STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555542	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer House	415 P Street Sacramento, CA 95814

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 48140 Based on interviews and record reviews the facility failed to ensure one out of 16 sampled residents (Resident 21), maintained their right to retain and use personal possessions when staff were aware Resident 21's cell phone was taken without his permission. This failure resulted in the unrecovered loss of Resident 21's personal cell phone. Findings: A review of Resident 21's admission record indicated Resident 21 was admitted to the facility in March 2024 with diagnoses including intracerebral hemorrhage (an emergency condition in which a ruptured blood vessel causes bleeding inside the brain) and hemiplegia (complete paralysis) and hemiparesis (partial paralysis) to the left dominant side. During an interview on 11/13/24 at 10:23 a.m., in Resident 21's room, Resident 21 stated, They took my cellphone away a few months ago because I called 911 a couple of times because the nurse at night wouldn't come help me when I was in pain. When questioned where the cell phone was currently, Resident 21 stated, I don't know. During a concurrent interview and record review on 11/14/24 at 12:25 p.m. with the Social Services Director (SSD) and the Assistant Director of Nursing (ADON), Resident 21's Inventory of Personal Effects, dated 3/22/23 and Resident 21's progress notes were reviewed. The SSD confirmed Resident 21 was admitted to the facility with 1 Cell/Mobile phone and 2 Chargers as indicated on the resident's inventory sheet. A Nurse Practitioner Progress Note, dated 9/10/24 at 12:46 a.m. indicated, The fire fighters .took [Resident 21's] cell phone when he was not looking. When asked if the SSD knew where Resident 21's cell phone was currently, the SSD stated, The fire department took it months ago, but I don't know where it is now .I never followed up to see what happened to it [the cell phone] or where it ended up. The SSD confirmed this was a violation of the resident's right to have personal property. During a record review on 11/15/24 at 10:33 a.m., Resident 21's Care Plan (CP, a document that summarizes a person's health conditions, care needs, and current treatment) was reviewed. A focus statement dated 9/13/24 indicated, .Fire dept [sic] removed cell phone during one of their visits. No additional documentation was found that discussed the outcome or current location of Resident 21's cell phone. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/24 at 10:42 a.m. with the Director of Nursing (DON), the DON was questioned if she knew where Resident 21's cell phone was. The DON stated, I heard the fire fighters took it a while ago, I don't know where it is now. During a review of the facility's policy and procedure (P&P) titled, Personal Property, revised August 2022, the P&P indicated, Residents are permitted to retain and use personal possessions .Resident belongings are treated with respect by facility staff .The facility promptly investigates any complaints of misappropriation or mistreatment of resident property. During a review of the facility's P&P titled, Resident Rights, revised February 2021, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to .be free from misappropriation of property .retain and use personal possessions to the maximum extent . During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, the P&P indicated, All reports of resident abuse (including injuries of unknown origin) .theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents .All allegations are thoroughly investigated. The administrator initiates investigations .Witness statements are obtained in writing, signed and dated .The investigator notifies the ombudsman that an abuse investigation is being conducted .Within five (5) business days of the incident, the administrator will provide a follow-up investigation report .The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48140 Based on interviews and record reviews the facility failed to investigate and report an allegation of abuse for one out of 16 sampled residents (Resident 21), when Resident 21 notified a Licensed Nurse (LN) of an allegation of sexual and physical abuse, which included an injury of unknown origin. This failure caused Resident 21 to feel unsafe within the facility. Findings: A review of Resident 21's admission record indicated Resident 21 was admitted to the facility in March 2024 with diagnoses including intracerebral hemorrhage (an emergency condition in which a ruptured blood vessel causes bleeding inside the brain) and hemiplegia (complete paralysis) and hemiparesis (partial paralysis) to the left dominant side. During an interview on 11/13/24 at 10:38 a.m. in Resident 21's room, when asked if Resident 21 had concerns with the way the facility addresses his mood, behaviors, and care planning, Resident 21 stated, I keep telling them [I need help], I'm scared I'm going to die here .the staff don't care about me, they're going to let me die here .the [Social Services Director (SSD)] is supposed to help me, but she doesn't. I want to get out of here .they don't listen to me. During an interview on 11/15/24 at 8:53 a.m. with the Activity Director (AD) when asked how Resident 21's mood and activity participation were the AD stated, [Resident 21] would come to activities often when he first got here, he enjoyed the arts and crafts .he stated the Certified Nursing Assistants (CNAs) didn't get him up, but then when [Resident 21] was up, he wanted to go back to bed after a short period of time then [Resident 21] just didn't want to participate anymore. A record review of Resident 21's Behavior Note created 8/2/24 at 3:42 a.m. written by LN 4, indicated, .