STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Richmond Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 955 23rd Street Richmond, CA 94804	

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45091 Based on observation, interview, and record review, the facility failed to allow four residents (Residents 15, 5, 9, and 13) to exercise their rights to self-determination when: 1. One out of 27 residents (Resident 15) was not provided nutrition in accordance with their preferences. 2. Three of six residents (Resident 5, 9, and 13) who followed the facility's smoking policy were not allowed to continue from smoking. These failures had the potential to result in Residents 15, 5, 9 and 13 feeling upset and disrespected. Findings: 1.During a review of Resident 15's Admission Record, printed 1/16/25, the record indicated Resident 15 was admitted to the facility in January 2024 with a diagnosis of difficulty in walking. During a review of Resident 15's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.), dated 1/10/25, the record indicated Resident 15's BIMS score was 15. During an observation on 1/13/25, at 12:35 p.m. Resident 15's lunch tray was observed with chicken parmesan as the main entree. The chicken entree was not eaten. During a review of Resident 15's Lunch Meal Ticket, dated 1/13/25, the Meal Ticket indicated, Resident 15's Dislikes: . No Chicken. During an interview on 1/13/25, at 12:42 p.m. with Resident 15, Resident 15 stated Resident 15 did not like chicken, did not eat any of the chicken served for lunch and was hungry. During an interview on 1/13/25, at 12:50 p.m. with [NAME] 1 (CK 1), CK 1 stated Resident 15 should not have been given chicken for lunch and it was a mistake. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/25, at 9:25 a.m. with Registered Dietician (RD), RD stated their policy was to honor resident food choices, likes and dislikes. RD stated staff should have given Resident 15 an alternative to chicken. RD stated it was important to follow resident's food choices because they may not have eaten food they didn't like and to maximize their nutrition. During an interview on 1/15/25, at 9:55 a.m. with Infection Preventionist (IP), IP stated it was important to follow resident food choices otherwise residents may have eaten less, or they could have been upset. During a review of the facility's policy and procedure (P&P) titled, Food Preferences, dated 2018, the P&P indicated, Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group. 50474 2. During a review of Resident 13's Admission Record, printed on 1/16/25, the record indicated, Resident 13 as admitted to the facility in December 2024 with diagnosis of Atrial fibrillation (an irregular and often very rapid heart rhythm). During a review of Resident 13's Smoking Assessment record, dated 1/6/25, the record indicated Resident 13 was Safe to smoke with supervision and Resident's smoking privileges will be suspended if she violates the safety protocol. During an interview on 1/14/25 at 1:19 p.m. with Resident 13, Resident 13 stated she had been a long-time smoker. Resident 13 stated the facility previously allowed them to smoke with staff's supervision. Resident 13 stated they followed all the smoking rules including the smoking schedules. Resident 13 stated the facility informed all smoking residents that they were not allowed to smoke anymore because one resident violated the smoking protocols. Resident 13 stated the facility should have not punished other smoking residents who followed all the smoking protocols. Resident 13 stated the facility did not respect their rights when they were informed, they could not smoke anymore. During a review of Resident 5's Admission Record, printed on 1/16/25, the record indicated, Resident 5 was admitted to the facility in June 2024 with diagnosis of peripheral vascular disease (a disorder caused by narrowing, blockage, or spasm in a blood vessel). During a review of Resident 5's Smoking Assessment record, dated 1/7/25, the record indicated Resident 5 was Safe to smoke with supervision and Resident's smoking privileges will be suspended if he violates the safety protocol. During an interview on 1/15/25 at 8:29 am with Resident 5, Resident 5 stated, when they were informed about the changes to the facility's smoking policy, Resident 5 stated it was not fair for the facility to stop other residents from smoking if they followed all the smoking protocols. Resident 5 stated some residents who smoked together during smoking schedule could have had an impact with their social skills since the facility had banned smoking. During a review of Resident 9's Admission Record, printed on 1/16/25, the record indicated, Resident 9 was admitted to the facility in January 2024 with diagnosis of Cellulitis (bacterial skin infection). (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 9's Smoking Assessment record, dated 1/7/25, the record indicated Resident 9 was Safe to smoke with supervision and Resident's smoking privileges will be suspended if she violates the safety protocol. During an interview on 1/15/25 at 10:04 a.m. with Resident 9, Resident 9 stated it was brought to their attention that one resident was caught smoking inside the facility. Resident 9 stated after the incident, the facility did not allow them to smoke anymore. Resident 9 stated the facility should not have banned the others from smoking because they were following the smoking protocols. Resident 9 stated most of them have smoked most of their lives and stopping them from smoking