STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555769	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Retirement Community at Davis	1515 Shasta Drive Davis, CA 95616

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36681 Based on observation, interview, and record review, the facility failed to ensure a comprehensive care plan was developed and implemented for two of 13 sampled residents (Resident 9 and Resident 18) when: 1. Resident 9 had no care plan for the use of an anticoagulant (blood thinner, medication to prevent blood clots); and 2. Resident 18 had no care plan for the incidence of a fall. Theses failures increased the potential for Resident 9 and Resident 18 to have unmet needs due to a lack of monitoring. Findings: 1. A review of the 'ADMISSION RECORD' indicated Resident 9 had diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing daily activities), and atherosclerotic heart disease of native coronary artery (caused by buildup of fats and other substances blocking the blood flow from the heart to the body). A review of Resident 9's Order Summary Report indicated the following orders: -Monitor for signs/symptoms bleeding every shift such as increased bruising every shift for anticoagulation usage dated 3/21/24; and -Xarelto (blood thinner) 2.5 mg (milligram, unit of measurement) 1 tablet two times as day for Atherosclerotic Heart Disease dated 5/2/24. A review of Resident 9's Monitoring order for signs/symptoms of bleeding which included increased bruising indicated 0 from 6/1/24 to 6/11/24. In a concurrent observation and interview on 6/11/24 at 4:45 p.m., Resident 9 was sitting in a regular wheelchair assisted by Certified Nursing Assistant 1 (CNA 1). Resident 9 had bruises on his left forearm, left elbow, and right forearm. Resident 9 was unable to state how he obtained the bruises. The CNA 1 did not know why Resident 9 had bruises and CNA 1 stated to ask Resident 9's nurse. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/11/24 at 4:49 p.m., the Licensed Nurse 3 (LN 3) stated she did not get a report regarding Resident 9's bruises. The LN 3 further stated she worked yesterday, and she had not noticed the bruises on Resident 9. The LN 3 confirmed Resident 9 was taking Xarelto. In a concurrent interview and record review on 6/14/24 at 10:18 a.m., the Minimum Data Set Coordinator (MDSC) stated Resident 9 was on anticoagulant from the two MDS assessments conducted for Resident 9 on 2/19/24 and 5/20/24. The MDSC confirmed Resident 9 had no care plan for the use of an anticoagulant. The MDSC stated if a resident was on an anticoagulant it should be care planned due to the side effect, risk of bleeding. In an interview on 6/14/24 at 10:53 a.m., the Nurse Consultant (NC) stated if a CNA observed any skin conditions, the CNA would report any skin condition to the nurse and the nurse would assess the resident and document the assessment in the progress note. There was no documented evidence in Resident 9's clinical records of the bruises identified prior to 6/11/24. In a concurrent interview and record review on 6/14/24 at 11:27 a.m., the Director of Nursing (DON) confirmed Resident 9 had no care plan for the use of an anticoagulant and the monitoring for bruising was not documented on 6/11/24. The DON stated her expectation was for the care plan to be completed within 72 hours. 2. A review of the ADMISSION RECORD indicated Resident 18 had diagnoses that included unspecified atrial fibrillation (irregular, rapid heart rate that causes poor blood flow). A review of Resident 18's Incident Note dated 5/27/24 indicated, Resident found by CNA [Certified Nursing Assistant] on floor of bathroom. States trying to pull up pants after toileting and fell .States hit arms on walker beside her in bathroom .Skin tears to right lower arm and left elbow noted. Mentation at baseline, A/O [alert/oriented x 3. Further review of Resident 19's clinical record indicated a care plan dated 1/29/24 for high risk for falls related to gait/balance problems, poor safety awareness and progression of disease process. There was no care plan initiated for the actual fall on 5/27/24 and there was no monitoring for the skin tears from the fall. In a concurrent observation and interview on 6/11/24 at 9:43 a.m., Resident 18 was inside her room and noted with steri-strips (strips of tape to keep the edges of wound together) on her left side of the elbow and a dry dressing on her right forearm. Resident 18 stated she had a fall 2 weeks ago and obtained a skin tear on her left elbow and right forearm. Resident 18 further stated she was using her four wheeled walker and she was not sure how it [fall] happened. In an interview on 6/14/24 at 1:28 p.m., the DON confirmed Resident 18 had no care plan for the fall on 5/27/24 and the skin tear obtained from the fall. The DON stated the licensed nurse who documented the fall should have completed the care plan and obtained treatment orders. The DON further stated if the physician did not order any treatments, monitoring should be done for the skin tears. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy revised 10/2023 and titled, Fall Reduction and Management Program - SNF indicated, .When a fall occurs .The Licensed Nurse will review/revise the care plan as needed and communicate any care plan changes to the unit staff and interdisciplinary team. A review of the facility's policy revised 10/2023 and titled, Care Planning indicated, .The care planning process serves as a means to identify the resident's individual needs, goals of care and provide staff direction on resident's care .Within 21 days of admission and/or within 7 days after the completion of the comprehensive assessment, the interdisciplinary team including the resident and/pr responsible party will develop a comprehensive care plan . The comprehensive care plan will . Describe the care/services that are furnished and the type of staff or discipline to furnish the care/services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48445 Based on interview and record review, the facility failed to ensure professional standards of quality was maintained for one of 13 sampled residents (Resident 25) when the attending physician was not notified of Resident 25's episodes of hypoglycemia (low blood sugar) as ordered. This failure had the potential to cause a delay in the management of Resident 25's change in condition. Findings: During a review of Resident 25's admission records, the records indicated Resident 25 was admitted in March 2023 with diagnoses that included Type 2 Diabetes Mellitus (high levels of blood sugar in the blood). During a review of Resident 25's care plan, revised on 3/13/24, the care plan indicated, The resident has hypoglycemia episodes r/t [related to] Disease process Low Blood sugar .Monitor/document/report PRN [as needed] s/sx [signs and symptoms] of hypoglycemia . During a review of Resident 25's physician order, dated 5/24/24, the order indicated, HumaLOG KwikPen [medication used to help blood sugar get into cells so the body can use it for energy] Subcutaneous [under the skin] Solution Pen-injector 100unit/mL [milliliters, a unit of measurement] (Insulin Lispro) Inject as per sliding scale [varied dose based on blood sugar level] .Notify MD [medical doctor] for Hypoglycemia (If blood sugar below 80 [mg/dl]). During a review of Resident 25's Medication Administration Record (MAR), dated 6/2024, the MAR indicated Resident 25 had episodes of hypoglycemia with blood sugar of 74 [mg/dl] on 6/10/24 at 4:30 p.m. and blood sugar of 74 [mg/dl] on 6/10/24 at 8 p.m. The MAR also indicated the episodes were coded as Vitals Outside of Parameters for Administration. The MAR did not indicate there were interventions or documentation done for the episodes of hypoglycemia. During an interview on 6/13/24 at 3:13 p.m. with Licensed Nurse 2 (LN 2), LN 2 stated, If there's an order to notify the doctor, you would have to notify, and document in the chart. If not reported to the doctor, the doctor will not be able to order the proper interventions for the situation. During a concurrent interview and record review on 6/14/24 at 10:33 a.m. with the Director of Nursing (DON), the DON verified the order for Humalog indicated to notify the doctor for blood sugar below 80 [mg/dl]. The DON verified there were two episodes of blood sugar of 74 [mg/dl] on 6/10/24 at 4:30p.m. and at 8 p.m. The DON indicated she cannot find any documentation on physician notification and stated, I don't see any notification on the progress notes .problem is they did not follow doctor's order .resident can have more hypoglycemia, the doctor can't order any treatment because he's not aware .expectation is to follow the doctor's order and notify the doctor in case of low blood sugar. During a review of the facility's P&P titled, Medication and Treatment Administration, revised 1/2020, the P&P indicated, 2. Medications and treatments shall be administered as prescribed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require substantial amount of specific knowledge of the following: (4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition .and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing - State of California Department of Consumer Affairs).

