STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555588	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vibra Hospital of Northern California D/P Snf	2801 Eureka Way Redding, CA 96001

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review the facility failed to ensure a copy of the discharge notice was sent to the Office of the State Long-Term Care Ombudsman (assists with conflict resolution and protection of resident rights) for two out of three sampled residents (Residents 14 and 16). This failure had the potential to violate the resident right to appeal their discharge. Findings: A review of the facility's policy and procedure (P&P) titled, Transfer and Discharge Nursing Services, dated, 1/1/24, indicated, when the residents were discharged from the facility, the residents would be notified in writing. The P&P indicated, The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. A review of the, Clinical Record Abstract, dated 5/21/25, indicated, Resident 14 was admitted to the facility on [DATE] with the diagnosis of type 2 diabetes mellitus (uncontrolled blood sugar levels) with diabetic chronic kidney disease (an organ that filtered out the body's waste, became damaged due to uncontrolled blood sugar). Resident 14 was transferred to the hospital and discharged from the facility on 3/25/25. A review of the, Clinical Record Abstract, dated 5/21/25, indicated, Resident 16 was admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease (breathing problems that worsen over time). Resident 16 left the facility against medical advice (AMA) and was discharged from the facility on 4/9/25. During an interview on 5/21/25 at 3:30 pm, Case Manager (CM) confirmed, Resident 14 was transferred to the hospital on 3/25/25 and Resident 16 left the facility AMA on 4/9/25. CM stated, we haven't been doing the notification to Ombudsman for transfer to hospitals or for residents who leave AMA. During an interview on 5/21/25 at 3:44 pm, Director of Nursing confirmed the notification of discharge for Residents 14 and 16 had not been sent to the Ombudsman office.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to follow their Self-Catheterization (a procedure where the resident inserts and removes a flexible tube into the bladder and drains urine without the assistance of staff), policy and procedure (P&P) for one of one sampled residents (Resident 13) when: 1. The facility did not maintain adequate self-catheterization supplies; and 2. There was no physician order for Resident 13 to perform self-catheterization; and 3. There was no nursing assessment performed to ensure Resident 13 was able to perform self-catheterization safely. This had the potential to damage the bladder, cause infection, and could cause psychosocial harm. Findings: 1. A review of the facility's P&P titled, Self-Catheterization revised 6/1/24, indicated, the facility would ensure residents that performed self-catheterization were provided with supplies and equipment. A review of the Clinical Record Abstract, dated 5/22/25, indicated, Resident 13 was admitted to the facility on [DATE] with the diagnosis of Parkinson's disease without dyskinesia, without mentation of fluctuation (a disease that caused uncontrolled body movements and these uncontrolled body movements were not present at this stage of the disease). A review of the admission Minimum Data Set (MDS, a resident assessment tool), dated 5/4/25, indicated, Resident 13 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13 out of 15, indicating Resident 13's memory was intact. During a concurrent observation and interview on 5/20/25 at 2:39 pm, Resident 13 stated, I have asked for female self-catheterization kits, they only have male self-catheterization kits, and I just use what they give me. On a bedside table next to Resident 13's bed was a self-catheterization kit, and the label indicated, it was male cath-kit, 14.9 inches in length (Female self-catheterization tubes were approximately seven inches in length (sometimes shorter) and male self-catheterization tubes were approximately 15 inches in length (sometimes longer). When a female used the male self-catheterization tube, it placed them at a higher risk for infection or damage to the bladder). Resident 13 stated, it's frustrating that I don't have the right supplies. During a concurrent observation and interview on 5/22/25 at 9:05 am, with the facility's Infection Preventionist (IP), the central supply room, located at the nurse's station was observed. IP confirmed, there were no female self-catheterization kits present in the central supply room and stated, I didn't know there was a male or female straight cath [self-catheterization kit]. