

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555521	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Rancho Mesa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9333 LA Mesa Drive Alta Loma, CA 91701	

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)
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44841</p> <p>Based on interview and record review, facility failed to ensure that a Minimum Data Set (MDS- a computerized assessment instrument) Discharge Assessment was completed and transmitted in accordance with federal guidelines for one of three residents (Resident 53) reviewed for residents assessment.</p> <p>This failure resulted in Resident 53's assessment not completed upon discharge on March 28, 2024.</p> <p>Findings:</p> <p>During a review of Resident 53's Admission Record (a document that contains demographic and clinical data), the Admission Record indicated, Resident 53 was admitted to the facility on [DATE], with diagnoses which included hyperlipidemia (an abnormally high concentration of fats or lipids in the blood) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a concurrent interview and record review, on August 9, 2024, at 9:15 AM, with the License Vocational Nurse/Minimum Data Set Nurse (LVN/MDS Nurse), the LVN/MDS Nurse reviewed Resident 53's clinical record dated March 28, 2024, indicated Resident was discharged home with home health services .</p> <p>Further review of Resident 53's MDS assessment, indicated last assessment was MDS Admission Assessment completed on February 15, 2024. The LVN/MDS nurse, confirmed no other MDS assessments had been completed since February 15, 2024. The LVN/MDS nurse stated he missed completing the discharged assessment for Resident 53 and it should have been completed on March 28, 2024.</p> <p>During an interview on August 9, 2024, at 9:25 AM with the Director of Nurses (DON), the DON stated the discharge assessment should have been completed on March 28, 2024. (The assessment was neither completed nor transmitted, and 133 days had passed since Resident 53's discharge date).</p> <p>(continued on next page)</p>

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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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on August 9, 2024, at 9:40 AM with DON, The DON reviewed the facility Policy and Procedure titled Resident Assessment, revised March 2022, which indicated, . A comprehensive assessment of every, resident's needs is made at intervals designated by OBRA[Omnibus Budget Reconciliation Act] and PPS [Prospective Payment System] requirements. Policy Interpretation and Implementation. Definitions OBRA-Required Assessments - are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes . 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. required assessments - conducted for all residents in the facility: . (7) Discharge Assessment (return anticipated and return not anticipated) . The DON stated that the facility did not follow the policy.</p> <p>During a review of CMS (The Centers for Medicare & Medicaid Services) RAI manual (Resident Assessment Instrument, this manual provides guidelines and definitions for completing MDS assessment) revised October 2023, it indicated, . OBRA -Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include: Tracking records o Entry o Death in facility Assessments o Admission (comprehensive) o Quarterly o Annual (comprehensive) o SCSA (comprehensive) o SCPA (comprehensive) o SCQA o Discharge (return not anticipated or return anticipated) .</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49669</p> <p>Based on observation, interview, and record review, the facility failed to maintain acceptable parameters of nutritional status for one of 55 sampled residents (Resident 58) when tube feeding (process where food is delivered into the stomach by a machine) was not administered based on physician order.</p> <p>This failure had the potential to result in decline in function and unplanned weight change to Resident 58.</p> <p>Findings:</p> <p>A review of Resident 58's Admission Record, (contains demographic and medical information), indicated Resident 58 was initially admitted to the facility on [DATE], with diagnoses which included cerebral infarction (disruption of blood supply to the brain), aphasia (difficulty in talking), dysphagia (difficulty in swallowing), and debility (physical weakness).</p> <p>During an observation on August 6, 2024, at 9:45 AM, Resident 58 was laying in his bed. He was not able to answer questions and he appeared frail. His tube feeding was not connected and the machine was off. There was no tube feeding bag hanging next to the machine.