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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. 36681 Based on observation, interview, and record review, the facility failed to ensure there was safe and accurate provision of pharmaceutical services, for four of 13 sampled residents (Resident 89, Resident 5, Resident 23 and Resident 31) when: 1. Resident 89's medication was not available for administration as scheduled; 2. Resident 5's order for bladder treatment was not followed as ordered; and 3. There was no accurate accountability of controlled medications (high potential for abuse or addiction) for two of four residents (Resident 23 and Resident 31). These failures increased the potential for Resident 89 and Resident 5 to have unresolved symptoms and the potential for abuse, misuse, and diversion of controlled medications. Findings: 1. A review of the ADMISSION RECORD indicated Resident 89 was admitted with diagnoses including urinary tract infection (bladder infection) and Benign Prostatic Hyperplasia (enlarged prostate gland [located below the bladder in men, surrounds the tube that empties the bladder]) with lower urinary tract symptoms. A review of the Order Summary Report indicated an order dated 6/5/24 for Oxybutynin (medication to treat problem with bladder function) ER (extended release) 5 mg (milligram, unit of measurement) 1 tablet two times a day related to Benign Prostatic Hyperplasia with lower urinary tract symptoms. During a medication pass observation conducted on 6/12/24 starting at 8:07 a.m., with the Licensed Nurse 1 (LN 1). The LN 1 stated Resident 89 had no supply of oxybutynin in the medication cart. The LN 1 further stated she ordered the medication from the pharmacy yesterday (6/11/24). In an interview on 6/12/24 starting at 3:58 p.m., the Director of Nursing (DON) stated her expectation was for the licensed staff to reorder the medications 9 days before the medication runs out and not to wait for the last day to reorder medications. A review of the facility policy revised 01/2020 and titled Medication and Treatment Administration indicated, . Medications and treatments shall be administered as prescribed. 2. A review of the ADMISSION RECORD indicated Resident 5 was admitted with diagnoses that included a history of urinary tract infection (bladder infection) and neuromuscular dysfunction of the bladder (lacks bladder control due to brain, spinal cord or nerve problems). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Order Summary Report as of 6/1/24 indicated a physician order dated 6/27/23 for Gentamicin sulfate injection solution 40 mg (milligram, unit of measurement)/ml (millimeter). The instruction indicated Use 60 ml via irrigation one time a day for bladder treatment Inject 4 ml (120 mg) into 250 ml of Normal Saline. Then using a catheter tip syringe, inject 60 ml into bladder. Clamp tube for 1 hour, then connect back to bag for drainage. A concurrent observation and interview were conducted on 6/12/24 starting at 11:11 a.m., with the Resident Care Manager (RCM) in the medication room. Inside the refrigerator, there was an opened bottle of 500 ml of sterile water (not normal saline as ordered). The sterile water bottle was labeled 6/9/24 mixed with Gentamicin (antibiotic used to treat bladder infection). The RCM stated this bottle was used for Resident 5. The LN further stated she was informed the pharmacy sent the 500 ml of sterile water and the night shift doubled the dose since the Gentamicin was mixed with 500 ml of sterile water. Further review was conducted with the RCM on 6/12/24 at 11:30 a.m. The RCM confirmed Resident 5's Gentamicin order indicated 250 ml of normal saline and the facility stock was 500 ml of sterile water. The RCM further confirmed the opened bottle of sterile water mixed with Gentamicin did not have Resident 5's name and the amount of Gentamicin mixed in the solution was not indicated. In an interview on 6/12/24 at 3:58 p.m., the DON stated the opened bottle of sterile water with Gentamicin was used for Resident 5's suprapubic catheter (a urinary catheter inserted through a hole in the abdomen then directly into the bladder) flush. The DON further stated I don't think so when she was asked if the solution was properly labeled and if [they] were following the physician's order. A review of the facility policy revised 01/2020 and titled Medication and Treatment Administration indicated, . Medications and treatments shall be administered as prescribed. 3. A review of Resident 23's physician order dated 2/21/24 indicated the following orders: - Oxycodone HCl [hydrochloride] (medication used to treat moderate to severe pain) 5 milligrams (mg, unit of measurement), give 0.5 (2.5 mg) tablet every 6 hours as needed for moderate pain; and - Oxycodone HCl 5 mg, 1 tablet every 6 hours as needed for severe pain. Resident 23's Controlled Drug Record (CDR) indicated the Oxycodone 5 mg (0.5 or 2.5 mg) was signed out for Resident 23 on 2/28/24 at 2240 [10:40 p.m.]. The Medication Administration Record (MAR) did not indicate the Oxycodone was administered to Resident 23 on this date and time. In a concurrent interview and record review on 6/13/24 at 3:13 p.m., the DON confirmed the finding. The DON stated the licensed nurse probably forgot to document the Tramadol in the MAR for Resident 23 on 2/28/24. A review of Resident 31's physician order dated 5/6/24 indicated Tramadol HCl 50 mg, give 1 tablet every 4 hours as needed for moderate to severe pain. Resident 31's CDR indicated the Tramadol was signed out on 5/16/24 at 2345 [11:45 p.m.]