abruptly was going to be hard for them. Resident 9 stated they felt it was not right that they had to suffer from another resident's mistake. During an interview on 1/15/25 at 11:11 a.m. with Social Worker (SW), SW stated the facility allowed smoking residents to smoke in the designated area with a staff's supervision. SW stated one resident was not compliant with the smoking protocols and the facility decided to discontinue all smoking privileges for all residents who smoked. SW stated she was sure that Resident 13 and Resident 9 followed all smoking protocols and had not broken any of them. SW stated the Resident 13, Resident 5 and Resident 9 might have felt bad because of the changes in their smoking policy. SW stated she did not have documentations that she assessed Residents 13, 5, and 9's psychosocial well-being after they were not allowed to smoke anymore. During an interview on 1/15/25 at 2:59 p.m. with the Director of Nursing (DON), the DON stated the facility decided to discontinue smoking privileges on 1/11/25. The DON stated Residents 13, 5, and 9 must have felt upset about not being able to smoke because smoking had been part of their lifestyle. The DON stated there were also no documentations of monitoring for any physical and psychosocial side effects for Residents 13, 5, and 9 after they were not allowed to smoke. During an interview on 1/16/25 at 10:10 a.m. with the Administrator (ADM), ADM stated they discontinued the smoking privileges because one resident violated the smoking protocols, and the facility did not have enough staff to supervise this non-compliant resident. ADM stated the rest of the residents who smoked followed the facility's smoking protocols. ADM stated the facility implemented the no smoking policy for safety concerns but did not consider the resident's dignity. ADM stated the facility had a safe designated area where the residents smoked with supervision from staff. During a review of the facility's policy and procedure (P&P), titled, Smoking Policy - Residents, revised in July 2017, the P&P indicated, 1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and to which the facility can accommodate their smoking or non-smoking preferences .10. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised December 2016, 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: . self-determination.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45091 Based on interview and record review, the facility failed to ensure two out of three sampled residents (Resident 22 and Resident 77), participated in their care planning process. This failure had the potential for Residents 22 and 77 to receive inappropriate interventions and care that was not aligned with their choices. Findings: During a review of Resident 22's Admission Record, printed on 1/16/25, the record indicated, Resident 22 was admitted to the facility in December 2024 with a diagnosis of muscle weakness. During a review of Resident 22's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information., dated 12/10/24, the record indicated, Resident 22's BIMS score was 15.(A BIMS score of thirteen to fifteen is an indication of intact cognitive status). During an interview on 1/16/25, at 11:21 a.m., with Resident 22, Resident 22 stated they have not had a care conference or had a chance to participate in their care planning. Resident 22 stated they would have liked to have a care conference so they could have discussed their plan of care. During a review of Resident 77's Admission Record, printed 1/16/24, the record indicated, Resident 77 was admitted to the facility in December 2024 with a diagnosis of difficulty in walking. During a review of Resident 77's BIMS, dated 1/2/25, the record indicated Resident 77's BIMS score was 15. During an interview on 1/13/25, at 12:19 a.m., with Resident 77, Resident 77 stated they have not had a care conference or had a chance to participate in their care planning. Resident 77 stated they were frustrated and felt like they did not know what was going on with their plan of care. During a concurrent interview and record review on 1/15/25, at 3:32 p.m., with Medical Records (MR), Resident 22's and 77's medical charts were reviewed. MR stated Residents 22 and 77 have not had a care conference. During an interview on 1/16/25, at 10:15 a.m., with Director of Nursing (DON), DON stated Care Conferences were important because it was where they discussed as a team residents' plan of care, care plans, progress, condition, and discharge plan. DON stated Care Conferences should be done as a team and should have included nurses, nursing assistants, social services, residents, responsible parties, and doctors or the doctors stand in. DON stated Care Conferences should have been on admission, quarterly, after any significant change, and as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Care Planning - Interdisciplinary Team, revised September 2013, the P&P indicated, The resident, the resident's family and/or the residents legal representative/ guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. 