STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555711	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care on Palm	4768 Palm Avenue Riverside, CA 92501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure a comprehensive nutritional assessment was completed within 14 calendar days after admission for one of three residents reviewed (Resident 42). This failure had the potential to delay the provision of resident-centered care (care focusing on the needs of individuals) and nutritional interventions necessary to address the resident's health needs. Findings: On April 8, 2025, at 12:26 p.m., during a concurrent observation and interview in Resident 42's room, Resident 42 was observed eating her lunch meal. Resident 42 stated she had a new denture and was ready to eat regular food. Resident 42 further stated, she was tired of eating baby food and she did not like to lose weight. On April 10, 2025, Resident 42's record was reviewed. Resident 42 was admitted to the facility on [DATE], with diagnoses which included protein-calorie malnutrition (inadequate intake of nutritional food). A review of Resident 42's History and Physical, dated March 11, 2025, indicated Resident 42 was mentally capable of understanding. A review of Resident 42's Nutritional Assessment Form, dated March 28, 2025, indicated showed a goal weight range of 110-115 pounds and a current diet order of a regular pureed diet with thin liquids. A further review of Resident 42's Nutritional Assessment Form indicated the nutritional assessment was completed 17 days after admission. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 10, 2025, at 8:20 a.m., during a concurrent interview and record review with the Registered Nurse (RN), the RN stated Resident 42 had been readmitted on [DATE], and the nutritional assessment was not completed until March 28, 2025, 17 days wafer admission. The RN stated, the nutritional assessment should have been completed upon admission to determine the resident's nutritional status, identify potential problems, and initiate timely interventions. The RN stated, the delay could contribute to malnutrition, functional decline, weight loss and reduced food intake. On April 10, 2025, at 3:50 p.m., during a concurrent interview and record review with Registered Dietician (RD) 2. RD 2 stated she did not recall the last time she had seen Resident 42. RD 2 stated, a nutritional assessment should have been completed within 14 days of admission per regulation. RD 2 stated, a delay in assessment could result in unmet nutritional needs and unplanned weight loss. A review of the facility's policy and procedure titled, Nutritional Assessment, dated October 2017, indicated, . As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident .The dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition .The nutritional assessment will be conducted .Dietician .an estimate of calorie, protein, nutrient and fluid needs .whether the resident's current intake is adequate to meet his or her nutritional needs .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on interview and record review, the facility failed to ensure pharmacy services were provided to meet the needs of the resident when one prescribed medication was not administered as ordered on twelve separate occasions for one of one resident (Resident 23). This failure had the potential to result in ineffective treatment of Resident 23's symptoms and interrupted care. Findings: Resident 23's record was reviewed. Resident 23 was readmitted to the facility on [DATE], with diagnoses which included dementia with psychotic disturbances (a cognitive decline accompanied by psychosis - hallucinations and/or delusions) and impulse disorder (inability to resist urges or impulses that can lead to harmful or disruptive behaviors). A review of Resident 23's Physician Order, dated March 14, 2025, indicated, .increase Rexulti (antipsychotic medicine used to treat dementia that helps balance chemicals in the brain known to affect mood and thoughts.) 0.5 mg (milligram - a unit of measurement) to Rexulti 2 mg by mouth one time a day for unspecified psychosis manifested by delusions . A review of Resident 23's Medication Administration Record (MAR), for the month of March and April 2025, indicated Rexulti 2 mg was not administered on March 15, 19, 27, 28, and 30, and on April 1, 2, 3, 5, 6, 7, 8, 2025 - 12 missed doses total. A review of Resident 23's Progress Notes indicated, - Dated March 15, 19, and 27, 2025, indicated .pending rx (prescription) delivery, physician notified . - Dated March 28, 2025, indicated .pending authorization . - Dated March 30, 2025, did not indicate the medication Rexulti was administered. - Dated April 1, 2, and 3, 2025, indicated .pending auth (authorization) .followed up with pharmacy . - Dated April 5 and 6, 2025, indicated .medication not on hand will follow up with pharmacy MD (physician) aware no new orders at this time . - Dated April 7 and 8, 2025, indicated .pending auth, MD aware no new orders . - Dated April 10, 2025, at 7:10 a.m., indicated .discontinue Rexulti 2mg . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 10, 2025, at 11:15 a.m. an interview and a concurrent record review was conducted with the DON. The DON stated the medication was not available due to delayed delivery, pending insurance authorization, and lack of follow-up with pharmacy. The DON stated, the medication should have been given or substituted with a covered alternative. On April 11, 2025, at 9:06 a.m., an interview and concurrent record review was conducted with the Pharmacist. The Pharmacist stated Rexulti 2 mg was prescribed and should not have been missed. The facility's policy and procedure titled, Administering Medication revised, April 2019, was reviewed. The policy indicated, .The director of nursing services supervises and directs all personnel who administer medications .Medications are administered in accordance with prescribed orders, including any required time frame .