. The MAR did not indicate the Tramadol was administered to Resident 31 on this time and date. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 31's progress notes dated 5/17/24 indicated, At midnight resident c/o [complained of] back/legs pain, Tramadol ofered, [sic] refused . resident wants more pain medication but refused Tramadol . There was no documented evidence the Tramadol signed out for Resident 31 on 5/16/24 was discarded. In an interview on 6/13/24 at 3:57 p.m., LN 4 stated when a controlled medication was taken out for administration, the LN 4 should have signed out on both the CDR and the MAR. In a concurrent interview and record review on 6/13/24 at 5:01 p.m., the DON confirmed the finding for Resident 31. The DON stated there was a progress note dated 5/17/24 regarding Resident 31's refusal to take Tramadol. The DON further stated if Resident 31 refused the Tramadol, the medication should be wasted with another nurse. The DON stated her expectation was for licensed nurses to document controlled medication administration both in the CDR and the MAR. A review of the facility policy revised 02/2024 and titled Medication Administration: Controlled Drugs Record Keeping - SNF indicated, It is the policy of the Company to maintain controlled drug audit forms for all controlled drugs according to state regulations .When a controlled medication is administered to a resident, the person administering the medication must record on the narcotic record form or narcotic record book: the date, the time, the amount administered, the amount remaining, and sign the sheet. A review of the facility policy revised 06/2024 and titled, Medication Administration: Disposition of Discontinued Medications indicated, . In instances when a controlled medication/narcotic is refused . It must be wasted and destroyed by two (2) licensed nurses as allowed by state.

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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** 36681 Based on observation, interview, and record review, the facility failed to ensure drugs and supplies were stored and labeled in accordance with current acceptable professional standards, for a census of 36, when: 1. A medication container labeled Gabapentin (medication used to treat seizures and pain) was in the medication room on the countertop; 2. An opened bottle of sterile water with Gentamicin (antibiotic used to treat bladder infection) was stored in the refrigerator without a resident's name; 3. There was incomplete documentation of room temperature in the medication room; 4. The discontinued non controlled medications were stored in usable form; 5. There were expired supplies in the medication room; and, 6. An opened bottle of mineral oil was in the medication cart unlabeled with resident name or date. These failures increased the risk for unsafe administration and storage of medications, and potentially increase loss or diversion of medications. Findings: 1. A concurrent observation and interview was conducted with the Resident Care Manager (RCM) on [DATE] at approximately 11 a.m. inside the medication room. There was a plastic bag on the countertop and inside the bag was a medication container labeled Gabapentin. The RCM confirmed the finding and stated the container was taken out from the automated medication dispensing machine (ADM, a computer-controlled machine that functions to store, dispense, and track medications). The RCM stated they leave the medication inside the medication room until it was picked up by pharmacy. In a telephone interview on [DATE] at 11:11 a.m., LN 5 explained the process of restocking medication in the ADM. LN 5 stated when a new medication container was delivered and was scanned in the ADM, the drawer will open. Once the drawer was opened, the LN 5 will remove the old container and replace it with the new container delivered by the pharmacy. The LN 5 further stated her practice was to put the old container inside the non-resealable bag used by the pharmacy to deliver the new container and the LN 5 will put a note outside the bag to please return. There was no designated area in the medication room to store the old container taken out from the ADM. In an interview on [DATE] at 11:24 a.m., the DON agreed there should be a separate area to store the old medication container taken out from the ADM until the container was picked up by the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy revised ,d+[DATE] and titled, CUBIX - SNF Facility Process indicated, It is the policy of the company to utilize the CUBEX station as needed for medication dispensing . Remove cubies (a container of medication in Cubex, double locked) that have popped out during restock and place in tote for return to the pharmacy. Seal the tote once all cubies are restocked for return to pharmacy. 