[LN 4] went to resident's room with 1 CNA for witness .Resident started to claim and shown a bruise purplish on his R posterior hand radial side. Approximately 3x3 cm. No noted open skin noted. Resident claimed that it was inflicted last night (8/1/2024 noc [night]) when he was being changed by 2 CNAs, he described the event as follows. When the CNAs are changing me (the female CNA), she was playing with my [anus] .and the male CNA held my arm down. This is why I have this (pointing to the bruise) . During an interview on 11/15/24 at 1:43 p.m., CNA 4 stated if a resident notified her of an incident of abuse, I would tell the nurse what happened .verbally tell the nurse or any supervisor .ask the person about the situation and then alert the nurse. CNA 4 indicated she would fill out paperwork if requested by the nurse and ask what else needs to be done. CNA 4 was unsure if an abuse binder is available. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/24 at 2:03 p.m., LN 2 stated, If I received an allegation of abuse from a resident, I would interview the resident, get details and names, if the resident was willing to tell me .I would notify the Director of Nursing (DON) and Administrator (ADM) .check the policy and procedure (P&P) for abuse reporting .complete a change of condition form, perform frequent checks on the resident .and initiate behavioral monitoring. LN 2 added, I'd let the state [California Department of Public Health (CDPH)] know of the allegation as soon as possible I know there's an abuse binder around here somewhere. During a concurrent interview and record review on 11/15/24 at 2:14 p.m. Resident 21's Behavior Note dated 8/2/24 was reviewed with the DON and ADM. The DON and ADM reviewed the Behavior Note and stated they were unaware of the abuse allegation. DON stated in regards to allegations of abuse, I expected staff to start the 'abuse protocol' . which included notifying the facility's Abuse Coordinator (ADM), complete an SOC 341 (Report of Suspected Dependent Adult/Elder Abuse) and to fax it to the number on form .as well as notify myself and to monitor the resident .notify the Medical Director (MD) and assess for physical injury. The DON added she does not have access to the SOC 341 reports; the ADM does. The ADM stated, I would expect the incident to be reported to me immediately since I'm the abuse coordinator and to the proper authorities .I would complete an investigation with the CNAs named in the allegation, make sure a physical assessment is completed on the resident and file the SOC 341. During a phone interview on 11/15/24 at 3:35 p.m. with LN 4, LN 4 stated she was familiar with the resident and remembered the incident in question. LN 4 added, [Resident 21] reported to me that two CNAs were changing him and the female one was playing with his ass .I didn't see her doing that . and, I'm definitely a mandated reporter [person legally required to report suspicion of abuse or neglect to the relevant authorities] for the residents .for the bruise, I didn't know where he got it so I did a change of condition form .no, I did not do anything for the sexual abuse allegation, it was a non-emergency situation, he wasn't in respiratory distress or anything. When questioned further about the details of the incident LN 4 stated, I don't know when the allegation occurred .I just documented everything [Resident 21] said .I should have notified [DON] about the incident and allegations . A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022 indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents .All allegations are thoroughly investigated. The administrator initiates investigations . The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation . The investigator notifies the ombudsman that an abuse investigation is being conducted .Within five (5) business days of the incident, the administrator will provide a follow-up investigation report.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. 48140 Based on observations, interviews, and record reviews the facility failed to ensure one out of 16 sampled residents (Resident 21), was provided with an environment that supported Resident 21's quality of life when Resident 21 received meals in polystyrene containers with plastic utensils. This failure resulted in Resident 21's lack of self-worth, self-esteem, and well-being. Findings: A review of Resident 21's admission record indicated Resident 21 was admitted to the facility in March 2024 with diagnoses including intracerebral hemorrhage (an emergency condition in which a ruptured blood vessel causes bleeding inside the brain) and hemiplegia (complete paralysis) and hemiparesis (partial paralysis) to the left dominant side. During a concurrent observation and interview on 11/14/24 at 12:07 p.m., in Resident 21's room, Resident 21's lunch meal was served in a polystyrene container with plastic utensils. Resident 21 stated, I don't know why [meals are served in polystyrene with plastic utensils], they never told me, but I don't like it. They [staff] don't care about me; I'm going to die here. During a concurrent interview and record review on 11/15/24 at 10:42 a.m. with the Director of Nursing (DON), Resident 21's Order Summary Report (OSR, physician orders) was reviewed. The DON confirmed there were no orders for the use of plastic utensils and polystyrene containers for Resident 21's meals. The DON acknowledged that serving Resident 21's meals in polystyrene with plastic utensils was a dignity issue and Resident 21 had the potential for feeling less than and singled out from his peers. During a concurrent interview and record review on 11/15/24 at 12 p.m. with the Dietary Manager (DM), Resident 21's dietary order was reviewed. The DM confirmed there was no order for the use of plastic utensils and polystyrene containers. The DM stated, I don't know why [Resident 21] receives his meal tray like that, it's just always been done that way .it's not specified on the meal ticket. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised February 2021, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity . p. be informed of, and participate in, his or her care planning and treatment.

