a concurrent observation and an interview on 5/20/25, at 11:00 a.m., with Certified Nursing Assistant (CNA) 1, (CNA) 2, and Director of Nursing/Infection Preventionist (DON/IP), Resident 167 was sitting in a Geri chair in the dining room. The Geri chair had a hard table cover over it. CNA 1 and CNA 2 stated Resident could not remove the tray on the Geri chair by himself. Resident 167 was in a reclining position. CNA 2 stated facility staff needed to remove the Geri chair from the recline position in order for Resident 167 to get out of the Geri chair. CNA 1 also stated Resident 167 was placed in the Geri chair so staff could go care for other residents, such as change another resident's diaper. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and an interview on 5/21/25, at 11:26 a.m., with CNA 3, Resident 167 was sitting in a reclined position in a Geri chair. The Geri chair had a tray attached to it, over his lap. CNA 3 stated Resident 167 would try to stand and then he would fall, and that Resident 167 cannot balance himself. CNA 3 stated Resident 167 cannot come out of the Geri chair by himself. During a review of facility's policy and procedure (P&P), the P&P titled, Restrants Policy, indicated, Geriatric Chair . The Geri-chair is considered a restraint . The resident must be repositioned and exercised 10 minutes out of every two hours . A physical restraints is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. These can include cloth vests, soft ties, soft mittens, wheelchair safety bars, geri-chairs and or other devices including side rails . Restraints can jeopardize the resident's feeling of dignity and self-worth. All other means of dealing with the problem must be exhausted before a restraint is applied. All measures tried prior to application of the restraints must be documented in the resident's medical record.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. Based on interview and record review, for five (Residents 118, 112, 164, 3, and 117) of five sampled residents, the facility failed to complete the quarterly Minimum Data Set assessments (MDS - Resident Assessment and care guide tool) according to the regulation. This failure had the potential to result in the delayed assessment of residents' needs, goals of care and inability to monitor each residents' progress over time. Findings: During a concurrent interview and record review on 5/21/25, at 1:19 p.m., with the Administrator/Minimum Data Set Coordinator (ADM/MDSC), the following MDS record reviews were not completed every three months as follows: Review of Resident 118's MDS assessment indicated Resident 118 did not have quarterly MDS assessment. Review of Resident 112's MDS assessment indicated Resident 112 did not have quarterly MDS assessment. Review of Resident 164's MDS assessment indicated there was no quarterly assessment completed from 11/2/23 thru 5/2/25. Review of Resident 3's MDS assessment indicated the last quarterly assessment was completed on 12/18/24. Review of Resident 117's MDS assessment indicated the last quarterly assessment was completed on 12/18/24. ADM/MDSC acknowledged that residents' MDS's were late and MDSC was responsible for the completion and transmission of all the residents' MDS assessments. ADM/MDSC stated it was important to complete the MDS assessments for reimbursement purposes and to ensure that resident needs were met. Review of the Long -Term Care Facility Resident Assessment Instrument 3.0 User's Manual CH 2: Assessments for the RAI, dated October 2024, indicated the quarterly assessment an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. {Reference: https://downloads.cms.gov/files}

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review of all its nurse aide staff at least once every 12 months, not following its policy and procedures and standards of practice. This failure had the potential to have incompetent nurse aides caring for residents, poor quality of care and quality of life for residents, risk for injury, accidents, infection, hospitalization, and possibly death. Findings: During a concurrent interview and record review on 5/22/2025, at 10:21 a.m., with Administrator/Minimum Data Set Coordinator (ADM/MDSC), the nurse aide staff personnel files were reviewed. There was no record of annual performance reviews in all nurse aide staff personnel files. ADM stated facility does not have record of annual performance review for their nurse aide staff. ADM stated the importance of completing performance review for all nurse aide staff is so facility can provide quality care to the residents and give staff feedback on how they are doing. ADM further stated the facility's process was to complete performance review for each nurse aide annually.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the hospital failed to ensure the accuracy of controlled drug records as evidenced by: 1. The facility failed to ensure the scheduled (narcotic) medication records (Controlled Drug Record, MAR) were accurate. For three (Residents 160, 165, 167) out of three residents sampled, the Controlled Drug Record (inventory of scheduled drug) and the Medication Administration Record (MAR, record of drug administration) were not accurate. This failure resulted in the potential for residents to be exposed to avoidable medication errors. In addition, this failure resulted in the potential for scheduled drug diversion. 