2. In a concurrent observation and interview on [DATE] starting at 11:11 a.m., there was an opened bottle of 500 ml (milliliter, unit of measurement) of sterile water inside the refrigerator. The sterile water bottle was labeled [DATE] mixed with Gentamicin (antibiotic used to treat bladder infection). The RCM stated this bottle was used for Resident 5. In an interview on [DATE] at 3:58 p.m., the DON stated the opened bottle of sterile water with Gentamicin was used for Resident 5's suprapubic catheter (a urinary catheter inserted through a hole in the abdomen then directly into the bladder) flush. The DON further stated I don't think so when she was asked if the solution was properly labeled. A review of a policy revised [DATE] and titled, Medication Storage in the Facility, indicated, .Refrigerated medications are kept in . labeled containers . 3. In a concurrent record review and interview on [DATE] at approximately 11:20 a.m., the room temperature log had missing documentation. The room temperature for today ([DATE]) was not documented, there were 18 days of undocumented room temperatures for [DATE] and 5 days of undocumented room temperatures for [DATE]. The RCMP confirmed the findings and stated the room temperature log was completed by morning shift. In an interview on [DATE] at 3:58 p.m., the DON stated her expectation was for the room temperature to be checked and logged daily. A review of the facility policy revised ,d+[DATE] and titled, CUBIX - SNF Facility Process indicated, It is the policy of the company to utilize the CUBEX station as needed for medication dispensing . Room temperature shall be maintained between 68 degrees to 77 degrees Fahrenheit to maintain the integrity of the medications . A temperature log should be maintained in the vicinity of the CUBEX machine. A review of a policy revised [DATE] and titled, Medication Storage in the Facility, indicated, .The facility should maintain a temperature log in the storage area to record temperatures at least once a day. 4. In a concurrent observation and interview on [DATE] at 11:35 a.m., the RCM confirmed there were loose pills, cream, ointments inside a large blue top container and the medications were retrievable. The contents of the ointments and creams were not pushed out of their containers. The RCM stated these were discontinued noncontrolled medications. In a follow up interview on [DATE] at approximately 11:47 a.m., the RCM stated this was not an effective way of ensuring medications were not retrievable. The RCM further stated the 'drug buster' (neutralize the active ingredients in pills preventing misuse, abuse and contamination) should be poured when there were loose pills. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 3:58 p.m., the DON stated there was a potential for the loose pills to be taken out from the container and can be potentially diverted. The DON further stated a drug buster should be used to solidify the medications for destruction. The DON confirmed they used the wrong container, and it cannot be locked. A review of the facility policy revised ,d+[DATE] and titled, Medication Administration: Disposition of Discontinued Medications indicated, .Discontinued medications . Destroyed in the facility . The person in charge of destroying the medications is to dispose of them as follows: . Pills, tablets, liquids, creams .etc., are to be pushed out of their unit dose package or container and poured/emptied directly into a sharp container identified for this purpose OR medication wastes container. 5. In a concurrent observation and interview on [DATE] at 11:47 a.m., there were 8 pieces of expired needleless connectors (designed to provide safe, needle-free connection at the end of vascular catheter [inserted into a vein to provide access to the bloodstream] mixed with other supplies. The RCM confirmed the finding and stated everybody was responsible in making sure there was no expired supplies in the medication room. The RCM further stated there was risk for infection if the connector was expired and it potentially will not work properly. In an interview on [DATE] at 3:58 p.m., the DON stated expired supplies should be taken out from the medication room and should be replaced. 6. In a concurrent observation and interview on [DATE] at 3:44 p.m., there was an opened bottle of mineral oil, approximately ,d+[DATE] full, on the bottom drawer of medication cart B with no resident name on the label. The LN 2 confirmed the bottle was unlabeled and the LN 2 had no idea which resident it belonged to. In an interview on [DATE] at 7:56 a.m., the DON stated LN 2 told her about the unlabeled mineral oil on the bottom drawer of the medication cart. The DON confirmed the bottle was unlabeled. The DON stated she had no idea who used the mineral oil. The DON further stated the bottle can be stored in the medication cart provided it was labeled. A review of the facility policy revised ,d+[DATE] and titled, CUBIX - SNF Facility Process indicated, It is the policy of the company to utilize the CUBEX station as needed for medication dispensing . Room temperature shall be maintained between 68 degrees to 77 degrees Fahrenheit to maintain the integrity of the medications . A temperature log should be maintained in the vicinity of the CUBEX machine . Remove cubies (a container of medication in Cubex, double locked) that have popped out during restock and place in tote for return to the pharmacy. Seal the tote once all cubies are restocked for return to pharmacy.