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/25 at 9:10 am, Materials Manager (MM) stated, we have never had any other straight cath than this and I didn't know there was a female one. MM confirmed that the facility did not provide Resident 13 with adequate supplies to perform self-catheterization safely. 2. A review of the facility's P&P titled, Self-Catheterization revised 6/1/24, indicated, Physician or NP (Nurse Practitioner) orders must confirm the resident is competent and appropriate for self-catheterization. During a concurrent interview and record review on 5/22/25 at 10:15 am, with Charge Nurse (CN), Resident 13's Orders were reviewed. CN stated, there was no order for [Resident 13] to perform self-catheterization. 3. A review of the facility's P&P titled, Self-Catheterization revised 6/1/24, indicated, residents would demonstrate self-catheterization and would be assessed to ensure the resident was competent and maintained a sterile technique (preventing contamination). A review of the, Plan of Care, dated 5/3/25, indicated, Resident 13 had difficulty with urinating, performed self-catheterizations, and would demonstrate knowledge of the bladder program. During a concurrent interview and record review on 5/22/25 at 10:15 am, CN reviewed nursing assessments dated 5/1/25 through 5/15/25 and stated, there were no self-catheterization assessments present in Resident 13's medical record. During an interview on 5/22/25 at 10:47 am, the Director of Nursing confirmed there was no physician's order for Resident 13 to perform self-catheterization and there was no assessment present indicating Resident 13 was able to perform self-catheterization safely.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 47442 Based on observation, interview, and record review, the facility failed to ensure that medications were administered in accordance with manufacturer's instructions and accepted standards of clinical practice for 3 of 31 medication administration opportunities observed, resulting in a medication error rate of 9.7%. This failure placed residents at risk of reduced therapeutic effect and potential harm. Findings: Review of Resident 217's record titled, Discharge Reconciliation Report, dated 5/21/2025, indicated Resident 217 had an order for MiraLAX; 1 packet (medication used for constipation) daily and Trelegy Ellipta inhaler (used to treat asthma and the management of chronic obstructive pulmonary disease) 1 puff daily. The instructions were to breathe out slowly and then fully inhale the dose while taking a slow deep breath through the mouth and hold breath for 10 seconds or as long as long as comfortable, then breathe out slowly. During an observation at 8:25 am, in Resident 217's room, Licensed Nurse (LN) A was preparing Resident 217's morning medications. LN A mixed the MiraLAX in approximately 8 ounces of fluid. Resident 217 drank about half the solution and placed the glass with the remaining liquid on the bedside table. LN A made no effort to prompt Resident 217 to complete the dose or remove the medication before leaving the room. Review of the manufacturer's directions for MiraLAX, dated 12/2024, indicated the full contents of the dissolved powder must be ingested to ensure effectiveness. The manufacturer of MiraLAX specifically instructs that it should be mixed with 4-8 ounces of a liquid (such as water, juice, or tea) and consumed immediately. The product is not intended to sit for long periods after mixing. If it is mixed and left out, it may change in consistency or texture, which could increase the risk of choking, especially in older adults or residents with swallowing difficulties (dysphagia). Review of the facility's policy titled, Medication Management; Administrations of Medications, dated 10/2024, indicated prepared medications may never be left unattended at the patient's bedside without a licensed practitioner's order. During a review of Resident 13's record titled, Orders, dated 5/16/2025, indicated Resident 13 had an order for Lovenox (medication used to thin the blood) 40 milligrams (mg, a unit of measure), to be given subcutaneously (under the skin), every day for blood clot prevention. The order indicated in capital letters, ROTATE INJECTION SITES. During a medication pass observation on 5/21/2025 at 9:00 am, in Resident 13's room, LN B administered Lovenox subcutaneously into the right lower abdomen. The injection was clearly below the belly button on the lower right side. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 13's Medication Administration Record (MAR), indicated the previous dose had also been given in the right lower abdomen, indicating the same site was used on consecutive days. LN B confirmed that she did not verify the prior injection site before administration. When asked about site rotation, LN B stated, I just asked the resident where she wanted it. A review of the manufacturer's insert for Lovenox (enoxaparin sodium) indicated that subcutaneous injections should be rotated to different areas of the abdomen to reduce the risk of local irritation or tissue damage. The manufacturer specifically stated: Administer Lovenox by deep subcutaneous injection in the abdominal area. Alternate injection sites between the left and right anterolateral and left and right posterolateral abdominal wall (left and right upper and lower abdomen). This means that each dose should be given at a different site, rotating between the four recommended quadrants of the abdominal area to avoid repeated injections in the same spot.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47442 Based on observation, interview and record review, the facility failed to ensure: 1. Metoprolol injectable vials (intravenous medication use to treat high blood pressure, and heart problems), were not stored and protected according to manufacturer recommendations for 1 of 1 pharmacy storage areas reviewed. 2. The nursing staff discarded MediSense (a brand name) glucose control solution (a solution with a specific known concentration of sugar used to calibrate and check the accuracy of a blood glucose meter) vials, when they expired. This failure had the potential to affect the stability and effectiveness of medications administered to residents and produced inaccurate patient blood glucose test results which could have led to negative clinical outcomes. Findings: 1. During an observation on [DATE] at 11:00 am, in the facility's pharmacy, three injectable vials of metoprolol were stored in a small container directly under an overhead light. The vials were not enclosed in an amber bag, or otherwise shielded from light. Review of the manufacturer's guidelines product insert for metoprolol under the heading titled, Supplied /Storage and Handling, dated [DATE], indicated metoprolol must be protected from heat and light to preserve its stability and potency. During an interview on [DATE] at 2:00 pm, with Director of Pharmacy (DOP), DOP confirmed the vials of metoprolol were not protected from light. DOP confirmed the vials should have been protected from light. Review of the facility's policy titled, Medication Management; Storage of Medications, dated ,d+[DATE], indicated medications must be stored under proper conditions of sanitation, light, humidity, ventilation, segregation and security as determined by the manufacturer's labeling. 2. During a concurrent observation and interview, on [DATE] at 8:35 am, in the medication room, with Assistant Director of Nursing (ADON), two MediSense glucose control vials, one labeled HI and one labeled LOW, had the manufacturer's printed expiration date of [DATE]. ADON confirmed the expiration date on the vials were [DATE], and should have been checked and discarded by the nursing staff. Review of the manufacturer's guideline for MediSense Glucose and Ketone Control Solutions, dated , d+[DATE], under the heading of Storage and Handling, indicated, discard control solutions 3 months after opening or on the expiration date printed on the bottle, whichever comes first. Under the heading, Precautions and Warnings, indicated do not use control solutions if they are expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Nursing; Fingerstick Blood Glucose, dated ,d+[DATE], indicated the meter will be cleaned, maintained and properly calibrated per manufacturer's guidelines.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41567 Based on observation, interview, and record review, the facility failed to ensure dietary menus were followed when: 1. [NAME] D did not follow the puree pork recipe; and 2. [NAME] D did not consistently use the required scoop sizes when measuring portions of food. These failures had the potential for under or over nourishment resulting in poor health outcomes for 30 out of 30 residents who received food prepared in the facility kitchen. Findings: A review of the facility's Matrix dated 5/20/25, indicated there were 30 residents residing in the facility who received food prepared in the kitchen. 