2. The facility failed to ensure the Consultant Pharmacist reviewed the scheduled (narcotic) medication records (Controlled Drug Record, MAR) for accuracy. For three (Residents 160, 165, 167) out of three residents sampled, the Controlled Drug Record (inventory of scheduled drug) and the Medication Administration Record (MAR, record of drug administration) did not match. These inaccuracies were not identified by the Consultant Pharmacist. This failure resulted in the potential for residents to be exposed to avoidable medication errors. In addition, this failure resulted in the potential for controlled drug diversion. Findings: 1. During a concurrent observation, interview, and record review, on 5/19/25 at 1145, in the medication room, Licensed Vocational Nurse (LVN 3) identified Resident 167's morphine (narcotic pain reliever) 20 milligram (mg)/milliliter (ml) plastic bottle. Inspection of the bottle showed it contained 13 mls of morphine. LVN 3 inspected the bottle and stated it contained 13.75 mls of morphine. LVN 3 identified the Controlled Drug record for the morphine. Inspection of the Controlled Drug Record showed the amount in the bottle was 16 ml. Continued review of the Controlled Drug Record showed 0.25 mls were removed from the bottle four times between 5/1/25 and 5/11/25. LVN 3 identified the MAR for the morphine. Review of the May 2025 MAR did not show morphine 0.25 ml administered between 5/1/25 and 5/11/25. LVN 3 reviewed the Controlled Drug Record and the MAR and acknowledged the above information. During a concurrent observation, interview, and record review, on 5/19/25 at 1210, in the medication room, LVN 3 identified Resident 160's Hydrocodone (narcotic pain reliever)/APAP (acetaminophen pain reliever) 5/325 mg Controlled Drug Record and MAR. Inspection of the Controlled Drug Record showed Hydrocodone/APAP 5/325 removed on 4/6 for one tablet, and 4/8 for two tablets. Inspection of the MAR showed 0 tablets administered on 4/6, and one tablet administered on 4/8. LVN 3 reviewed the Controlled Drug Record and the MAR and acknowledged the above information. During a concurrent observation, interview, and record review, on 5/19/25 at 1405, in the medication room, LVN 3 identified Resident 165's Hydrocodone/APAP 5/325 Controlled Drug Record and MAR. Inspection of the MAR showed three tablets given every day from 5/1/25 through 5/18/25. Inspection of the Controlled Drug Record, from 5/1/25 through 5/18/25, did not show three tablets of medication removed every day. LVN 3 reviewed the Controlled Drug Record and the MAR and acknowledged the above information. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review, on 5/21/25 at 1335, Director of Nursing (DON) inspected Resident 160, 165, and 167's Controlled Drug Records and the MARs identified above. DON acknowledged the Controlled Drug Records and MARs did not match. DON stated that it was her expectation the scheduled medication records were to be accurate. 2. During a concurrent observation, interview, and record review, on 5/19/25 at 1145, in the medication room, Licensed Vocational Nurse (LVN 3) identified Resident 167's morphine (narcotic pain reliever) 20 milligram (mg)/milliliter (ml) plastic bottle. Inspection of the bottle showed it contained 13 mls of morphine. LVN 3 inspected the bottle and stated it contained 13.75 mls of morphine. LVN 3 identified the Controlled Drug record for the morphine. Inspection of the Controlled Drug Record showed the amount in the bottle was 16 ml. Continued review of the Controlled Drug Record showed 0.25 mls were removed from the bottle four times between 5/1/25 and 5/11/25. LVN 3 identified the MAR for the morphine. Review of the May 2025 MAR did not show morphine 0.25 ml administered between 5/1/25 and 5/11/25. LVN 3 reviewed the Controlled Drug Record and the MAR and acknowledged the above information. During a concurrent observation, interview, and record review, on 5/19/25 at 1210, in the medication room, LVN 3 identified Resident 160's Hydrocodone (narcotic pain reliever)/APAP (acetaminophen pain reliever) 5/325 mg Controlled Drug Record and MAR. Inspection of the Controlled Drug Record showed Hydrocodone/APAP 5/325 removed on 4/6 for one tablet, and 4/8 for two tablets. Inspection of the MAR showed 0 tablets administered on 4/6, and one tablet administered on 4/8. LVN 3 reviewed the Controlled Drug Record and the MAR and acknowledged the above information. During a concurrent observation, interview, and record review, on 5/19/25 at 1405, in the medication room, LVN 3 identified Resident 165's Hydrocodone/APAP 5/325 Controlled Drug Record and MAR. Inspection of the MAR showed three tablets given every day from 5/1/25 through 5/18/25. Inspection of the Controlled Drug Record, from 5/1/25 through 5/18/25, did not show