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	555769	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Retirement Community at Davis	1515 Shasta Drive Davis, CA 95616

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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. 45718 Based on observation, interview and record review, the facility failed to ensure recipes were used and followed during meal preparation when: 1. The Beef Fajitas were prepared without following the recipe with measured ingredients, and 2. The Beef Fajitas were not served according to portion sizes. This failure had the potential to alter the nutritional value of the meals and to affect the health status of the 36 residents receiving food from the kitchen. Findings: 1. During an observation and interviews on a return visit to the kitchen on 6/12/24 at 9:35 a.m., the Lead [NAME] (LC) was preparing the lunch meal. The lunch meal included: Beef Fajitas, Chicken Salad on Croissant, Grilled Chayote Squash, Jicama Mango Slaw, Sweet Pepper Black beans, Quinoa Pilaf, and Sugar Cookie. The LC stated she was cooking the Beef Fajitas. She stated she was cooking for about 50 servings- 36 for Skilled Nursing and 11 for memory care unit. The LC was asked for the Beef Fajitas recipe as recipes where not seen in the food preparation area. The LC then pulled a folder with recipes and showed the recipe for the Beef Fajitas. Cut beef slices and cut vegetables (onions, red and green peppers) were observed in separate stainless food containers. When asked, the LC was not able to say how many pounds of beef and vegetables were in the stainless food container. The LC then started sauteing half portion of the sliced beef with unmeasured amount of oil on the griddle then she added 5 finger pinches of mixed red, white, and brown powder. The LC stated it's a mixture of cumin, chili powder, salt, and pepper. When asked about how much seasoning powder she added on the beef, she stated, not too much because you don't want too much. The LC then added 3 handfuls of mixed vegetables (onions, red and green peppers). She then stirred and cooked the beef with vegetables for about 15 minutes and transferred to the metal serving bin. She stated, she will cook the remaining beef and vegetables later and that she is cooking by batch. She then stated she has enough beef for both memory care and skilled nursing. A review of facility provided Beef Fajitas recipe (Meal Tracker Recipe- Number: 301531) indicated the following ingredients for 50 servings: Beef, Roast, inside round, raw - 9 1/2 lbs. (lbs., pounds, unit of measurement) Green Bell Peppers- 6 1/4 lbs. Onions, Raw- 1 2/3 lbs. Cheese, Cheddar, Shredded- 3 lbs. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tomatoes, Fresh - 7 lbs. Lettuce, Fresh, Head - 5 lbs. Tortillas, Flour, 8 - 50 ea. (each) The recipe did not indicate seasonings in the list of ingredients. During a follow up interview on 6/12/24 at 10:15 a.m., the LC verified the recipe did not indicate that seasoning should be added to the Beef Fajitas. The LC stated, if we don't put the seasoning then the residents will complain that it does not taste good. During a telephone interview on 6/12/24 at 4:10 p.m., the Corporate Registered Dietitian (CRD) stated, he expected the staff to follow the recipe for the number of portions they are cooking. He stated, he also expected the staff to follow the recipe when seasoning the food. A review of facility policy titled, Dietary Services: Dining, revised 1/2020, indicated, It is the policy of the Company that residents will receive well-balanced, nourishing, and palatable meals .that meet their nutritional and special dietary needs . A review of facility policy titled, Cycle Menu Production, revised, 10/2022, indicated, Foods will be prepared to meet the nutritional and therapeutic needs of the residents .3. Food is prepared to conserve nutritional value . 2. During a dining observation on 6/12/24 at 12:15 p.m., the Lead Nutritional Aide (LNA) was observed serving Beef Fajitas on tortillas with chopped tomatoes and lettuce without cheese. The LNA used a gray scoop for the beef, blue scoop for the chopped tomatoes and a metal tong for the lettuce. She stated, the gray scoop was number 4 which means half a cup of beef, the blue scoop was a quarter cup for tomatoes and just a sprinkle of lettuce using the tongs. The LNA verified, they did not put cheese on the Beef Fajitas served. She stated, if the recipe doesn't call for cheese, then we don't put but if recipes call for it then there should be cheese. The chef would have prepared the cheese if those were needed. There was no guide for scoop sizes and disher (used to measure portions) sizes observed in the dining room. A review of facility provided Beef Fajitas recipe (MealTracker Recipe- Number: 301531) indicated, Procedures: .Fill each tortilla with #16 scoop of meat mixture, #30 scoop of cheese, #8 scoop of lettuce and #16 scoop of tomatoes. A review of facility provided Disher Sizes indicated, #16 scoop (for meat mixture and tomatoes) was royal blue colored scoop and was approx. 1/4 cup, the #30 scoop (for cheese) was black colored scoop and was approx.2 1/4 tablespoons, #8 scoop (for lettuce) was gray colored scoop and was approx. 1/2 cup. During a telephone interview on 6/12/24 at 4:10 p.m., the CRD stated, the kitchen staff should be using the tools and servings size guide to communicate the serving sizes and it should be posted to somewhere to guide them. He stated, he expected the staff to use the correct utensils for each item being served. The CRD stated, it is important to follow the serving sizes in the recipe because it ensures that we are providing the residents with the nutrition they need. (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 concurrent observation and interview on 6/13/24 at 3:20 p.m., in the kitchen food preparation area, with the Executive Chef (EC), he stated they don't' have the disher sizes guide posted anywhere in the kitchen and he does not know if they have it posted in the skilled nursing dining room. A review of facility policy titled, Cycle Menu Production, revised, 10/2022, indicated, 2. Standard size portions are established by the Executive Chef, Food Service Manager .This information is to be posted in the food preparation area and followed by staff members plating meals .