</p> <p>During a concurrent interview and record review on August 6, 2024, at 10:00AM with Licensed Vocational Nurse/Minimum Data Set (LVN/MDS), LVN/MDS stated that the tube feeding was stopped at 9:40AM.</p> <p>During a review of Resident 58's physician orders, dated August 2, 2024, Physician order indicated, Osmolite 1.5 (therapeutic nutrition that provides complete, balanced nutrition for tube feeding for patients) at 60ml (milliliters - unit of measure) / hr (hour) x (times) 20 hours via enteral pump (a machine that delivers food to the stomach) .Turn on @ [at] 2:00PM, turn off @10:00 AM or until dose is consumed .</p> <p>During a concurrent observation and interview on August 6, 2024, at 10:30AM in Resident 58's room, LVN/MDS stated he discarded the tube feeding bottle in the trash can. The tube feeding bottle was labeled with Resident 58's name, room number, August 5, 2024 (date the formula bottle had been hung) and time 0900 [9:00AM] (date and time the feeding was started) and the rate of the administration which was 60 mls an hour (60 ml/hr - rate of nutrition administration via enteral pump). LVN/MDS stated that he was not able to calculate how much in total the resident received during his last feeding.</p> <p>During an interview on August 6, 2024, at 11:45AM with the Director of Nurses (DON), DON stated that the resident's tube feeding should be on for 20 hours from 2:00PM through 10:00AM at a rate of 60ml/hr. She stated that the tube feeding bottle was last hung on August 5, 2024 at 9:00AM and resident received 60ml from 9am to 10am. DON further stated that the enteral bottle would have 940 ml left when the feeding was scheduled to be turned on at 2:00PM. DON stated that a new bag should have been hung on August 6, 2024, at 6:00AM until 10:00am so that the resident could get the total 1200ml that is ordered by the physician. She stated that the resident did not get the required dose as ordered by the physician.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on August 8, 2024, at 2:15 PM with the Registered Dietitian (RD), RD stated if the tube feeding is not running, they are not getting their nutrition and residents on tube feeding are more prone to losing weight.</p> <p>During a review of Resident 58's Nutrition Assessment, dated August 6, 2024, the nutrition summary indicated that the resident has malnutrition r/t (related to) dysphagia secondary to dementia (decreased ability to think), severe muscle wasting, severe fat loss, BMI 19, and G-tube dependent.</p> <p>During a review of Resident 58's Care Plan (a plan that provide directions on thre type of care an individual needs), dated August 6, 2024, the care plan indicated, Resident 58 has the potential for nutritional problem r/t (related to) tube feeding, dysphagia, unspecified protein-calorie malnutrition.</p> <p>During a review of Resident 58's Nutrition Assessment, dated August 6, 2024, the nutrition assessment indicated Resident 58 had a recent weight of 131 pounds and a current BMI (body mass index - weight and height measurement) of 19.3. Resident 58's goal weight range is 160-170 pounds.</p> <p>During a review of Resident 58's Speech Therapy Evaluation and Plan of Treatment, dated August 1, 2024 through August 28, 2024, the Speech Therapy Evaluation and Plan of Treatment indicated, Resident 58's risk factor . without skilled therapeutic intervention, the patient is at risk for weight loss and malnutrition.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49669</p> <p>Based on observation, interview, and record review, the facility failed to have nursing staff with appropriate competencies and skills set to provide nursing services to Resident 58 when he only received 940 ml (milliliters - unit of measure) of tube feeding (supply of food delivered via tube to the stomach) but should have received 1200 ml (millimeters) of medically prescribed enteral tube feeding formula as ordered by his physician on August 6, 2024.</p> <p>This failure had the potential to result in altered nutrition status for one of 55 medically compromised residents.</p> <p>Findings:</p> <p>A review of Resident 58's Admission Record, (contains demographic and medical information), indicated Resident 58 was initially admitted to the facility on [DATE], with diagnoses which included cerebral infarction (disruption of blood supply to the brain), aphasia (difficulty in talking), and dysphagia (difficulty in swallowing).