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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** 39920 Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were properly stored and disposed of when expired sterile (entirely free of microorganisms) dressings (medical bandage designed to protect a wound from infection), were found inside a treatment cart and were readily available for use. This failure had the potential to result in residents receiving wound treatments with expired dressings, leading to ineffective treatment and an increased risk of infection. Findings: On [DATE], at 11:55 a.m., during a treatment cart inspection with the Registered Nurse (RN), expired dressings were found stored in the cart and available for use. One pack of sterile, non-adhesive (designed to not stick to the wound) foam dressing with an expiration date of [DATE], and five packs of sterile gauze (made from woven fabric) dressings with an expiration date of [DATE], were observed in the treatment cart. In a concurrent interview, the RN stated the expired dressings should not have been kept in the treatment cart, readily available for use and should have been discarded. On [DATE], at 1:30 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the expired dressings should not be stored in the treatment cart. The facility's policy and procedure, titled, Storage of Medications, revised [DATE], was reviewed. The policy indicated, .Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 44504 Based on observations, interviews, and record review, the facility failed to ensure that dietary staff safely and effectively carried out the functions of food and nutrition services when: 1. Dietary staff, including the dietitian, were not aware of the manufacturer's recommended time guidelines for testing the red bucket Quaternary (Quat) sanitizer (sanitizing solution used for sanitizing food contact surfaces); 2. [NAME] 2 did not demonstrate competency in performing assigned duties; (Cross reference 803) 3. [NAME] 1 did not demonstrate competency in performing assigned duties; and (Cross reference 803) 4. [NAME] 3 did not follow the prescribed recipe when preparing pureed macaroni and cheese during dinner on April 9, 2025. These failures had the potential to cause foodborne illness for 49 out of 50 sampled residents and compromised the nutritional status of residents receiving food from the facility's kitchen. Findings: 1. A review of the Quat sanitizer manufacturer's guidelines posted above 2 compartment sink at the kitchen indicated, Dip test paper for 10 seconds in test solution On April 8, 2025, at 10:45 a.m., a concurrent observation and interview was conducted with [NAME] 1 (CK 1). CK 1 was asked to test the Quat sanitizer solution in the sanitizer bucket. CK 1 dipped the test strip into sanitizer solution for 3 seconds and stated she needed to dip the test strip for 3 seconds to check the concentration of the Quat sanitizer. On April 8, 2025, at 11:05 a.m., a concurrent observation and interview was conducted with Diet Aide 1 (DA 1). DA 1 was asked to test the Quat sanitizer solution in the sanitizer bucket. DA 1 stated she need to dip the test strip into sanitizer solution for 5 seconds to check the concentration of the Quat sanitizer. On April 9, 2025, at 12:08 p.m., a concurrent observation and interview was conducted with DA 2. DA 2 was asked to test the Quat sanitizer solution in the sanitizer bucket. DA 2 stated she was not sure how long she needed to dip the test strip into sanitizer solution. On April 10, 2025, at 2:20 p.m., an interview was conducted with the Registered Dietitian 1 (RD 1) and Dietary Supervisor (DSS). The DSS stated the test strip needed to be dipped into the Quat sanitizer solution for 10 - 15 seconds to check the concentration of the Quat sanitizer. RD 1 was unsure of the duration but agreed the DSS statement. The RD stated failure to follow the manufacturer's guideline for testing Quat sanitizer could result in an inaccurate reading of Quat sanitizer concentration. The RD explained that inaccurate reading of Quat sanitizer concentration could lead to inadequate sanitation of food contact surfaces. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During general food production observations, issues were observed related to [NAME] 2 (CK 2) competency: a.) During an observation, on 4/9/2025, at 10:41 a.m., [NAME] 2 did not follow the recipes when preparing pureed peas and meat. b.) On April 9, 2025, at 11:59 a.m., during an observation before lunch tray plating started, it was noted that rice was not available on the trayline (a system of food preparation in which trays move along an assembly line). Resident 3, who was on a physician ordered renal diet, should have been served rice according to the [NAME] Spreadsheet (the document used to guide dietary staff on food items, portions, and therapeutic diets) and the resident was served oven-brown potatoes, the same food items as residents on the regular diet. c.) During an observation of noon meal plating, on 4/9/22, at 12:03 p.m., CK 2 was observed using a 3 oz scoop instead of the required 4 oz scoop to serve mechanical soft meat for residents on mechanical soft diets, as outlined in the [NAME] Spreadsheet. During a phone interview on April 10, 2025, at 3:16 p.m., with RD 2. RD 2 stated Cooks are expected to follow recipes, the [NAME] Spreadsheet, and the menu when preparing food. During a review of the facility Job Description, titled LINE COOK/PREP COOK, undated, the job description indicated, The purpose of your job position is to prepare, cook, and present well-balance meals .to the highest quality incorporating .dietary needs as required by the residents and staff of the facility. 3. During general food production observations, issues were observed related to CK 1 competency: a.) During a general food production observation on April 8, 2025, from 8:37 a.m. until 11:54 a.m., before the start of the lunch tray plating, corn was not available on the trayline. Resident 3 who had a physician-ordered renal diet and Resident 33 who had a physician-ordered heart-healthy diet should have been served corn. Residents 3 and 33 were served the same food item as residents on a regular diet-pinto beans. b.) On April 8, 2025, at 12:27 p.m., a concurrent observation, Resident 34, who had a physician-ordered consistent carbohydrate diet, was served an extra taco during lunch. During an interview on April 10, 2025, at 3:16 p.m., with the RD 2. The RD 2 stated Cooks were required to follow the [NAME] Spreadsheet when preparing and serving food. During a review of the facility Job Description, titled LINE COOK/PREP COOK, undated, the job description indicated, The purpose of your job position is to prepare, cook, and present well-balance meals .to the highest quality incorporating .dietary needs as required by the residents and staff of the facility. 4. During a review of the posted menu on 4/9/2025 indicated, Dinner: Creamy Ranch Macaroni and Cheese (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 9, 2025, at 6:01 p.m., a concurrent observation and interview were conducted with the Dietary Supervisor (DSS) in the dining room. During observation of pureed diets, an unidentified dark brown pureed food item was being served as an entree. The DSS stated CK 3 had modified the recipe for pureed Creamy Ranch Macaroni and Cheese by adding chicken, beef broth and a small amount of Macaroni and Cheese to increase the protein and calories content. During a phone interview on April 10, 2025, at 3:16 p.m., with RD 2. RD 2 stated she unaware CK 3 had modified the recipe. RD 2 stated as a best practice, cooks are required to consult the dietitian prior to modifying any recipes. During a review of the facility Job Description, titled LINE COOK/PREP COOK, undated, the job description indicated, The purpose of your job position is to prepare, cook, and present well-balance meals .to the highest quality incorporating .dietary needs as required by the residents and staff of the facility. During a review of the facility provided Recipe titled, Creamy Ranch Macaroni and Cheese, indicated, .Diet Notes: Meals need to be modified to suit individual patient/resident tolerance as determined by appropriate healthcare provider at the community level. The recipe did not include chicken and beef broth as ingredients.