1. A review of a facility's, Food and Nutrition Services policy titled, Standardized Diets, rev. 01/2025, indicated that regular and therapeutic [specialized] diets are planned to guide patient menu processing, meal production, and preparation. A review of a facility production recipe, undated, for pureed (ground) pork roast specified three ounce servings of pork; the directions indicated that water or stock could be used in the preparation of the recipe, and that the sodium content of the recipe as prepared should be 52 milligrams (mg, a unit of measure). Nutritional analysis of the recipe was based on using water and if other liquid was used nutritional analysis will vary. During a concurrent observation and interview in the kitchen on 5/21/25 at 10:22 am, [NAME] D was observed to remove slices of pork from a covered container and confirmed the pork slices totalled four portions of meat, and pureed the meat in a Robot Coupe food processor. When asked if he had weighed the pork to determine the correct portions, [NAME] D replied that he had not, and had eye-balled the portion sizes. [NAME] D added 1 cup of regular chicken broth to the recipe, and when asked if the broth were low sodium (salt), he provided the box he used in preparing the broth. According to the nutrition facts on the chicken broth box, each packet of chicken broth provided 1100 milligrams (mg, a unit of measure) of sodium; when divided by four, this indicated that pureed pork provided of 275 mg of sodium; 223 mg excess sodium in comparison to the puree pork recipe. During an interview on 5/22/25 at 9:10 am, the Registered Dietician (RD) confirmed that food portions should be weighed using a scale, and that regular broth should not be used in the puree pork recipe. 2. A review of a facility's Food and Nutrition Services policy titled, Standardized Diets, rev. 01/2025, indicated that regular and therapeutic diets are planned to guide patient menu processing, meal production, preparation, tray assembly and delivery, and that serving sizes as outlined in the spreadsheet are to be followed. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a diet menu spreadsheet for the lunch meal for 5/21/25, indicated the following portion sizes; a #8 scoop (1/2 cup) for soft/bite size pork, a #8 scoop for puree sweet potatoes, and a #16 a scoop (1/4 cup) for pureed seasoned beets. During a concurrent observation and interview, for lunch tray line preparation on 5/21/25 at 10:22 am, [NAME] D was observed to use a #10 scoop (3/8 cup) to portion soft/bite size pork, and stated he did not have enough of the correct sized scoops. [NAME] D used a #12 scoop (1/3 cup) to portion puree sweet potatoes, and a #8 scoop to portion puree seasoned beets. During an interview on 5/22/25 at 9:10 am, the RD confirmed that the scoop sizes used should match the diet menu spreadsheets.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observation, interview and facility document review the facility failed to provide a meal substitute equivalent in nutritive value and food preferences were not honored when: 1. Two of two residents (Resident 367 and Resident 9), received a grilled cheese sandwich as a meal substitute for the lunch meal; and 2. Food preferences were not honored for one of one residents (Resident 7) These failures posed the risk for resident nutritional needs not being met which could lead to unplanned weight loss. Findings: 1. Review of the facility's document titled, Diet Spreadsheet dated 5/21/25, showed for the CCHO (carbohydrate controlled) diet and the Low Potassium (K) diet, the lunch meal entree was three ounces of pork roast. Review of the facility's document titled, Detailed Menu Nutritional Analysis for day four, menu cycle: Summer Menu showed three ounces of pork roast provided 23 grams (gms, a unit of measure) of protein and 173 kilocalories (calories). Review of the facility's document titled, Grilled Cheese Sandwich dated 5/22/25 directed, 1. Place three ounces of cheese between two slices of bread. Review of the nutrition facts of the American pasteurized process cheese used to make the grilled cheese sandwiches showed that two slices of cheese was equivalent to 28 gms, or one ounce, provided five gms of protein and 90 kilocalories which was 18 gms protein and 83 kilocalories less than the entree served. A medical record review for Resident 365 was initiated on 5/21/25. Resident 365 was admitted to the facility on [DATE] with diagnoses including hemiplegia (a medical condition characterized by paralysis) following a cerebral infarction (ischemic stroke, when blood flow to the brain is blocked causing brain tissue to die). A CCHO (consistent carbohydrate) soft and bite-sized diet was ordered by the Physician on 1/28/25. During the lunch meal tray line observation on 5/21/25 at 11:30 am, Resident 365's lunch meal tray contained one grilled cheese sandwich and cooked beets. On 5/21/25 at 12:20 pm, an interview was conducted with [NAME] D. [NAME] D was asked to describe how he made a grilled cheese sandwich. [NAME] D stated he used two slices of American pasteurized process cheese and two slices of bread for the grilled cheese sandwich. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/25 at 9:10 am, an interview was conducted with the Registered Dietitian (RD). The RD confirmed a meal substitute should be equivalent in nutritive value as the entree served for that same meal. The RD confirmed the recipe for the grilled cheese sandwich called for three ounces of cheese, but six slices of American pasteurized process cheese should be used per sandwich. A Medical record review for Resident 9 was initiated on 5/21/25. Resident 9 was admitted to the facility on [DATE] with diagnoses including urinary tract infection and sepsis, a life-threatening complication of an infection. A low potassium diet was ordered by the Physician on 5/14/25. During the lunch meal tray line observation on 5/21/25 at 11:30 am, Resident 9's lunch meal tray contained one grilled cheese sandwich and cooked beets. On 5/21/25 at 12:20 pm, an interview was conducted with [NAME] D. [NAME] D was asked to describe how he made a grilled cheese sandwich. [NAME] D stated he used two slices of American pasteurized process cheese and two slices of bread for the grilled cheese sandwich. On 5/22/25 at 9:10 am, an interview was conducted with the RD. The RD confirmed a meal substitute should be equivalent in nutritive value as the entree served for that same meal. The RD confirmed the recipe for the grilled cheese sandwich called for three ounces of cheese, but six slices of American pasteurized process cheese should be used per sandwich. 2. A Medical record review for Resident 7 was initiated on 5/21/25. Resident 7 was admitted to the facility on [DATE] with diagnoses including syncope or fainting, and Diabetes Mellitus a condition in which the body has trouble controlling blood sugar. Review of the facility's document titled, Diet Spreadsheet dated 5/20/25, showed the vegetable for the lunch meal was yellow squash. Review of Resident 7's lunch meal ticket dated 5/20/25 showed Resident 7 disliked green beans, carrots, okra, green peas, squash and zucchini. During an observation and interview of the lunch meal on 5/20/25 at 11:58 am, Resident 7's lunch meal tray contained a vegetable mixture that included carrots, squash, and green beans. Resident 7 was asked about the vegetables on her plate, she stated she did not like the vegetables served and did not eat them. When asked how often she received food she didn't like, Resident 7 stated, This happens all the time, every day. On 5/21/25 at 12:23 pm, an interview was conducted the Menu Planner (MP). The MP stated the RD instructed her to serve a hot vegetable to all residents. On 5/21/25 at 5/22/25 at 9:10 am, an interview was conducted with the RD. The RD clarified it was not necessary to serve a hot vegetable to all residents and a salad would be fine to substitute if the resident did not like the hot vegetables. The RD added it was not necessary to serve both a salad and hot vegetables.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41567 Based on observation, interview and record review, the facility failed to ensure food safety and sanitation guidelines were followed when: 1. Time/Temperature Control for Safey (TCS) food, (food that requires specific temperature management to prevent harmful bacteria growth and toxin formation), for residents was not stored at appropriate temperatures in one of one nourishment refrigerators; and 2. The dish machine wash and rinse cycle temperatures did not meet manufacturer's temperature specifications; and 3. Black matter was found on the underside of the top surface of the ice machine storage bin located in the facility kitchen; and 4. A butcher block wooden cutting board was not cleaned with soap and water before being sanitized; and 5. [NAME] discoloration was found on the blending blades of two food processors in the kitchen; and 6. One plastic cutting board and three plastic bowls used for food preparation and food service showed signs of excessive wear. These failures had the potential to cause foodborne illnesses in 30 out of 30 residents who consumed food prepared in the facility's kitchen. Findings: A review of the facility's, Matrix dated 5/20/25, indicated there were 30 residents residing in the facility who received food prepared in the kitchen. 1. A review of a US Food and Drug Administration (USDA) Refrigerator and Freezer Storage Chart, dated 03/2018, indicated that keeping refrigerated TCS food at 40 degrees Fahrenheit (F, a unit of temperature measure), or less helps keep foods from spoiling or becoming dangerous. A review of a facility's, Food and Nutrition Services policy titled, Physical Plant and Equipment - Department Security, rev. 08/2024, indicated that Food and Nutrition Services were to maintain sufficient space, equipment, supplies and processes to provide for the safe, efficient and sanitary production and provision of food services to patients, including perishable foods being stored at proper temperatures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555588	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vibra Hospital of Northern California D/P Snf	2801 Eureka Way Redding, CA 96001