</p> <p>During a concurrent interview and record review on August 6, 2024, at 10:00AM with Licensed Vocational Nurse/Minimum Data Set (LVN/MDS), LVN/MDS reviewed the electronic medical record and verified that the tube feeding order as Osmolite 1.5 (therapeutic nutrition that provides complete, balanced nutrition tube-feeding for patients) @ 60 ml / hr (hour) x (times) 20 hours via enteral pump (infusion pump used for continuous tube feedings). Turn on @2:00PM, turn off at 10:00AM or until dose is consumed. May hold feedings during ADL care, showers, and transfers. LVN/MDS stated that the tube feeding was stopped at 9:40AM.</p> <p>During a concurrent observation and interview on August 6, 2024, at 10:30AM in Resident 58's room, with LVN/MDS stated he discarded the tube feeding bottle in the trash can. The 1000 ml tube feeding bottle was labeled with the resident's name, room number, August 5, 2024 (date the formula bottle had been hung) and time 0900 [9:00AM] (date and time the feeding was started) and the rate of the administration which was 60 mls an hour (60 ml/hr - rate of nutrition administration via enteral pump).</p> <p>During an interview on August 6, 2024, at 10:35AM with LVN/MDS, LVN/MDS stated that he determined the feeding was complete when he had heard the enteral pump alarm go off. LVN/MDS further stated that he was not able to calculate how much in total the resident received, because he did not know how much was infused during the prior shift.</p> <p>During an interview on August 6, 2024, at 11:45AM with the Director of Nurses (DON), the DON stated that the tube feeding bottle was last hung on August 5, 2024 at 9:00AM and resident received 60ml and it was turned off at 10:00AM. The DON further stated that the enteral bottle would have 940 ml left when the feeding was scheduled to be turned back on at 2:00PM. The DON stated that a new bag should have been hung on August 6, 2024, at 6:00AM and that the resident did not get the required dose as ordered by the physician. She [DON] stated she would have to conduct an investigation to determine why the tube feeding was stopped overnight and why a new bag was not hung at 6:00 AM. The DON stated the LVN/MDS should be able to calculate how much feeding was provided on the shift prior.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on August 7, 2024 at 12:00PM with the DON, the Licensed Vocational Nurses Competency Evaluation and Performance Satisfactory Completion, Gastric Tube Medication Administration competency was reviewed. The DON stated there is no competency for licensed nursing staff on how to determine how much feeding was administered on the shift prior based on physician orders.</p> <p>During an interview on August 8, 2024 at 2:15PM with the Registered Dietitian (RD), the RD stated the licensed nurses should always give the full dose of the tube feeding. The RD further stated the licensed nurses are responsible for knowing when to change the bottle and how to calculate how much was given per shift.</p> <p>During a review of Resident 58's physician's orders, dated August 2, 2024, the physician's order indicated, Osmolite 1.5 @ [at] 60ml / hr x 20 hours via enteral pump (a machine that delivers food to the stomach) . Turn on @2:00PM, turn off @10:00A or until dose is consumed .</p> <p>During a review of the facility's policy and procedure titled, Alliance Pharmacy Pharmaceutical Services Policy and Procedure Manual, titled Enteral Tube Medication Administration dated November 2020, the P&P indicated, c. Inservice training on .monitoring of enteral solutions and medications via the enteral tube shall be provided by the facility to nursing personnel.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098</p> <p>Based on observations, interview and record review, the facility failed to ensure medication for one of seven sampled residents (Resident 42) observed for medication administration, was administered according to the physician's orders, when Resident 42 received Omeprazole [medication prescribe to minimize the acid reflex] after breakfast, on August 7, 2024.</p> <p>This failure has the potential to cause less effective management of Resident 42's condition, as the medication may not work as intended when taken after meal.</p> <p>Findings:</p> <p>During a record Review of Resident 42's Admission Record (contains demographic and medical information) the admission record indicated, Resident 42 was admitted to the facility on [DATE], with the diagnosis which included hepatic encephalopathy (a condition that affects the brain and occurs when the liver isn't working properly), morbid (severe) obesity due to excess calories (the person has an extremely high amount of bodyfat), and phantom limb syndrome with pain (a condition where a person who has had a limb amputated still feels sensation in the missing limb).