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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. 48140 Based on observation, interview and record review the facility failed to ensure medications were stored in their original containers and in a safe manner for 16 sampled residents. This failure had the potential for medications to be incorrectly identified and misused. Findings: During a concurrent observation and interview on 11/14/24 at 9:01 a.m. with Licensed Nurse (LN) 3, at Medication Cart 1 (Med Cart 1). LN 3 opened the top drawer to Med Cart 1 where there were three 30 mL (milliliters, a unit of measurement) plastic cups observed, stacked on top of one another, in the top drawer. Each plastic cup had two or more items in it, unlabeled and unidentified. LN 3 confirmed the plastic cups were not labeled and included the following: 1. One plastic cup had one pink pill and one red liquid-gel pill, 2. One plastic cup had two orange-colored pills, 3. One plastic cup had seven red and white liquid-gel pills. LN 3 acknowledged the medications should not be removed from their original packaging; this is a safety concern. During an interview on 11/15/24 at 10:42 a.m. with the Director of Nursing (DON), the DON confirmed medications are not to be removed from their original packaging. The DON stated, The next nurse who takes over the medication cart won't know what these pills are .this is a safety hazard. A review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised February 2023, indicated, Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .Medications may not be transferred between containers.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46242 Based on observation, interview, and record review, the facility failed to ensure food was prepared and stored in a safe and sanitary manner for a census of 42 residents who received food prepared from the kitchen, when: 1. Expired half-gallon of milk, opened salad dressing and creamer containers without open dates labeled, and full egg crates without received or expiration dates labeled were found in the kitchen refrigerators; 2. No temperature monitoring logs for resident food freezer section and for the dry storage room; 3. Ice and water dispensers in the dining room were not clean; and, 4. Lids used for covering prepared food on the steam table were stored on top of the unclean oven top. These failures decreased the facility's potential to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Findings: 1. During a concurrent observation and interview on [DATE] commencing at 8:39 a.m. with the Dietary Manager (DM) the initial tour of the kitchen was conducted. Half-gallon opened container of milk was found in the beverage refrigerator with manufacturer's label, BEST BY [DATE]. DM confirmed that the milk was expired and should have been thrown away. Further inspection of walk-in refrigerator found four (4) crates of eggs, containing 30 eggs per crate, were found without received date or expiration date labeled, one gallon (unit of volume) of Creamy Caesar Dressing and a 56 fluid ounces (units of volume) bottle of opened French Vanilla coffee creamer found open without opened on date labeled. DM confirmed observations and stated the salad dressing and coffee creamer should be labeled with open dates and eggs should have a date labeled. A review of facility's list of residents receiving food from the kitchen titled Resident Listing Report, dated [DATE] (print date), indicated 42 residents were receiving food from the kitchen. A review of facility's policy and procedure titled, Food Receiving and Storage, revised [DATE], indicated, Foods shall be received and stored in a manner that complies with safe food handling practices . All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date) . Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded . Other opened containers are dated and sealed or covered during storage . 2. During a concurrent observation and interview on [DATE] commencing at 2:18 p.m. with DM in the dining room, a refrigerator with a freezer section on top, that was used for storage of resident foods, was observed with no temperature log for the freezer section which contained frozen foods. DM confirmed observation and stated that freezer section should have a temperature log for monitoring. (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 concurrent observation and interview on [DATE] at 9:14 a.m. with DM in the dry storage room in the basement, no temperature log was observed in the room. DM confirmed there was not a temperature log for the room and acknowledge one needs to be placed for temperature monitoring. A review of facility's policy and procedure titled, Food Receiving and Storage, revised [DATE], indicated, Foods shall be received and stored in a manner that complies with safe food handling practices . Functioning of the refrigeration and food temperatures are monitored daily and at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements . 3. During a concurrent observation and interview on [DATE] at 2:18 p.m. with DM in the dining room, ice and water dispensers of the ice machine were observed with white and brown residue on the surface. DM confirmed that ice and water dispensers were not clean. A review of facility's policy and procedure titled, Ice Machines and Ice Storage Chests, revised [DATE], indicated, Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice . Clean and sanitize the tray and ice scoop daily . Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions . 4. During an observation on [DATE] at 10:26 a.m. [NAME] (CK1) was observed in the kitchen preparing food. CK1 took tray cover from the top of the oven and placed it over a food tray containing food on the steam table. Surface on top of oven was observed with dusty sticky residue. During a concurrent observation and interview on [DATE] at 10:45 a.m. with DM in the kitchen by the oven. DM confirmed the top of the oven surface was unclean with food tray lids, used to cover foods, were stored on the dirty surface. DM added staff needed to clean the dirty surface. A review of the facility's policy and procedure titled, Cleaning and Disinfection of Environmental Surfaces, revised on [DATE], indicated, Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard . Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46242 Based on observation, interview, and record review, the facility failed to maintain infection prevention and control practices to help prevent the development and transmission of communicable diseases and infections when: 1. Housekeeping staff dipped contaminated gloves into mop bucket sanitizing solution; 2. Laundry room did not contain a hand washing station, and laundry room staff did not use gown for handling dirty laundry, did not sanitize equipment after handling dirty laundry, did not perform hand hygiene after glove removal, did not perform hand hygiene between resident room visits, and hung contaminated clothes hangers back on the clean linens cart; 3. Facility unable to provide evidence of timely corrective action following positive legionella tests in the water systems; 4. Licensed Nurse 1 (LN 1) did not perform hand hygiene when going in and out of residents' rooms while passing lunch trays; 5. Certified Nursing Assistant 2 (CNA 2) and CNA 3 did not perform hand hygiene when going in and out of residents' rooms while passing lunch trays; and, 6. LN 1 did not follow Enhanced Barrier Precautions (EBP, an infection control intervention that involves wearing gowns and gloves during high-contact patient care activities to reduce the spread of multidrug-resistant organisms for residents with wounds or indwelling medical devices, regardless of whether they are known to be infected or colonized) when providing wound care for Resident 42. These failures had the potential to result in infection among a facility census of 41 residents. Findings: 1. During an observation on 11/14/24 commencing at 10:08 a.m. Housekeeper (HK 1) was observed cleaning room [ROOM NUMBER]. HK 1 used gloved hands to wipe table tops and doorknobs with rags soaked in sanitizer solution. After completing wiping process HK 1 moved on to moping without changing gloves and dipped gloved hands into the mop bucket solution to take out mop pad that was soaked in it and squeezed out extra sanitizing solution out of the mop pad. HK 1 went on to mop the room, and after completing mopping the room HK 1 used gloved hands to remove dirty contaminated mop pad by rolling it off the mop and disposing of it in a separate container on the cleaning cart. HK 1 did not change gloves and dipped his hands into the bucket second time to take fresh mop pad for mopping restroom. In an interview on 11/14/24 at 10:08 a.m. HK 1 confirmed that he did not change gloves after wiping or when changing mop pads while cleaning room [ROOM NUMBER], he also agreed that this practice did contaminate the bucket with floor sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/15/24 at 9:32 a.m. Infection Preventionist (IP) agreed that during room cleaning process not changing gloves after wiping and removal of contaminated mop pads and dipping contaminated gloved hands into the floor sanitizer bucket constituted cross-contamination and was not expected practice. A review of facility's Policy and Procedure (P&P) titled, Cleaning and Disinfection of Environmental Surfaces, revised August 2019, indicated, Environmental surfaces will be cleaned and disinfected according to current CDC [Centers for Disease Control and Prevention] recommendations for disinfection of healthcare facilities and the OSHA [Occupational Safety and Health Administration] Bloodborne Pathogens Standard . 