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation made on 5/20/25 at 3:08 pm, of the nourishment refrigerator used to store snacks for facility residents and food brought from the outside located in the residential dining room, it was noted the internal section of the refrigerator felt warmer than expected; a sensor device used to monitor the refrigerator temperature was observed, however, no readable thermometers were visible in the refrigerator. During an interview on 5/20/25 at 3:18 pm, the Director of Plant Operations (DPO) stated that all refrigerator temperatures were monitored remotely and if the range was out of normal for more than an hour, the DPO and the Dietary Manager (DM) were notified. During an interview on 5/20/25 at 3:25 pm, DM confirmed he received an alert if the refrigerator temperatures were two degrees over set parameters but did not know the temperature set-points, and stated he would like a back-up thermometer in the nourishment refrigerator. During an interview on 5/20/25 at 3:34 pm, DPO stated that the maximum temperature for the nourishment refrigerator was set at 46 degrees F. DPO added the nourishment refrigerator temperature range had been at that range for years and he was not sure what the proper temperature range for perishable food items should be. During an interview on 5/20/25 at 3:37 pm, DM confirmed that the refrigerator temperature should be less than 41 degrees F. During an observation of the nourishment refrigerator in the residential dining room on 5/20/25 at 4:22 pm, food temperatures were checked with a thermometer; the internal temperature of string cheese was 46.2 degrees F, and the internal temperature of cheddar cheese was 48 degrees F. During an interview on 5/20/25 at 4:33 pm, DM stated he would discard the cheese stored in the nourishment refrigerator. During an interview on 5/22/25 at 9:10 am, the Registered Dietician (RD) confirmed that the nourishment refrigerator temperatures were monitored online and that she does not inspect the nourishment refrigerators. A record review made of the nourishment refrigerator temperature graphs, dated 5/13/25 through 5/20/25, indicated the temperature peaked at or above 41 degrees F on 30 separate occasions. 2. A review of a facility Food and Nutrition Services policy titled, Dishwashing, Pot Washing, rev. 01/2023, indicated the automatic dish machine operations are maintained to ensure that dishes, pots and pans are clean, sanitized and dry before returning to service and temperatures for chemical sanitizing machines should be 120 degrees F, or higher, for both wash and final rinse cycles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 5/20/25 at 10:25 am, with [NAME] C and the DM present, [NAME] C was observed loading the automatic dish machine. The temperature gauge registered 100 degrees F for the wash cycle and 110 degrees F for the rinse cycle; when asked the expected temperature of the wash and rinse cycles, [NAME] C stated 120 degrees F. Another wash cycle was observed and the dish machine temperature reached 108 degrees F; on a third observation the wash cycle temperature reached 120 degrees F, and the rinse cycle 117 degrees F. [NAME] C stated he runs the dish machine four times to get the water hot. At 10:47 am, the automatic dish machine temperatures were rechecked two more times; the wash cycle registered 110 degrees F, the rinse cycle 116 degrees F, and the wash cycle 110 degrees F and the rinse cycle 118 degrees F on the second check. The DM confirmed the findings. A review of the manufacturer's signage plate on the dishwasher titled, NSF Machine Operation Requirements indicated wash and rinse water temperatures were required to be at 120 degrees F at minimum. 3. A review of the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces and Utensils, (A) Equipment, food-contact surfaces and utensils shall be clean to the sight and touch. A review of Follet manufacture's procedural, untitled, undated, on maintenance and cleaning of the ice making machine, indicated that sanitizing solution was to be wiped on the interior of the ice storage area. During a concurrent observation and interview with the DPO on 5/21/25 at 9 am, the underside of the interior ice storage compartment was wiped with a white cloth; a black substance was evident on the cloth and shown to DPO who confirmed the finding and stated he cleaned the internal components, and the DM cleaned the ice storage bin. During an interview on 5/21/25 at 9:30 am, DM confirmed the finding and stated he wiped down the sides and back of the ice storage bin but not the underside of the top near the dispensing chute as the DPO cleaned that part. During an interview on 5/22/25 at 9:10 am, the RD stated the ice machine should be cleaned according to the manufacturer guidelines. 