50474 Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 4 and Resident 22), were free from unnecessary medications when: 1. Resident 4's antibiotic (treats bacterial infection) order of Levaquin oral tablet 250 milligrams (mg) did not have an adequate indication for use. 2. Resident 22's antibiotic order of Ciprofloxacin oral tablet 500mg did not have an adequate indication for use and a stop date. These failures had the potential to result in unnecessary and prolonged use of antibiotic medications, placing Resident 4 and Resident 22 at risk for adverse side effects and health safety issues. Findings: 1. During a record review of Resident 4's Admission Record, printed on 1/16/25, the record indicated Resident 4 was admitted to the facility in October 2024 with diagnosis of congested heart failure (a chronic condition in which the heart doesn't pump blood efficiently). During a record review of Resident 4's Order Summary, dated 10/30/24-1/16/25, the record indicated, Resident 4 had a doctor's order of Levaquin oral tablet 250mg, Give 2 tablets by mouth one time a day for congested cough for 7 days with a start date of 12/31/24 and an end date of 1/8/25. 2. During a record review of Resident 22's Admission Record, printed on 1/16/25, the record indicated Resident 22 was admitted to the facility in December 2024 with diagnosis of cirrhosis of liver (chronic liver damage). During a record review of Resident 22's Order Summary, printed on 1/16/25, the record indicated, Resident 22 had a doctor's order of Ciprofloxacin oral tablet 500mg, Give 1 tablet by mouth in the morning for Peritonitis (inflammation of the inner lining of the abdomen) with a start date of 12/6/24 and had no end date. During a concurrent interview and record review on 1/15/25 at 11:15 a.m. with the Infection Preventionist (IP), the facility's record of Antibiotic Surveillance, dated 1/14/25, was reviewed. IP stated congested cough was not a correct indication of antibiotic use. IP stated the indication should have been more specific of what type of infection Resident 4 was being treated for. IP stated the correct indication use for antibiotic should have been entered accurately to determine the effectiveness of the antibiotic medication for Resident 4. IP further stated Resident 22's Ciprofloxacin antibiotic did not have an end date because the hospital order indicated indefinitely. IP stated on 12/24/24, the Medical Director (MD) ordered to continue the antibiotic for Resident 22. IP stated there was no clear indication for the continued use of antibiotic for Resident 22. IP stated Resident 22 was still taking the antibiotic even though Resident 22 did not have any more symptoms of Peritonitis. IP stated Resident 22's antibiotic should have had a stop date or a clear indication for the continued use to monitor the effectiveness of the antibiotic. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/15/25 at 2:35 p.m. with the Director of Nursing (DON), Resident 4 and Resident 22's electronic health record (EHR) were reviewed. The DON stated Resident 4's congestive cough indication for the antibiotic use was not correct. The DON stated the licensed nurse who entered the order probably did not know that it should have included the correct indication for the antibiotic use. The DON further stated Resident 22's antibiotic should have had a clear indication why it was given with no stop date. The DON stated the use of antibiotics should have had correct indications and stop date for effective antibiotic treatment. During a concurrent follow up interview and record review on 1/16/25 at 12:51 p.m. with the DON, Resident 22's MD's note, dated 12/24/24, was reviewed. MD's note indicated Peritonitis resolved. The DON stated there were no other documentations from the MD with clear indications and rationale for Resident 22's indefinite use of antibiotic. During a concurrent phone interview on 1/16/25 at 11:11 a.m. with the Consultant Pharmacist (CP), CP stated she had made a recommendation last December 2024 to MD to re-assess the duration of the antibiotic use for Resident 22. CP stated MD's response to her recommendation was still pending. CP further stated she had not reviewed the Drug Regimen Review (DRR) for the month of January and had not seen Resident 4's antibiotic order. During a record review of the facility's undated policy and procedure (P&P), titled, Unnecessary Medications, the P&P indicated, Each resident's drug regimen must be free from unnecessary drugs. All unnecessary drugs are any drug used .2. For excessive duration .5. Without adequate indication for use. During a record review of the facility's undated P&P, titled, Antibiotic Stewardship, the P&P indicated, Keep in contact with MD in regards to antibiotic orders .Monitor antibiotic prescribed .look for indications; if it does not meet the criteria, communicate with MD to make changes .Follow up with the patient when they come with antibiotic; look for diagnosis, what it justifies .Ensure the antibiotic meets diagnosis/indication, if not clarify with MD .Check patient; duration of prophylaxis or no stop date, clarify with MD regarding indefinite order.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50474 Based on observation, interview, and record review, the facility failed to ensure safe medication storage and labeling practices for a census of 28 when: 1. The medication refrigerator contained five bags of Resident 9's expired and discontinued intravenous (IV, administered directly into the vein) medications. 2. An unlabeled, undated, and unsecured prefilled pen (an injection device that delivers preloaded medication) of Ozempic (Diabetes medicine) was stored in the refrigerator. 3. An expired insulin pen (Diabetes medicine) was stored in an active storage area of the medication cart. 4) An unopened insulin pen with pharmacy label of refrigerate until opened was stored at room temperature in the medication cart. 5) The medication cart contained a discharged resident's bottle of Nitroglycerin medication (medicine to treat and prevent chest pain). 