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44504 Based on observations, interviews and record reviews, the facility failed to ensure: 1. [NAME] 2 followed the recipe when preparing pureed meat and peas during lunch on April 9, 2025; 2. [NAME] 2 used the correct scoop to portion mechanical soft meat during lunch on April 9, 2025; 3. Resident 34, who had a physician-ordered Consistent Carbohydrate (CCHO) diet, was served the correct portion of taco during lunch on April 8, 2025; 4. Resident 3, who had a physician-ordered renal diet, was served appropriate food items during lunch on April 9, 2025, and April 10, 2025; and 5. Resident 33, who had physician-ordered heart healthy diet, was served appropriate food items during lunch on April 9, 2025. These failures had the potential to result in residents receiving food that did not meet their prescribed dietary needs, which could lead to nutrition-related health complications. Findings: (Cross Reference 802) 1. During a general food production observation and interview conducted on April 9, 2025, at 10:41 a.m., in the kitchen with [NAME] 2 (CK 2), CK 2 was observed preparing pureed peas. CK 2 blended peas with white bread together to make pureed peas. CK 2 stated he added six slices of white bread to make 12 servings of pureed peas. During the process, CK 2 did not refer to the pureed vegetable recipe. During a general food production observation and interview conducted on April 9, 2025, at 11:45 a.m., with CK 2. CK 2 was observed preparing pureed meat. CK 2 placed some beef, slices of white bread, some unmeasured meat juice and beef broth into a food processor. CK 2 stated he used 10 servings of beef and five slices of white bread as stabilizer to prepare the pureed meat. During the process, CK 2 did not refer to the pureed meat recipe during preparation. During a phone interview on April 10, 2025, at 3:16 p.m., with the Registered Dietitian 2 (RD 2). The RD 2 stated this was unusual practice for cooks to add bread to make pureed diet and unaware CK 2 adding breads into pureed food items. The RD explained adding breads into pureed food items would alter the nutritional content by increasing the carbohydrate level. The RD stated all food service staff were required to follow recipes when preparing food. During a review of the facility provided recipes for the Pureed vegetables and Pureed Meat, the recipes did not indicate adding breads as stabilizer. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility document titled, The Facility's Resident Diet order Listing Report, dated April 8, 2025, indicated Nine residents, Residents 6, 8,10, 19, 20, 26, 28, 33 and 42 were on a pureed diet (the food texture should be smooth for residents who have difficulty chewing and/ or swallowing ability). During a review of the facility's Policy and Procedure (P&P) titled, Standardized Recipes, Revised dated April 2007, the P&P indicated, .Standardized recipes will be used to prepare foods. 2. During a review of the [NAME] Spreadsheet (the document used to guide dietary staff on food items, portions, and therapeutic diets) on April 9, 2025, indicated, Mechanical soft diet: Meat used number (#) 8 scoop [4 ounces (oz- a unit of measurement]. On April 9, 2025, at 12:03 p.m., a concurrent observation and interview was conducted with CK 2 at the trayline (a system of food preparation in which trays move along an assembly line). CK 2 was observed using a # 10 scoop (3 oz) to serve mechanical soft meat for residents on mechanical soft diet. CK 2 confirmed that the scoop he used was 3 ounces, not the required 4 oz. During a phone interview on April 10, 2025, at 3:16 p.m., with RD 2. RD 2 stated CK 2 did not serve the correct portion size by using a 3 oz scoop. The RD stated, using a smaller scoop could result in residents not receiving adequate calories. RD 2 stated all food service staff were required to follow menu and the [NAME] spreadsheets. During a review of the facility document titled, The Facility's Resident Diet order Listing Report, dated April 8, 2025, indicated ten residents, Residents 2, 3, 9, 21, 22, 24, 25, 34, 37, and 46 were on a Mechanical soft diet. During a review of the facility's Policy and Procedure (P&P) titled, Menus, Revised dated October 2017, the P&P indicated, Menus are developed and prepared to meet resident .needs while following established national guidelines for nutritional adequacy.1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutritional Board. 