</p> <p>A medication administration observation for Resident 42 by a License Vocational Nurse 2 (LVN 2) was conducted on August 7, 2024, at 8:20 AM, in Resident 42's room, LVN 2 administered Omeprazole DR [Delayed release, is designed to release medication slowly overtime, used to control acid reflex] 20 mg (mg - milligrams unit of measurement). Resident 42 stated, she already had her breakfast.</p> <p>During a review of Resident 42's physician's orders, dated June 3, 2024, at 2:12 PM the physician's orders indicated, Omeprazole Cap [capsule] Delayed Release 20 mg. Give 1 capsule by mouth in the morning for Gastroesophageal Reflux Disease (GERD - When the stomach acid irritates the food pipe lining).</p> <p>During a follow up interview on August 7, 2024, at 8:42 AM with LVN 2, LVN 2 stated Resident 42 received Omeprazole after breakfast, despite the physician's order to administer it before breakfast.</p> <p>During a concurrent interview and record review on August 8, 2024, at 9:57 AM, with the Director of Nurses (DON), the DON reviewed Resident 42's physician's orders, dated June 3, 2024, and indicated Omeprazole Cap Delayed Release 20 mg cap, to administer 1 cap by mouth in the morning for GERD give before breakfast. The DON stated, Omeprazole should have been given before breakfast. The DON further stated that it would not have the same effect if given after breakfast.</p> <p>During a concurrent interview and record review on August 8, 2024, at 9:59 AM, with the DON, the facility's policy and procedure titled, Pharmaceutical Services Policy and Procedure Manual indicated, Administration . J. Medications shall be administered in accordance with written orders of the attending physician. The DON stated, the nurse should have followed the policy, but she did not.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44841</p> <p>Based on observation, interview and record review, the facility failed to store medications under proper temperature control, as specified by the manufacturer when two vaccine solutions were found inside the medication cart (used to transport medication between patients' rooms), instead of the refrigerator.</p> <p>This failure had the potential to increase the risk of residents receiving vaccine medications with decreased efficacy.</p> <p>Findings:</p> <p>During a concurrent observation and interview on August 6, 2024, at 12:10 PM, while inspecting the 30's hall medication cart with Licensed Vocational Nurse 1 (LVN 1) 1 unopened vial of Covid Spikevax 23-24 (an updated COVID-19 vaccine for the 2023-[AGE] year), was stored inside the medication cart, the vial was labeled Do not freeze. Keep Medicine in Refrigerator. In addition, 1 unopened syringe of medication Afluria Quad 2023-2024 (a flu vaccine for the 2023-2024 flu season), labeled Refrigerator, was stored inside the medication cart. LVN 1 stated the vaccines had been in the medication cart since the start of his shift at 7:00 AM. Furthermore, LVN 1 stated that both vaccines should not have been in the medication cart and should have been stored in the refrigerator.</p> <p>During an interview on August 6, 2024, at 1:10 PM, with the Director of Nurses (DON), the DON acknowledge the two vaccines were inside the medication cart. The DON further stated the two vaccines should had been stored in the refrigerator.</p> <p>During an interview and concurrent record review with the DON, on August 9, 2024, at 10:11 AM, the DON reviewed the facility's policy and procedure titled, Storage of Medication, effective date November 2020, which indicated, Policy Statement. Medications and biologicals shall be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . K. Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) shall be kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place shall be refrigerated unless otherwise directed on the label . The DON stated, the facility did not follow the policy.</p> <p>Manufacture product information quick guide for Spikevax (COVID-19 Vaccine, mRNA) by Moderna 2023-2024 Formula, dated September 2023, indicated, . Store Refrigerated (up to 30 days, until expiration date) 36 F to 46 F (2 C to 8 C) Thawed vials and syringes can be handled in room light conditions .</p> <p>CDC Dosage, Administration, and Storage of Influenza Vaccines, indicated, Storage of Influenza Vaccines In all instances, approved manufacturer packaging information should be consulted for authoritative guidance concerning storage of all influenza vaccines. Vaccines should be protected from light and stored at recommended temperatures. In general, influenza vaccines should be refrigerated between 2 to 8 C (36 to 46 F) and should not be frozen; vaccine that has frozen should be discarded .