6) Resident 127's Triamcinolone ointment (treats skin conditions such as eczema, rash, allergies, etc.) and Resident 13's Terbinafine hydrochloride cream (treats fungus infection of scalp, groin, feet, nails, etc.) were stored with oral and inhalation medications and a body lotion was stored with oral inhalation medications. 7) Narcotic (controlled substance) medications were stored with residents' personal belongings. These failed practices had the potential for causing medication error and contribute to unsafe use of medications. Findings: 1) During a concurrent observation and interview on [DATE] at 12:20 p.m. with Infection Preventionist (IP), the medication refrigerator was observed. The medication refrigerator contained five bags of Resident 9's IV medication called Cefepime 2 grams (treats bacterial infections) 1000 milliliter (ml, a unit of volume) that had a use by date of [DATE]. IP stated Resident 9 was not taking the IV medication anymore. IP stated the Resident 9's expired and discontinued IV medications should have been discarded for patient safety. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) During a concurrent observation and interview on [DATE] at 12:23 p.m. with IP, the medication refrigerator contained an unlabeled, undated, and unsecured Ozempic pen. The Ozempic pen did not have a resident's name and date it was opened. The Ozempic pen was also not in a box or a zip lock bag and was stored in one of the medication refrigerator shelves with other refrigerated medications. IP stated she could not identify who it belonged to. IP stated the Ozempic pen should have been labeled and stored properly. IP stated it was important to label a medication correctly to prevent medication errors. 3) During a concurrent observation and interview on [DATE] at 11:03 a.m. with Registered Nurse (RN) 1, Resident 21's insulin Lispro 100 unit/1ml with an open date of [DATE] was stored in an active storage of the medication cart. RN 1 stated, the insulin Lispro expired on [DATE]. RN 1 stated, the insulin Lispro should have been discarded after 28 days from opening. RN 1also stated storing expired insulin could have caused medication errors and risk for less effective potency. 4) During a concurrent observation and interview on [DATE] at 11:05 a.m. with RN 1, the medication cart contained Resident 21's unopened insulin Glargine 100 unit/1ml that had a pharmacy label of refrigerate until opened. Resident 21's insulin Glargine's zip lock bag did not have open and discard after dates. RN 1 stated Resident 21's insulin Glargine was unopened and had not been used. RN 1 further stated he was not sure how long the insulin Glargine had been stored in the medication cart and in room temperature. RN 1 stated Resident 21's insulin Glargine should have been refrigerated because it was never opened, and it was at risk for less effective potency and efficacy. 5) During a concurrent observation and interview on [DATE] at 11:08 a.m. with RN 1, a small bottle of Nitroglycerin was stored in an active storage area of the medication cart. RN 1 stated the Nitroglycerin belonged to a discharged resident. RN 1 stated discharged medications should have not been stored in the medication cart to prevent medication error. 6) During a concurrent observation and interview on [DATE] at 11:15 a.m. with RN 1, Resident 127's Triamcinolone ointment and Resident 13's Terbinafine hydrochloride cream were stored together with oral tablets, liquid, powder and inhalation medications. A small bottle of body lotion was also stored in a compartment with two inhalers. RN 1 stated every licensed nurse should have been responsible in maintaining the medication cart. RN 1 stated the medications should have been separated and stored by administration route to prevent medication error and contamination. 7) During a concurrent observation and interview on [DATE] at 11:24 a.m. with RN 1, the narcotic medications were stored with multiple items such as pack of cigarettes, cables, loose paper money, discharged resident's wallet, charger, cellphone, a zip lock with money, etc. RN 1 stated a zip lock bag containing a wallet and a cellphone charger belonged to a discharged resident. RN 1 stated residents' personal items had been stored in the narcotic box ever since he started working in the facility. RN 1 stated they did not give the residents' personal items to the social worker. RN 1 stated he was not sure what the policy was for storing residents' personal items. During an interview on [DATE] at 12:04 p.m. with the IP, IP stated all nurses were responsible in maintaining the medication cart. IP stated medications should have been stored by administration route. IP stated the treatments or ointments should have been stored in the treatment cart and not with the oral medications. IP further stated the residents' personal belongings should not have been stored together with the oral narcotic medications. IP stated these practices could have caused contamination of the medications and spread of infection because those items were considered dirty. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:24 p.m. with the Director of Nursing (DON), the DON stated, the medication refrigerator and medication carts should have been free from expired and unlabeled medications. The DON stated Resident 9's IV medication should have been discarded when Resident 9 was transferred to the hospital and the medication was discontinued. The DON stated storing unlabeled, expired, discontinued, and discharged resident's medications could have caused medication errors and drug diversion. The DON stated the medications should have been stored by route to prevent cross contamination of the medications. The DON further stated resident's personal belongings should have been given to the social worker for safe keeping and not stored with the narcotics medications. The DON stated keeping personal items in the medication cart could have caused cross contamination. During an interview on [DATE] at 11:11 a.m. with the Consultant Pharmacist (CP), CP stated maintaining proper storage of the medication carts and medication refrigerators should have been done by nursing. The CP stated unlabeled medications should have been discarded and reordered by the facility if they were not able to identify who the medication belonged to. The CP stated medications should have been stored by route of administration because it was the regulation. During a review of the facility's policy and procedure (P&P), titled, Storage of Medications, revised in [DATE], the P&P indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner .3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing .5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to dispensing pharmacy or destroyed. 10. Resident medications are stored separately from each other to prevent possibility of mixing medications between residents .11. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. During a record review of the facility's P&P, titled, Labeling of Medication Containers, revised in [DATE], the P&P indicated, All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations .2. Any medication packaging or containers that are adequately or improperly labeled are returned to the issuing pharmacy Labels for individual resident medications include all necessary information, such as: a. The resident's name b. The prescribing physician's name c. The name, address, and telephone number of the issuing pharmacy d. The name, strength, and quantity of drug .

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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. 45091 Based on observation, interview, and record review, the facility failed to ensure food was stored under safe and sanitary conditions when: 1. Refrigerated and frozen food items were stored beyond their use by date. 2. Refrigerated and frozen resident food items were unlabeled and undated. 3. Staff food items were stored in the Resident refrigerator with resident food items. These failures had the potential to put 27 residents residing at the facility at risk for food borne illness and cross-contamination (transfer of bacteria or other microorganisms from one substance to another) that could have resulted in infection or spread of infection. Findings: During a concurrent observation and interview on 1/13/25 at 9:43 a.m. with cook 1, (CK 1), the refrigerator and freezer were observed. The refrigerator had a container of olives with a use by date of 1/7/25 and a container of sweet potatoes with a use by date 1/12/25. The freezer had a pack of garden burgers with a use by date of 1/11/25. CK 1 stated their policy was to throw out any food that was beyond their use by date because they could have caused residents to get sick. During a concurrent observation and interview on 1/13/25 at 2:08 p.m. with infection preventionist (IP), the resident refrigerator and freezer were observed. The refrigerator had one bag of ready to eat salad, one bottle of coffee creamer, and two opened water bottles that were not labeled with resident names or dates and three staff lunch bags. The freezer had one sandwich labeled Resident 8 that was undated and three pieces of candies and one opened water bottle that were not labeled with resident names or dates. IP stated staff should not have stored their food with resident food because it was a risk for cross contamination. IP stated food should be labeled with resident name and date to know who owned it and to know how old it was. IP stated undated food was a risk for food born illness because it could have been old. During an interview on 1/15/25 at 9:49 a.m. with Registered Dietician (RD), RD stated it was important to throw out food that was beyond their use by date because it may have been less nutritious, and they may have gone bad. RD stated it was important to separate resident food brought from outside and staff food because it was a potential risk for cross contamination and food borne illness. RD stated it was important to label residents' food with date otherwise they may they would not know how old it was, and it could have gone bad. During a review of the facility's policy and procedure (P&P) titled, Food For Residents From Outside Sources, dated 2018, the P&P indicated, Prepared foods, beverages, or perishable food that requires refrigeration, can be stored for the resident in the nurse's station refrigerator . If opened, the food must be sealed, dated to the date opened and disposed of in 3 days after opening. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555735	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Post Acute Care	955 23rd Street Richmond, CA 94804