3. During a review of the [NAME] Spreadsheet on April 8, 2025, indicated, CCHO: Beef Soft Taco 1 Each. On April 8, 2025, at 12:27 p.m., a concurrent observation, interview and review of Resident 34's meal tray card were conducted with the Activity Director (AD). Resident 34's meal tray card indicated CCHO diet. Observation revealed that Resident 34 was served two tacos. The AD confirmed that Resident 34 had been served two Tacos. On April 10, 2025, at 3:16 p.m., a concurrent interview and review of the [NAME] spreadsheet dated 4/8/25 were conducted with RD 1. RD 1 stated residents on a CCHO diet should receive one Taco. RD 1 further stated [NAME] 1 should have followed the [NAME] spreadsheet. RD 1 explained that not following the [NAME] spreadsheet and serving extra food items could potentially cause hyperglycemia (high blood sugar) and weight gain. During a review of the Resident's 34 Order Summary Report, dated 4/9/2025, Physician's Diet order indicated, Order date: 5/28/2024: CCHO. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a general food production observation on April 8, 2025, from 8:37 a.m. until 11:54 a.m., before the start of a lunch tray plating, there was no corn available on the steam table at the trayline. Resident 33, who had a physician-ordered Heart Healthy diet should have been served corn per the [NAME] Spreadsheet but was instead served the same food item as residents on a regular diet - pinto beans. During a phone interview on April 10, 2025, at 3:16 p.m., with RD 2. RD 2 stated cooks should make the effort to follow the Cooks Spreadsheet. RD 2 stated, otherwise, residents on therapeutic diets may be served food items not appropriate for their diet which could result in residents not receiving proper nutrients. During a review of the Resident's 33 Order Summary Report, dated 4/9/2025, Physician's Diet order indicated, Order date: 2/10/2025: Heart Healthy diet During a review of the facility provided Recipe titled, Pinto Beans, indicated, NOT APPROPRIATE for the following diet(s).HEART HEALTHY. During a review of the facility provided document titled, HEART HEALTHY DIET, indicated, General Information. The Heart Healthy (Low Fat/Low Cholesterol/2-2.5 gram Sodium) diet is intended for lowering the risk of developing heart disease by limiting the intake of fat, cholesterol and sodium.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care on Palm	4768 Palm Avenue Riverside, CA 92501

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure a resident with a prescribed nectar-thick liquid consistency, as ordered by the physician, was served regular thin liquid coffee, for one of nine residents (Resident 8). This failure had the potential to cause resident to choke or aspirate (inhalation of food or liquid into the lungs), placing them at risk for serious health complications. Findings: On April 8, 2025, at 12:17 p.m., during a concurrent observation and interview with the Certified Nursing Assistant (CNA). Resident 8 was observed eating her lunch in the dining room. Resident 8 was served a cup of regular thin liquid coffee. The CNA who was assisting Resident 8 with feeding, stated, the coffee was provided ready to drink and stated she had not checked the consistency. The CNA stated, Resident 8 should not have received a thin liquid. On April 10, 2025, Resident 8's record was reviewed. Resident 8 was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty in swallowing). A review of Resident 8's History and Physical, dated May 15, 2024, indicated Resident 8 was not capable of making her own decisions. A review of Resident 8's Order Summary, dated January 19, 2025, indicated, .Puree texture, Nectar Thick Liquid consistency . A review of Resident 8's Nutritional Assessment Form, dated February 19, 2025, indicated Resident 8 had a swallowing problem. On April 10, 2024, at 3:34 p.m., during an interview with Registered Dietician (RD) 2. RD 2 stated dietary and nursing staff should follow dietary order. RD2 further stated serving a thin liquid instead of nectar-thickened liquid could lead to choking or aspiration. A review of the facility's diet manual section titled, Mildly Thick, was reviewed. The manual dated July 2019, indicated, .No oral processing or chewing required-can be swallowed directly . A review of the facility's diet manual section titled, Pureed Fish/Meat/Poultry, dated August 2018, indicated, . Process until meat is smooth in consistency .Ensure mixture achieves moist mashed potato or pudding-like consistency .