4. A review of a facility's policy titled, Cleaning and Conditioning of Butcher Block Cutting Board in Cafe, undated, indicated that the butcher block was to be cleaned with hot soapy water and a clean towel, then rinsed with hot water, and wiped with sanitizing solution after each meal or use. During an observation of the lunch meal tray line in the facility cafe on 5/21/25 at 11:00 am, [NAME] D sliced pork and fish on a wooden butcher block. After the lunch meal tray line was finished, at 12:15 pm, the butcher block and steam table had bits of food and juices. [NAME] D used a sanitizing solution and a cloth to wipe down the butcher block cutting board and steam table surfaces. He was not observed to use soap and water. During an interview on 5/21/25 at 3:22 pm, the DM stated that [NAME] D should wash the butcher block with soap and water, rinse and then sanitize and that it was not alright to sanitize only. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. A review of the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces and Utensils (A) Equipment, food-contact surfaces and utensils shall be clean to the sight and touch. A review of a facility's, Food and Nutrition Services policy titled, Physical Plant and Equipment - Department Security, rev 08/2024, indicated that Food and Nutrition Services were to maintain sufficient space, equipment, supplies and processes to provide for the safe, efficient and sanitary production and provision of food services to patients. During a concurrent observation of the kitchen and interview with the DM on 5/20/25 at 9:22 am, brown discolorations were observed on the cutting blades of two [Robot Coupe] food processors. DM confirmed the findings and stated the blades were less than a year old, and he would order replacements. 6. A review of a facility's, Food and Nutrition Services policy titled, Physical Plant and Equipment - Department Security, rev 08/2024, indicated that all serving ware that have lost their glaze or are otherwise damaged are to be discarded. During a concurrent observation of the kitchen and interview with the DM on 5/20/25 at 9:22 am, excessive wear was found on three food bowls and a plastic cutting board; the finding was confirmed by DM who removed the items from circulation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained when Certified Nursing Assistant (CNA) F did not perform hand hygiene between resident care. This had the potential to spread infection. Findings: A review of the facility's policy and procedure (P&P) titled, Infection Control, revised 7/1/20, indicated, facility staff would use alcohol-based hand gel upon entering and exiting a resident's room, touching a resident, and, After contact with inanimate objects (bed, curtains, bed rails, etc.) in the immediate vicinity of the patient. During an observation on 5/20/25 at 12:13 pm, CNA F was observed placing a dirty lunch tray into a metal cart. CNA F pulled a pen and paper out of the right leg pocket of her pants, wrote something down, and placed the pen and paper back into the pocket. CNA F walked into room [ROOM NUMBER] and removed a dirty lunch tray and placed it in the metal cart. CNA F pulled a pen and paper out of the right leg pocket of her pants, wrote something down, and placed the pen and paper back into the pocket. At 12:16 pm, CNA F walked into room [ROOM NUMBER] and touched the footboard of the bed, touched the privacy curtain that was between bed A and B, and exited the room. CNA F was observed walking into room [ROOM NUMBER], touched an item on the bedside table, picked up the dirty lunch tray, and placed it in the metal cart. CNA F opened the door to the nourishment refrigerator (contained drinks and snack food items for residents), moved something out of the way, removed a drink, and took it to the resident in room [ROOM NUMBER]. CNA F went back to the room where the nourishment refrigerator was located, and began opening cupboard doors, looking for crackers. The observation ended at 12:25 pm. During an interview on 5/20/25 at 12:26 pm, CNA F confirmed the entirety of the observation and stated, I didn't perform hand hygiene entering and exiting [resident] rooms, after placing dirty trays into cart, and in between each tray pick up. During an interview on 5/21/25 at 9:49 am, Director of Staff Development stated, hand hygiene was expected to be performed in between resident care, gel in, gel out, in between things that you're touching, and after touching dirty meal trays.