</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>49669</p> <p>Based on observation, interview and record review, the facility failed to follow the menu on Monday August 5, 2024, for lunch for 45 residents when:</p> <ol style="list-style-type: none"> The cook served 1/2 cup of mashed potatoes instead of 1/3 cup as indicated on the menu for the CCHO (carbohydrate controlled- diet involves eating the same number of carbohydrates every day, and the purpose is to help people manage their blood sugar levels) diets. Facility did not have a way to ensure 4 oz (ounce - unit of measure) of meat was served for residents on the CCHO and regular diets, for lunch on August 5, 2024, as indicated on the menu. <p>These failures have the potential for 45 of 52 highly vulnerable residents to have altered nutrition intake and weight loss.</p> <p>Findings:</p> <ol style="list-style-type: none"> During an observation of the kitchen's meal preparation and tray line (process where the cook serves food on plates for each resident) for lunch on August 5, 2024, at 11:45 AM with the Dietetic Services Supervisor (DSS) and [NAME] (Cook), [NAME] served residents on a CCHO diet, mashed potatoes using a #8 scoop (4 oz). <p>During a review of the Cooks Spreadsheet, [undated], the lunch menu indicated the following serving sizes, Herb Mashed Potatoes for the CCHO diet, #12 scoop (3.25 oz).</p> <p>During an interview on August 5, 2024, at 3:37 PM with the Dietetic Services Supervisor (DSS), DSS stated the cook should follow the menu.</p> <p>During an interview on August 8, 2024, at 2:15 PM with the Registered Dietitian (RD), the RD stated that the staff should always follow the menu.</p> <ol style="list-style-type: none"> During an observation of the kitchen's meal preparation and tray line for lunch on August 5, 2024, at 11:45 AM, with the DSS and Cook, after the cook plated a meal for a resident on a regular diet, the surveyor asked to validate the weight of the portion of meatloaf. DSS stated he could not verify the weight of the meatloaf served because they did not have an ounce scale. <p>During an interview on August 5, 2024, at 3:37 PM with the Dietetic Services Supervisor (DSS), DSS stated the cook should follow the menu.</p> <p>During an interview on August 8, 2024, at 2:15 PM with the Registered Dietitian (RD), the RD stated that the staff should always follow the menu. RD further stated that the expectation is that the menu is followed to ensure that the portion size is correct and a scale is needed to ensure portion size is correct.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a record review of the facility document titled, Cooks Spreadsheet the lunch menu indicated the meatloaf portion size for the regular diet as 4 oz.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Menu Planning, dated 2000, the P&P indicated: #4. The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician Orders, to the extent medically possible.</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>49669</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs when the regular diet (no modifications) meatloaf was not served to 26 residents who are on a medically prescribed mechanical soft diet (designed for people who have trouble chewing and swallowing) instead of meatloaf that is mashable and topped with gravy.</p> <p>This failure had the result to increase the risks of choking and aspiration (process when swallowing food enters the lungs) for 26 out of 52 highly vulnerable residents.</p> <p>Findings:</p> <p>During an observation in the kitchen on August 5, 2024, at 11:46 AM, the [NAME] (Cook) prepared a plate for a resident on a mechanical soft diet. She served the resident the regular diet meatloaf.</p> <p>During a review of the facility document titled, Cooks Spreadsheet - Summer Menus, [undated], indicated that mechanical soft diet meatloaf should be served mashable & moist with gravy.</p> <p>During an interview on August 5, 2024, at 3:37 PM with the Dietetic Services Supervisor (DSS), DSS stated the cook should follow the menu.</p> <p>During an interview on August 8, 2024, at with the Registered Dietitian (RD), the RD stated that the cook should serve the meatloaf with gravy to prevent aspiration and should follow the menu.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Menu Planning, dated 2000, the P&P indicated: #4. The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician Orders, to the extent medically possible.