three tablets of medication removed every day. LVN 3 reviewed the Controlled Drug Record and the MAR and acknowledged the above information. On 5/20/25 at 1000, Administrator was requested to provide the Consultant Pharmacist reports (report on pharmacy services) for the past three months. During a concurrent interview and record review, on 5/21/25 at 1335, Director of Nursing (DON) inspected Resident 160, 165, and 167's Controlled Drug Records and the MARs identified above. DON acknowledged the Controlled Drug Records and MARs did not match. DON stated that it was her expectation the scheduled medication records were to be accurate. During a concurrent interview and record review, on 5/21/25 at 1400, DON identified the Executive Summary of Consultant Pharmacist's Medication Regimen Review (Consultant Pharmacist reports dated 4/18/25) provided by Administrator. Review of the document did not show issues with accuracy of the controlled medication documents. DON stated that it was her expectation that the pharmaceutical consultant identified issues with controlled medications. During an administrative record review, of the Executive Summary of Consultant Pharmacist's Medication Regime Review, reports dated 2/19/2025, 3/24/2025, and 4/18/2025, were reviewed. Review did not show issues with accuracy of the controlled medication documents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an administrative record review, of the Pharmacy Services Policy 483.60 (undated) showed, F427, A licensed pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. The pharmaceutical services consultant establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to have a full time (working 35 or more hours a week) Certified Dietary Manager for food and nutrition services for 24 Residents residing in the facility, not following standards of practice. This failure had the potential of not meeting the resident's nutritional needs, and placing residents at risk of not receiving meals/diet in a safe and sanitary manner, with the potential for infection, pressure injury, and possibly hospitalization. Findings: During a brief kitchen observation task and an interview on 5/19/25, at 09:21 a.m., with the Dietary [NAME] (DC) 1, DC 1 was the only staff in the kitchen. The DC 1 stated the facility Dietary Manager (DM) was off for the day and he was the only assigned staff to the kitchen for the day. The DC 1 stated the DM only worked one or two days a week. During a telephone interview on 5/19/2025, at 09:28 a.m., with the DM, the DM stated he was off for the day, and he was employed by the facility for one or two days a week, on a part time basis. During an interview on 5/22/2025, at 12:07 p.m., with Dietary [NAME] (DC) 2, DC 2 stated the DM worked only on weekends, all day until 7:00 p.m., and that DC 2 worked at the facility two days a week. During a review of facility's detail payroll report for the DM, dated 3/02/2025 to 3/15/2025, the payroll indicated,'DM's workdays are Saturday and Sunday, total hours for pay period 23.25, weekly hours was16.25 hours, actual in, at 10:00 a.m., out at 06:30p.m., daily hours of 8 hours, regular 8 hours, overtime (OT) 0. During a review a facility's detail payroll report for the DM, dated from 4/1/2025 to 4/30/2025, the payroll indicated, DM workdays are Saturday and Sunday, in, 10:30 a.m., to 06:30 p.m., DM worked on dates 3/16/2025, 3/22/2025, and 3/23/2025, 3/29/2025, and 3/30/2025. During a review a facility's detail payroll report for the DM, dated 5/1/2025 to 5/16/2025, the payroll indicated, DM workdays is Saturday and Sunday, in, 10:00 a.m., to 06:30 p.m., DM worked on dates 5/4/2025, 5/10/2025, and 5/11/2025. During a review of facility's staff schedule, titled CNA schedule, the schedule indicated, DM is only scheduled to work two days a week, Saturday and Sunday. During an interview on 5/19/2025, at 1:02 p.m., with the Registered Dietitian (RD), the RD stated she was employed as a consultant and only worked for the facility a couple hours less than eight hours a week. The RD stated in most cases facility would reach her by phone. During an interview on 5/22/2025, at 12:21 p.m., with the Director of Nursing/Infection Preventionist (DON/IP) the DON/IP stated the DM was scheduled twice a week. DON/IP also stated the DM was needed on a full time basis to make sure the menus are followed correctly, for food sanitation, meeting resident's nutritional calories, and providing proper diet to residents. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P), titled, Personnel Management, dated 02/2010, the P&P indicated, A qualified Dietary Services Supervisor, chosen by the Administrator, is responsible for total operation of the Dietary Department. All diabetic service is performed under their direction . If a person is not a Registered Dietitian, he must be a graduate of a state approved course that provides ninety or more hours of classroom instruction in Diabetic Service Supervision, and receive regular consultant from a Registered Dietitian, or have met equivalent requirements . Responsibilities of the dietary service Supervisor . Assuring that dietary personnel who exhibit signs of a communicable disease do not work . Complete residents dietary profile, nutritional screening, quarterly note, annual review and MDS . Visit all new residents to record food preference and allergies. During a review of facility's policy and procedure (P&P), titled, Dietary Supervisor Job Description, the P&P indicated, This position must provide management for the Dietary Department, ensuring quality food. The Dietary Supervisor will direct and assist the preparation and serving of regular meals and therapeutic diets, order food and supplies and maintain area and equipment in sanitation condition and assure the smooth operation with other nursing home departments.