2. During a concurrent observation and interview on 11/14/24 commencing at 11:59 a.m. with the HK 2 in the laundry room. HK 2 demonstrated how she processed laundry. No hand washing sink was observed in the room. HK 2 in gloved hands and wearing no gown, opened a bin of dirty laundry and loaded it into the washing machine. HK 2 stated that using gown was not necessary because laundry did not come from the isolation rooms. After loading the dirty laundry HK 2 used automatic detergent dispenser to add detergent to the washing machine and closed the lid and using gloved hands without changing gloves prior, and pushed buttons on the machine to start washing. HK 2 did not sanitize exterior of the washing machine after loading dirty laundry, and she stated that she uses sanitizing wipes to wipe down equipment surfaces couple of times during her shift [not every time after dirty laundry loading]. HK 2 removed gloves and without performing hand hygiene took cart with clean clothes to bed delivered to six different resident rooms (614, 613, 612, 610, 605, and 604). HK 2 did not perform hand hygiene prior to entering these rooms, while in the rooms she touched closet doors and took empty hangers from residents' closets and hung them on the clean clothing cart. HK 2 confirmed that she did not perform hand hygiene after handling dirty laundry and removing gloves nor between different resident rooms, she had taken hangers from resident rooms and hung them on the cart with clean clothes, and the laundry room did not have a hand washing sink. In an interview on 11/15/24 at 9:32 a.m. the IP stated that staff must use gowns when handling dirty laundry and remove gloves and perform hand hygiene after handling dirty linens and in-between room visits. The IP clarified, empty hangers from residents rooms are potentially contaminated and should not go back to the clean linen cart without prior sanitation. The IP added, the washing machine needed to be sanitized after loading dirty laundry and confirmed the laundry room did not currently have a handwashing sink, due to maintenance issues. A review of facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces, revised August 2019, indicated, Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard . A review of facility's P&P titled, Departmental (Environmental Services) - Laundry and Linen, revised January 2014, indicated, .Wash hands after handling soiled linen and before handling clean linen . Consider all soiled linen to be potentially infectious and handle with standard precautions . Employees sorting or washing linen must wear a gown and gloves. A mask may be worn if aerosolization is expected . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555542	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer House	415 P Street Sacramento, CA 95814

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's P&P titled, Handwashing/Hand Hygiene, revised October 2023, indicated, . Environmental measures are taken to reduce contamination associated with sinks and sink drainage, including: hand washing sinks that are constructed and installed according to health department codes; sinks that are dedicated to handwashing, when possible . Hand hygiene is indicated . after contact with blood, body fluids, or contaminated surfaces . after touching the resident's environment . immediately after glove removal . The use of gloves does not replace hand washing/hand hygiene . 3. During a review of facility's water management plan on 11/14/24 at 3:30 p.m., facility's water management plan binder contained a positive legionella (a waterborne opportunistic lung pathogen) testing report dated 11/2/23, which indicated that four facility locations tested positive for legionella. The binder did not contain evidence the facility took corrective action following the positive legionella tests nor was re-testing, of all involved locations, performed. In an interview on 11/15/24 at 7:59 a.m. Facility's Administrator (ADM) confirmed that no evidence of corrective action or retesting of all involved legionella positive locations following the 11/2/23 report was available. During a concurrent interview and record review on 11/15/24 at 9:32 a.m. with IP, water flush logs dated 10/15/24 were reviewed. The IP stated water flushes were used as an intervention to control legionella. However, the IP confirmed there was no documented evidence that water flushes or retesting, of all involved positive locations reported on 11/2/23, were performed. IP confirmed he expected interventions and retesting to be completed, documented, and documentation should be available in the water management binder. A review of facility's document titled, Water Management Program, dated 6/7/2024, indicated, The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease [a lung disease caused by Legionella] . The water management program that the facility will use is based on the CDC recommendations for the facility's water management program . Facility will hire [Water testing company name] to test samples of water throughout the facility on an annual basis . The binder called Water Management Program kept in the Administrator's office will consist of the program, the annual results sample test . The facility water management team will meet annually to review the program or sooner if . the control limits are consistently not met . 