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure the therapeutic diet order (diet ordered by a physician) prescribed by the physician was followed for one of three residents (Resident 42) who had an order for a fortified diet (additional nutrients). This failure had the potential for Resident 42 to not receive adequate nutrition, which could further compromise her medical status. Findings: On April 8, 2025, at 12:26 p.m., during a concurrent observation and interview in Resident 42's room, Resident 42's meal tray card indicated a fortified diet. Resident 42 was served a full eight oz cup (ounce-unit of measurement) of tea. Resident 42 stated, she was always served tea at lunch but would prefer milk. Resident 42 further stated, I don't want to lose weight. On April 10, 2025, Resident 42's record was reviewed. Resident 42 was admitted to the facility on [DATE], with diagnoses which included mild protein-calorie malnutrition (deficiency of protein and/or calories). A review of Resident 42's History and Physical, dated March 11, 2025, indicated Resident 1 was mentally capable of understanding. A review of Resident 42's Order Summary, dated March 11, 2025, indicated, .Regular diet Pureed texture, Thin liquid consistency, fortified diet, 4 oz. heath shake with breakfast and at 1000 & 1400, and snack at bedtime . On April 9, 2024, at 5:45 p.m., during a concurrent observation and interview at bedside with the Licensed Vocational Nurse (LVN), the LVN stated, the resident's meal card indicated a fortified diet and there was no pudding served. The LVN stated she was unable to determine if the meal provided met the fortified diet requirement. On April 10, 2025, at 9:51 a.m., during a concurrent interview with the Registered Nurse (RN). The RN stated she did not know how dietary staff prepared the fortified diet. The RN further stated if resident would not receive a fortified diet, it could result in weight loss and functional decline. On April 10, 2025, at 3:47 p.m., during an interview with Registered Dietician (RD) 2, RD 2 stated she expected dietary staff to follow physician's orders and the facility's policy on therapeutic diets. RD 2 stated, Resident 42 should have received a fortified diet as ordered, and not following the therapeutic diet order could lead to weight loss, decline in function, and possible hospitalization . A review of the facility's diet manual section titled, Special Nutrition Program, dated August 2019, indicated, . The Special Nutrition Program (SNP) is a fortified food program that should provide for the increased nutritional requirements of residents .

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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** 50204 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when: 1. Dust was observed on kitchen equipment and in various locations within the kitchen; 2. An expired sanitizer test strip was found in use. 3. A box of nutritional shake was stored next to defrosting raw meat in the refrigerator; 4. Wilted cilantro was found stored in Reach in Refrigerator # (number) 1; 5. An open bottle of lemonade syrup was stored next to a sanitizer solution bucket; 6. Dust accumulation was oberved on the floor under a table counter; 7. Black grime buildup was observed on the outside of the oven; 8. Three white plastic spatula, two serving tongs handle, and one small spatula had chipped; 9. A trash bag was used as a liner to store a bulk quantity of sugar; and 10. One unlabeled soda was found in a resident's refrigerator. These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) in a medically vulnerable population of 49 out of 49 residents who received food prepared in the kitchen. 11. Pureed meat and bread were not prepared in the correct texture and consistency. This failure had the potential to cause difficulties with swallowing, increase the risk of choking or aspiration (food entering the lungs), and impact the resident's nutritional intake. Findings: 1. On [DATE], at 8:57 a.m., a concurrent observation and interview with the Dietary Service Supervisor (DSS) was conducted in the kitchen, in the reach-in refrigerator area. The fan grids were observed to covered in dust. The DSS confirmed fan's grids were covered with dust. On [DATE], at 10:03 a.m., a concurrent observation and interview with the DSS was conducted, in the kitchen. Dust was noted behind and above the convection oven. The DSS confirmed behind and above the convention oven was dusty. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], at 2:38 p.m., an interview with Registered Dietitian (RD 1) was conducted. RD 1 stated, dust in food preparation area could cause cross-contamination. During a review of the U.S. Food and Drug Administration's (FDA) Food Code 2022, Section ,d+[DATE].13 Nonfood-Contact Surfaces, the Food Code indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. 