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, revised 2014, the P&P indicated, Food shall be received and stored in a manner that complies with safe food handling practices . All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Richmond Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 955 23rd Street Richmond, CA 94804	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50474 Based on observation, interview, and record review, the facility failed to implement infection control practices for four of four sampled residents (Resident 9, 3, 129, and 22) when the blood pressure (BP) cuff and medication tray were not cleaned and sanitized after each use. These deficient practices had the potential spread of infection among residents at the facility. Findings: During a medication pass observation on 1/14/25 at 7:23 a.m. with Registered Nurse (RN) 2, RN 2 was observed passing Resident 9's medications using the medication tray. RN 2 placed the medication tray on top of Resident 9's tray table. RN 2 was then observed checking Resident 9's BP on the left wrist using an automatic BP cuff. After RN 2 checked Resident 9's BP and administered the medications, RN 2 returned to the medication cart. RN 2 did not disinfect the medication tray and the BP cuff she used for Resident 9. RN 2 placed the BP cuff inside the drawer and the medication tray on top of the medication cart. During a subsequent medication pass observation on 1/14/25 at 8:04 a.m. with RN 2, RN 2 was observed preparing Resident 3's medication. RN 2 placed Resident 3's medications on the medication tray she previously used for Resident 9. After RN 2 administered Resident 3's medications, RN 2 returned to cart and placed the medication tray on top of the medication cart without disinfecting it. During a subsequent medication pass observation on 1/14/25 at 8:10 a.m. with RN 2, RN 2 prepared Resident 129's medication using the same medication tray she previously used for Resident 9 and Resident 3. RN 2 entered Resident 129's room placed the medication tray on top of Resident 129's bed. RN 2 then proceeded to check Resident 129's BP on the left wrist using the same BP cuff she previously used for Resident 9. RN 2 did not disinfect the medication tray and the BP cuff after she administered Resident 129's medications. RN 2 returned the BP cuff inside the drawer and the medication tray on top of the medication cart. During a subsequent medication pass observation on 1/14/25 at 8:29 a.m. with RN 2, RN 2 prepared Resident 22's medications using the same medication tray she previously used for Residents 9, 3, and 129 without disinfecting. RN 2 entered Resident 22's room and placed the medication tray on top of Resident 22's tray table. RN 2 returned to the medication cart after she administered Resident 22's medications. RN 2 did not clean and sanitize the medication tray after using it with Residents 9, 3, 129 and 33. During a follow up interview on 1/14/25 at 8:40 a.m. with RN 2, RN 2 stated she did not clean and sanitize the medication tray and BP cuff after each use because she was going to do it all at once after she was done using them. RN 2 stated the BP cuff, and the medication tray should have been cleaned and sanitized after each use to prevent infection. During an interview on 1/15/25 at 12:01 p.m. with the Infection Preventionist (IP), IP stated all reusable items should be disinfected with their facility's approved disinfectant. IP stated the BP cuff, and the medication tray should have been disinfected to prevent cross contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555735	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Post Acute Care	955 23rd Street Richmond, CA 94804

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated policy and procedure (P&P), titled, Sanitizing/Cleaning Equipments , the P&P indicated Immediately cleaning all reusable equipment with a designated solution after each use . Adhering to standard infection control practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
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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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45091 Based on observation and record review, the facility had seven resident rooms (Rooms 3, 4, 5, 6, 7, 8, and 9) with multiple beds that provided less than 80 square feet (sq. ft.) per resident. This deficient practice had the potential to result in inadequate space for the delivery of care to each of the residents in each room and for storage of the residents' belongings. Findings: During random observations of care and services from 1/13/25 to 1/16/25, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment kept in the rooms that might interfere with resident's care, and each resident had adequate personal space and privacy. There were no complaints from residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/or safety concerns in the seven identified rooms. During a record review of the Client Accommodations Analysis, dated 1/14/25, the following resident rooms and corresponding square footage were identified: 1. room [ROOM NUMBER] was a total of 154 sq. ft. and had two beds providing 77 sq. ft. of space per resident; 2. room [ROOM NUMBER] was a total of 154 sq. ft. and had two beds providing 77 sq. ft. of space per resident; 3. room [ROOM NUMBER] was a total of 154 sq. ft. and had two beds providing 77 sq. ft. of space per resident; 4. room [ROOM NUMBER] was a total of 220 sq. ft. and had three beds providing 73 sq. ft. of space per resident; 5. room [ROOM NUMBER] was a total of 220 sq. ft. and had three beds providing 73 sq. ft. of space per resident; 6. room [ROOM NUMBER] was a total of 220 sq. ft. and had three beds providing 73 sq. ft. of space per resident; and 7. room [ROOM NUMBER] was a total of 220 sq. ft. and had three beds providing 73 sq. ft. of space per resident.