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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 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. Based on observation, interview, and record review, the facility failed to store and label food in the storage area (for the retention of food [before and after preparation] and associated dry goods), used for 13 out of 13 sampled residents' nourishment, not following their facility policy and procedure and professional standards of practice for food service safety. This failure has the potential for Residents not getting palatable food and nourishment, the potential for foodborne illnesses/outbreak, infection and potential for hospitalization. During a brief kitchen observation on 5/19/25, at 09:21 a.m., with the Dietary [NAME] (DC), Corn Flakes Cereal not in the original box, package labeled 6/9/2022. Bran Raisin package had been opened with no opened date labeled, and Oatmeal was still in its original manufacturer package and had no opened label on it. Opened food items stored in the one door freezer were not labeled with an opened date. The DC stated the food packaging had not been thoroughly checked for used by and opened date since he got employed with facility. The DC stated he had just started working at the facility about two weeks ago. The DC was the only assigned staff in the kitchen for the day shift. During an interview on 5/19/25, at 10:48 a.m., with DC, DC stated food and food packaging must be labeled immediately after opening, because it's the facility's policy, and also once food package has been opened, everything has a shelf life, based on when the item was opened. Food items may not be kept longer than they were supposed to be. DC also stated the food item might also be a potential throw away. During an interview on 5/22/25, at 12:21 p.m., with the Director of Nursing/Infection Preventionist (DON/IP), DON/IP stated when a food package has been opened, it should be labeled and dated, and that if it's not dated, the facility does not know whether the food item has expired. DON/IP further stated there were some foods that were good for this much date and expired food could not be served to residents for food sanitation and safety. During a review of facility's policy and procedure (P&P) titled, Dry Goods Storage Guidelines, dated 2018, the P&P indicated, food item, Cerael ready to eat, unopened on shelf 6 months, opened on shelf 2 months, opened refrigerated N/A . Cereal ready to cook, unopened on shelf 6 months, opened on shelf 6 months, opened refrigerated N/A. During a review of facility's policy and procedure (P&P) titled, Canned and Dry Goods storage, dated 2018, the P&P indicated, Grains and grains products, cereal ready to eat, recommended maximum storage period if unopened less than or equal to 85 degree Fahrenheit, 6 months, food-cereal, cooked, recommended maximum storage period if unopened less than or equals to 85 degree Fahrenheit, 8 months. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, General Receiving of Delivery of Food and Supplies, dated 2018, the P&P indicated, food deliveries will be inspected to assure high quality food and supplies. They are to be received in proper condition . Check deliveries for intact packaging. Broken boxes, leaky packages, or dented cans may be signs off mishandling and could be grounds for rejecting the shipment . Deliveries are to be put away as quickly as possible. Begin with refrigerated items, then frozen and then dry goods. Label all items with the delivery date or use by date . 9. Dry food items which have been opened, such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles, etc. will be tightly closed, labeled and dated. These items are to be used per times specified in the Dry 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. 