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555521	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Rancho Mesa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9333 LA Mesa Drive Alta Loma, CA 91701	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49669</p> <p>Based on observation, interview and record review, the facility failed to ensure food was stored/prepared under sanitary conditions when:</p> <ol style="list-style-type: none"> Shelf under coffee maker had crumbs and dust and this had the potential to attract pests and for microorganism (bacteria) growth. Floor under shelves in the dry storage had a build-up of food crumbs, white crumbs under one shelf and a liquid spill which can attract pests and cause microorganism growth. Old food and dust under the fridges stored in the staff lounge and this had the potential to attract pests and microorganism growth. Ice machine had some black and yellow discoloration in the area where ice is formed which can potentially contaminate the ice. <p>These failures had the potential to contaminate resident's food and cause food illness to 52 out of 52 vulnerable residents who receive food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> During an observation on August 5, 2024, at 9:40 AM in the kitchen, there was crumbs and dust in the bottom shelf where the coffee maker is stored. <p>During an interview on August 8, 2024, at 2:15 PM with the Registered Dietitian (RD), the RD stated the expectation is for everything to be tidy and there should be no crumbs or dust.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Sanitation dated 2018, the P&P indicated, 9. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas.</p> <p>During a review of the FDA Federal Food Code, dated 2022, 4-601.11 indicated, (C) nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. In addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted.</p> <ol style="list-style-type: none"> During an observation on August 5, 2024, at 9:50 AM in the dry storage room, there was a build-up of food crumbs on the floor around the wheels of the metal shelves. There were white crumbs under one side of the shelves on the floor and a liquid spill present. <p>During an interview on August 8, 2024, at 2:15 PM with the Registered Dietitian (RD), the RD stated the floors should be kept clean.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Sanitation dated 2018, the P&P indicated, 9. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas.</p> <p>During a review of the FDA Federal Food Code, dated 2022, 4-601.11 indicated, (C) nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. In addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted.</p> <p>3. During a concurrent observation and interview on August 5, 2024, at 3:31 PM with Dietetic Services Supervisor (DSS) in the break room, there was dust and old food underneath the refrigerator and freezer. The DSS acknowledged the presence of dust and old food underneath the refrigerator and freezer. DSS stated that housekeeping is responsible for cleaning around the refrigerator and freezer in the breakroom.</p> <p>During an interview on August 8, 2024, at 2:15PM with the RD, the RD stated the area underneath the refrigerator and freezer should be kept clean, up to the same standards that they have in the main kitchen.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Sanitation dated 2018, the P&P indicated, 9. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair.</p> <p>During a review of the FDA Federal Food Code, dated 2022, 4-601.11 indicated, (C) nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. In addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted.</p> <p>4. During a concurrent observation and interview on August 5, 2024, at 3:42 PM with Maintenance (MTN), in the presence of DSS, the area of the ice machine where the ice is formed was noted to have some black and yellow buildup. MTN acknowledges that there is black and yellow buildup in the ice machine.</p> <p>During an interview on August 8, 2024, at 2:15P with the RD, the RD stated that the ice machine is expected to be clean and free of any discoloration.</p> <p>During a review of Blueair Installation and User's Manual, dated 2022, indicated Depending on the installation condition, the machine may need more frequent cleaning and sanitizing.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Ice Machine Cleaning Procedures, the P&P indicated, The ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly or per manufacture recommendations .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the FDA Federal Food Code, dated 2022, 4-602.11 indicated, (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. In addition, ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms.</p>		