4. During observation on 11/12/24 at 11:50 a.m., lunch dining cart arrived on hallway B, observed LN 1 leaving hallway A, sitting at nursing station performing computer data entry, then going to hallway B's dining cart and started passing out lunch trays to residents. LN 1 did not perform hand hygiene, before handling lunch trays or when entering and exiting residents' rooms. During an interview on 11/12/24 at 12:05 p.m., standing in hallway B near nursing station, LN 1 acknowledged leaving hallway A, going behind the nurse's station, touching the computer, and not washing or sanitizing hands before going to dining cart on hallway B and passing out lunch trays. LN 1 stated . [sanitizing hands] is important to prevent infection between residents. During a concurrent interview on 11/12/24 at 12:50 p.m., near hallway B's nursing station, the ADM stated that hand sanitizing between residents' rooms was important to prevent the spread of infection and added, I will talk to my staff about that. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation on 11/13/24 at 11:59 a.m., the lunch dining cart arrived on hallway A, CNA 2 and CNA 3 were observed not performing hand hygiene prior to removing lunch trays from dining cart or when going in and out of residents' rooms. During an interview on 11/13/24 at 12:05 p.m., standing in hallway A near dining cart, CNA 2 and CNA 3 both acknowledged not performing hand hygiene between rooms when delivering lunch trays. CNA 2 stated when I don't wash my hands, it could cause infection. CNA 3 stated sanitizing stops germs between the patients but when you have 50 million things on your mind to do in a day, sometimes you forget. During an interview on 11/13/24 at 3:55 p.m., the IP stated he expected staff to use hand sanitizer dispensers located conveniently in hallways to prevent spread of infection and residents from becoming sick. A review of facility's policy and procedure (P&P) titled, Alcohol-Based Hand Rub Dispensers, Installation and Use, dated Revised July 2016, indicated, Alcohol-based hand rub dispensers shall be installed in areas that facilitate access by healthcare personnel and maintain a safe environment for the residents and staff. 48140 6. A review of Resident 42's admission record indicated Resident 42 was admitted to the facility in September 2024 with diagnoses which included spina bifida (a birth defect in where the spinal cord fails to develop properly) and paraplegia (the loss of muscle function in the lower half of the body, including both legs). A review of Resident 42's Order Summary Report (OSR, physician orders) indicated Resident 42 had the following orders: a) Bilateral nephrostomy tubes (a flexible tube that drains urine directly from the kidney through an opening in the skin of the lower back); cleanse tube site with normal saline, pat dry, apply dry dressing and secure, every day; b) A treatment order for a left sacral unstageable wound to be changed daily; and, c) Enhanced Barrier Precautions (EBP). During a concurrent observation and interview on 11/13/24 at 9:15 a.m. outside of Resident 42's room, an EBP sign was noted outside of the resident's room and Personal Protective Equipment (PPE, gowns, gloves, masks) were observed hanging on the door facing outside of the resident's room, into the hallway. CNA 5 was observed entering Resident 42's room without a gown. During a wound care observation on 11/13/24 from 9:28 a.m. to 9:48 a.m. in Resident 42's room, LN 1 did not wear a gown during Resident 42's wound care for his left sacral unstageable wound or when changing the dressings to his bilateral nephrostomy tubes. (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 follow up interview on 11/13/24 at 1:41 p.m. with CNA 5, CNA 5 admitted he did not use PPE while he provided personal care to Resident 42. CNA 5 acknowledged the EBP sign outside of the resident's door and stated, I should have gowned up. During an interview on 11/13/24 at 1:49 p.m. with LN 1, LN 1 acknowledged the EBP sign outside of Resident 42's door and admitted she should have gowned up during wound care. During an interview on 11/14/24 at 2:14 p.m. with the IP, the IP confirmed Resident 42 was on EBP and staff need to wear gowns when providing personal care and wound care. A review of the facility's P&P titled, Enhanced Barrier Precautions, dated August 2022, the P&P indicated, Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents .EBPs employ targeted gown and glove use during high contact resident care activities .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and wound care (any skin opening requiring a dressing) .EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.