6. During a concurrent medication administration observation and interview, on 5/20/25 at 7:45 a.m., Licensed Vocational Nurse (LVN 1) identified residents to receive medication. LVN 1 administered medications to residents in the order of Resident 161, 117, 118, and 160. For each resident, LVN 1 used a portable blood pressure (BP, vital sign) machine. The resident's BP measurement included placing an inflatable cuff around the arm. In between each resident, LVN 1 returned to the medication cart (cart to store medications) to prepare medications. After using the machine on Residents 161 and 117, LVN 1 placed the BP cuff directly on the top of the medication cart. During medication administration to the four residents, LVN 1 did not clean the BP cuff or the top of the medication cart. During a concurrent medication administration observation and interview, on 5/21/25 at 8:20 a.m., Licensed Vocational Nurse (LVN 2) identified residents to receive medication. LVN 2 administered medications to the residents in the order of Resident 1 and 114. For each resident, LVN 2 used a pole mounted blood pressure machine. The BP measurement included placing an inflatable cuff around the resident's arm. In between each resident, LVN 2 returned to the medication cart to prepare medications. LVN 2 did not clean the BP cuff between residents. During a concurrent interview and record review, on 5/21/25 at 2:04 p.m., Director of Nursing (DON) was asked if resident equipment (BP cuff, top of medication cart) was to be cleaned between residents. DON stated that it was the facility's expectation that equipment was cleaned between residents. DON identified the facility policy and procedure 7.2 Preparation for Medication Administration (1/23), Procedures, 2. :The nurse or authorized staff member on duty ensures equipment and supplies relating to medication storage and use are clean and orderly. Based on observation, interview, and record review, the facility failed to follow infection control prevention practices when: 1. House Keeping (HK)1 was in the hallway and in the dining room during resident mealtime wearing gown used for laundry services. 2. HK 1 did not have in-service training on environmental cleaning. 3. HK 1 did not know what to use for disinfecting high touch surface areas in resident rooms (i.e. bed rails, bedside table, doorknobs and light switches). 4. Clean linen were stored in the dirty area of laundry room. 5. Clean linen was covered with sheet protector that was touching the floor. 6. The facility failed to ensure equipment was cleaned between residents. For six (Residents 1, 114, 117, 118, 160, 161) out of six residents sampled, equipment was not clean. During resident medication administration, equipment was not cleaned between use. These failures had the potential for cross contamination and spread of infections among residents at the facility. Findings: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a concurrent observation and interview on 5/19/25 at 12:20 p.m., HK 1 entered the dining room from the hallway during resident's lunch wearing protective gown. HK 1 interacted with residents in the dining room and then proceeded to walk to the hallway and then into the lobby. When asked why he was wearing gown, HK 1 stated he was not direct care staff. HK 1 added, he was assigned to laundry to wash resident clothes. HK 1 also added, he was wearing protective gown to protect his clothing from splash when doing laundry. During a concurrent interview and record review on 5/20/25, at 11:43 a.m., with the DON/IP, the facility's policy and procedures (P&P) titled, LAUNDRY DEPARTMENT, undated was reviewed. The P&P indicated under policy, Careful precautionary procedures must be followed by laundry personnel to prevent the spread of infectious diseases to other staff members, residents and visitors. All soiled linen is considered potentially infectious. Under personnel guidelines, All employees shall wear designated uniforms. Employees in the soiled areas shall wear an outer garment over their uniforms and gloves. Protective garments shall be removed and hands washed each time the employee leaves the soiled area. DON/IP stated, the gown HK 1 was wearing was used in laundry to protect HK's clothing from splash when washing resident clothes and sheets. DON/IP also stated the gown was contaminated and HK 1 was not supposed to wear outside the laundry room especially in the resident area. DON/IP further added, HK 1 could spread infection to other residents by wearing contaminated gown in the hallway and dining room. 2. During an interview on 5/20/25 at 1:58 p.m., with HK 1, HK 1 did not recall training regarding use of disinfectant and or use of protective gown in the laundry room. HK 1 added, he only remembers training on handwashing, Personal Protective Equipment (PPE) use, and environmental cleaning. 3. During a concurrent observation and interview on 5/20/25, at 2:12 p.m., with HK 1, HK 1 demonstrated facility process for disinfecting high touch surfaces. HK 1 took one sheet from a pack of premium washcloths, then stated he wiped resident's bedside table, handrails, and call lights with the wipes. During a concurrent interview and record review on 5/20/25, at 2:21 p.m., with DON/IP, DON/IP revealed HK 1 did not have in-service training on environmental cleaning since his hire date in 2022. DON/IP acknowledged HK 1 did not know how to disinfect high touch surfaces because HK 1 used adult wipes for incontinent care. DON/IP further added, adult wipes that HK 1 used were not effective to kill microbes. 