2. On [DATE], at 10:45 a.m., a concurrent observation and interview with the DSS was conducted, in the kitchen. A Quat sanitizer test strip (brand of sanitizer test strip) was observed with an expiration date of [DATE]. The DSS stated the Quat sanitizer test strip was expired, should have been tossed away, and should not be use. On [DATE], at 2:38 p.m., an interview with RD 1 was conducted. RD 1 stated expired strip should have been removed and replaced with updated strip. RD 1 stated expired strip could give inaccurate readings, making sanitizing solutions ineffective. A review of the facility's policy and procedure titled, Cleaning and Disinfection of Environment Surfaces, dated [DATE], indicated, .Manufacturer's instructions will be followed for proper use of disinfecting (or detergent) products including .shelf-life .safe use and disposal . 3. On [DATE], at 8:51 a.m., a concurrent observation, interview, and record review with the DSS was conducted, in the kitchen, in front of the Reach-in refrigerator # 1. A ready-to-drink shake was stored next to raw defrosting meat in Reach-in Refrigerator # 1, against a posted storage guidelines, Ready-to-Eat-Foods stored at (Top Shelf). The DSS stated the staff kept the ready to drink shake in the bottom of the refrigerator beside the defrost raw meat. The DSS further stated it should have been stored on top of the shelves to prevent contamination of food. On [DATE], at 2:39 p.m., an interview with RD 1 was conducted. RD 1 stated staff should follow proper storage of the food. RD 1 further stated ready to drink food should have been placed on top of the shelves and not on the bottom shelves next to defrost meat to prevent potential contamination. A review of the facility's policy and procedure titled, Food Receiving and Storage, dated [DATE], indicated, . Foods shall be received in a manner that complies with safe food handling practices .Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods . 4. On [DATE], at 8:57 a.m., a concurrent observation and interview with the DSS was conducted, in the kitchen. Wilted cilantro was observed in REach-in Refrigerator $!. The DSS stated the wilted cilantro should have been discarded and should have been replaced with fresh item. On [DATE], at 2:39 p.m., an interview with RD 1 was conducted. RD 1 stated the wilted cilantro should have been tossed and should not been stored in the refrigerator. RD 1 further stated the vegetable should be kept fresh. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Food Receiving and Storage, dated [DATE], indicated, . Foods shall be received and stored in a manner that complies with safe food handling practices . 5. On [DATE], at 9:38 a.m., a concurrent observation and interview with the DSS was conducted in the kitchen at Prep area. An open bottle of pink lemonade syrup was stored next to a bucket of Quat sanitizer under a prep table. The DSS stated the bottle of pink lemonade syrup should not be stored next to the red bucket sanitizer. The DSS further stated the red bucket sanitizer would contaminate the open pink lemonade syrup. On [DATE], at 2:40 p.m., an interview with RD 1 was conducted. RD 1 stated the red bucket sanitizer, and the plastic bottle of pink lemonade should not placed next to each other. RD 1 further stated the pink lemonade would potentially contaminate from the red bucket sanitizer. A review of the facility's policy and procedure titled, Food Receiving and Storage, dated [DATE], indicated, . Foods shall be received in a manner that complies with safe food handling practices .Food services, or other designated staff, will maintain clean food storage areas at all times .Soaps, detergents, cleaning compounds or similar substances will be stored in separate areas from food storage and labeled clearly . 6. On [DATE], at 9:38 a.m., a concurrent observation and interview with the DSS was conducted, in the kitchen at Prep area. Dust was noted under a kitche prep table. The DSS confirmed the dust was accumulated under the table counter. The DSS further stated the area under the table counter was hard to reach and was missed during cleaning. On [DATE], at 2:40 p.m., an interview with RD 1 was conducted. RD 1 stated dust should have been removed and cleaned under the table to prevent contamination of the kitchen. A review of the facility's policy and procedure titled, Sanitization, dated [DATE], indicated, .All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish . 7. On [DATE], at 10:03 a.m., a concurrent observation and interview with the DSS was conducted in the kitchen. The exterior of the oven was observed to have accumulated black grime. The DSS stated the black grime should have been removed and the oven cleaned. On [DATE], at 2:42 p.m., an interview with RD 1 was conducted. RD 1 stated the oven should have been cleaned and should not have accumulation of grime, as it could potentially contaminate food being cooked. A review of the facility's policy and procedure titled, Sanitization, dated [DATE], indicated, .The food service area shall be maintained in a clean and sanitary manner .All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish . 8. On [DATE], at 10:10 a.m., a concurrent observation and interview with the DSS was conducted in the prep area of the kitchen. Several pieces of equipments were observed with chipped and damaged surfaces including: -Three white plastic spatula; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two serving tongs (damaged handles) and; -One small spatula. The DSS stated any equipment with chipped and damaged should have been replaced. The DSS further stated such damage could result in contamination if pieces chipped off into food. On [DATE], at 2:43 p.m., an interview with RD 1 was conducted. RD 1 stated the damaged spatulas and serving tongs that were damaged should have been replaced with a new equipment to prevent accumulation of food in rough surfaces and to prevent mixture of chipped part surfaces to the food. A review of the facility's policy and procedure titled, Sanitization, dated [DATE], indicated, .The food service area shall be maintained in a clean and sanitary manner .All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning . 9. On [DATE], at 10:33 a.m., a concurrent observation and interview with the DSS was conducted in the kitchen's dry storage area. A bulk quantity of sugar was observed stored inside a clear plastic trash bag being used as a liner. The DSS further stated plastic trash bag should not be used as a liner for storage of bulk sugar. The DSS was asked who among the dietary staff used the trash bag and she stated, I don't know. On [DATE], at 2:43 p.m., an interview with RD 1 was conducted. RD 1 stated the bulk of sugar should have been stored in food grade plastic liner and not in ordinary plastic bag. A review of the facility's policy and procedure titled, Food Receiving and Storage, dated [DATE], indicated, . Foods shall be received in a manner that complies with safe food handling practices .Food services, or other designated staff, will maintain clean food storage areas at all times . 10. On [DATE], at 3:10 p.m., a concurrent observation and interview with the Licensed Vocational Nurse (LVN) was conducted in the nurse's station. One unlabeled 7.5 oz. (ounce-unit of measurement) diet soda in can was observed inside resident's refrigerator. The LVN stated it should have been labeled with name of resident and date received. The LVN further stated food and drinks without labeled would be unsafe to resident to consumed it. On [DATE], at 3:38 p.m., an interview with RD 2 was conducted. RD 2 stated staff should follow the facility's policy and procedure in food storage. The RD 2 further stated, drinks and food should be labeled with resident's name and date received. A review of the facility's policy and procedure titled, Food Receiving and Storage, dated [DATE], indicated, . Foods shall be received in a manner that complies with safe food handling practices .All foods belonging to residents must be labeled with the resident's name, the item and the use by date .cleaning compounds or similar substances will be stored in separate areas from food storage and labeled clearly . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. On [DATE], at 12:26 p.m., a test tray (to evaluate the quality of a meal during a meal service and identify any areas for improvement) for pureed diet (food texture need to blend until smooth for residents who have difficulty chewing and/or swallowing) was conducted with the Dietary Supervisor (DSS). The pureed bread was observed to have a grainy texture. After tasting the pureed bread, the DSS stated, the pureed bread was not smooth and had a grainy consistency. The DSS stated, the pureed beef texture was not smooth and still contained intact meat fibers. The DSS stated, [NAME] 2 should have blended the beef and bread for a longer period to achieve the required smooth, mashed potato-like texture. On [DATE], at 3:40 p.m., during an interview with facility Registered Dietitian (RD) 2, RD 2 stated the texture and consistency of pureed food should be smooth, not grainy. The RD further stated, residents on a pureed diet could potentially choke if the correct texture was not followed. A review of the facility's diet manual section titled Mechanically Altered Diet Explanation, dated [DATE], indicated, .Puree diet: Puree all foods to the consistency of smooth, moist mashed potatoes or pudding -like consistency . A review of the facility's diet manual section titled, Pureed Fish/Meat/Poultry, dated [DATE], indicated, . Process until meat is smooth in consistency .Ensure mixture achieves moist mashed potato or pudding-like consistency .