4. During a concurrent observation and interview on 5/21/25, at 9:51 a.m., with HK 1, in the dirty area of laundry room, clean linen was stored in the shelves nearby where the dirty / soiled articles were rinsed prior to washing. HK 1 stated, he wore protective gown when rinsing dirty articles in this area. 5. During a concurrent observation and interview on 5/20/25, at 9:55 a.m., with DON/IP, in the presence of HK 1, DON stated, the linen stored in dirty area of laundry room was contaminated due to exposure to splash from dirty articles. DON/IP directed HK 1 to remove the clean linens to be rewashed. DON/IP also added, the clean linens covered in sheets that were touching the floor were also contaminated and needed to be rewashed. DON/IP added, she was not aware of the HK 1's practices and said, he needed in-service training on infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedures (P&P) titled, LAUNDRY DEPARTMENT, undated, the P&P indicated under policy, Careful precautionary procedures must be followed by laundry personnel to prevent the spread of infectious diseases to other staff members, residents and visitors. All soiled linen is considered potentially infectious.Under Laundry procedures, .Every laundry and housekeeping staff member will be trained to follow them. New personnel and older employees will attend inservice training programs in order to become familiar with new techniques and skills .All laundry employees will be expect4ed to attend inservice programs pertaining to infection control. During a review of the facility's P&P titled, BASIC INFECTION CONTROL IN HOUSEKEEPING AND LAUNDRY, dated 7/2003, the P&P indicated, .10. Schedule and hold regular in-service meetings for the department . 11. Design linen and laundry procedures to prevent cross-contamination. During a review of the facility's P&P titled, HOUSE KEEPING DEPARTMENT, undated, the P&P indicated under housekeeping policies, .Inservice training programs will be held for new personnel as well as older employees fo the purpose of introducing them to new techniques and skills.All housekeeping employees are expected to attend inservice programs pertaining to infection control. Under cleaning agents, .Reliable disinfectant germicides must be used in areas known to be contaminated with pathogenic bacteria (such as where active infection has been treated). These detergent germicides must be EPA registered, approved for the hard water conditions and health care or hospital tested.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview, the facility failed to ensure the Infection Preventionists (infection control nurse or designee) had completed specialized training in infection prevention and control. This failure had the potential to contribute to the residents' development of contracting healthcare acquired infections (infections from receiving treatment at a facility). Findings: During a concurrent interview and record review on 5/20/25, at 2:44 p.m., with the Director of Nursing/Infection Preventionist (DON/IP), in the presence of Administrator/MDSC (ADM/MDSC), the DON/IP stated two staff members were designated Infection Preventionists, including DON and Administrator (ADM). DON/IP also stated she had not completed the specialized training in infection prevention. Furthermore, the ADM/MDSC revealed she also had not completed the specialized training in infection prevention.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the facility had six resident rooms (Rooms 1, 3, 5, 7, 8, and 9) with multiple beds that provided less than 80 square feet (sq. ft) per resident who occupied these rooms. This deficient practice had the potential to result in inadequate space for the delivery of care to each of the residents in each room, or for storage of the residents' belongings. Findings: During an observation on 5/19/25 at 9:30 a.m., the following Resident (Rt) rooms and corresponding square footage (sq. ft) were identified: Room Activity Room Size Floor Area 1 Rt Room 299.63 sq.ft 74.9 sq.ft/bed 3 Rt Room 293.25 sq.ft 73.32 sq.ft/bed 5 Rt Room 299 sq.ft 74.75 sq.ft/bed 7 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Rt Room 299 sq.ft 74.75 sq.ft/bed 8 Rt Room 299 sq.ft 74.75 sq.ft/bed 9 Rt Room 299 sq.ft 74.75 sq.ft/bed During a concurrent observation and interview on 5/19/25, at 9:35 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated, rooms with four Residents had enough space to provide resident care. CNA 1 also stated, there was enough space even for residents using wheelchairs. During a concurrent observation and interview on 5/19/25, at 9:42 a.m., Resident 17 was seen wheeling self towards bedside from the hallway. Resident 17 stated there was enough space to wheel herself in and out of room. Resident 17 also stated staff were able to provide care without problem. During an interview on 5/21/25, at 12: 25 p.m., with the Administrator/Minimum Data Set Coordinator (ADM/MDSC), ADM/MDSC stated there were no changes in room sizes since the last survey. ADM/MDSC confirmed, (Rooms 1, 3, 5, 7, 8, and 9) with multiple beds that provided less than 80 square feet (sq. ft) per resident who occupied these rooms.