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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** 45718 Based on observation, interview, and record review, the facility failed to store and prepare foods according to professional standards for food safety when: 1. opened food products were not labeled/ dated; 2. food products past the best by dates were not discarded; 3. white and grayish powder accumulation and an unknown liquid was found on the lid of food bins; 4. floor in dry storage room found with onion peels; 5. steak knife was found in the dry storage room; 6. a small potato was found in the pasta bin; 7. cutting boards were badly scraped; 8. beard net was not worn as required, and 9. a pitcher of cranberry juice was served past the labeled consumed by date. These failures had the potential to increase the risk of foodborne illnesses for a total of 36 residents who received food from the kitchen. Findings: 1. During the initial kitchen tour on [DATE] starting at 8:46 a.m., accompanied by the Lead [NAME] (LC). The LC verified, a half-gallon of opened milk and opened heavy whipping cream was unlabeled in the refrigerator and an opened garlic naan bread and a cake was unlabeled in the walk-in freezer. In the dry storage room, a gallon of opened champagne vinegar, a jar of opened pepperoncini, a bottle of opened hot sauce and a container of sushi ginger was found unlabeled. The LC verified the food products were not labeled. She stated, opened food items should be labeled to know when it should be discarded. During a telephone interview on [DATE] at 4:10 p.m., the Corporate Registered Dietitian (CRD) stated, he expected all food products to be labeled once opened prior to putting them away. A review of facility policy titled, Data Code Genie (DCG) [an automated food labeling system] Food Labeling Standard, revised ,d+[DATE], indicated, 1. All .labels should be used for food item date marking must include the following: a. Item Name b. Preparation Date c. Must Use By Date .2. All prepackaged food and beverage items that have been opened, unsealed, and or exposed to outside environmental air must be date marked using a DCG label . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During the initial kitchen tour on [DATE] starting at 8:46 a.m., the LC, verified a box of liquid egg yolks in the refrigerator with use by date of [DATE] was past the best by date and a container of red chili pepper sauce with use by date of [DATE] was past the best by date. In a continued observation in the walk- in freezer with the LC, two strawberry shortcakes with use by date of [DATE], two vanilla flan cakes with use by date of [DATE], a chocolate peppermint cake with use by date of [DATE] and a chocolate peanut cake with a use by date of [DATE] were past the use by date. The LC stated, the cakes should have been discarded. The LC stated she does not know why they were not discarded. During a telephone interview on [DATE] at 4:10 p.m., the CRD stated, he expected anything expired from the manufacturing date or label should be thrown away. A review of facility policy titled, Dry Storage Standards, revised ,d+[DATE], indicated, 9. No outdated items should be in stock or stored . 3. During the initial kitchen tour on [DATE] starting at 8:46 a.m., the LC verified there were white powder on the lids of the polenta storage bin and pure sugar cane bag as well as the cornstarch bin. The LC also verified there were grayish and white powder accumulation on the lid of the thickener storage bin and there was an unknown liquid on the lid of the couscous bin. She stated, the night staff should wipe the bins, but they never wipe them. She further stated the staff were supposed to clean the storage bins and they should be free from spilled powders. During a telephone interview on [DATE] at 4:10 p.m., the CRD stated, he expected the staff to follow their cleaning protocol. He further stated containers should have been cleaned according to their cleaning protocol. A review of facility policy titled, Dry Storage Standards, revised ,d+[DATE], indicated, 2. Storage areas need to be clean .7. Regular schedules for cleaning .should be established and enforced . A review of the 2022 US FDA [United States Food and Drug Administration] Food Code Section ,d+[DATE]. 11 indicated, (A) Equipment food-contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred . 4. During the initial kitchen tour on [DATE] starting at 8:46 a.m., the LC verified there were onion peels (5 pcs of red onion and 2 pieces of yellow onion) on the floor of the dry storage room. During a telephone interview on [DATE] at 4:10 p.m., the CRD stated, he expected the staff to follow their cleaning protocol and spills should be swept. A review of facility policy titled, Dry Storage Standards, revised ,d+[DATE], indicated, 2. Storage areas need to be clean .7. Regular schedules for cleaning .should be established and enforced . A review of the 2022 US FDA [United States Food and Drug Administration] Food Code Section ,d+[DATE]. 11 indicated, (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During the initial kitchen tour on [DATE] starting at 8:46 a.m. the LC verified there was a steak knife on top of the quinoa box. She stated the knife was not supposed to be there. During a telephone interview on [DATE] at 4:10 p.m., the CRD stated, the knife should not be in the dry storage room. A review of the 2022 US FDA [United States Food and Drug Administration] Food Code Section ,d+[DATE]. 11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles: indicated, Cleaned equipment and utensils .shall be stored: in a clean, dry location. 6. During the initial kitchen tour on [DATE] starting at 8:46 a.m., the LC verified there was a small potato in the pasta bin. During a telephone interview on [DATE] at 4:10 p.m., the CRD stated, cleaning protocols should be followed by kitchen staff. A review of facility policy titled, Dry Storage Standards, revised ,d+[DATE], indicated, 2. Storage areas need to be .organized . 7. During the initial kitchen tour on [DATE] starting at 8:46 a.m., the Lead Nutritional Aide (LNA) verified there were twenty-two (11 green, 7 red, 2 brown, 2 blue) badly scraped cutting boards still in use in the kitchen. She stated, the cutting boards should have been changed and should not have been used. During a telephone interview on [DATE] at 4:10 p.m., the CRD stated, he expected the staff to replace the cutting boards when they were badly scraped. A review of the 2022 US FDA [United States Food and Drug Administration] Food Code Section ,d+[DATE]. 12 indicated, surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. A review of the 2022 US FDA [United States Food and Drug Administration] Food Code Annex, indicated, Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. 8. During a return visit to the kitchen on [DATE] at 11:55 a.m., a dietary aide chopping vegetables in the kitchen preparation area was not wearing a beard net. The Executive Chef (EC) verified the dietary aide was not wearing a beard net. He stated, if his beard is longer than half an inch then he should wear a beard net. During a telephone interview on [DATE] at 4:10 p.m., the CRD stated, he expected staff with beards should wear a beard net to prevent hair from falling on the food. A review of facility policy titled, Uniform Dining Services, revised ,d+[DATE], indicated, .Beards are subject to hair nets . (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 2022 US FDA [United States Food and Drug Administration] Food Code section ,d+[DATE]. 11 indicated, food employees shall wear .beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and Linens; and unwrapped single-service and single-use articles. 48445 9. During a dining observation on [DATE] at 12:28 p.m. at the Magnolia Dining Hall, a pitcher of cranberry juice was observed being used to serve residents during lunch. The label on the pitcher indicated Must use by [DATE] EOD [end of day]. Four residents were observed having cranberry juice. During a concurrent observation and interview on [DATE] at 12:36 p.m. with the LNA, the LNA confirmed the observation and stated, I think it's the wrong one, they made it yesterday, we keep it for three days .we have a system, we know it's made on the 10th, we'll just change the label, this is still good, it can cause confusion if people don't pay attention. When asked about the possible effect if juices past their consume-by-date were served to residents, the LNA stated, The taste will be different, the juice might be sour. During an interview on [DATE] at 12:51 p.m. with the EC, the EC stated, Juices are good for a day, they throw it out at the end of the day when not consumed .the consume-by-date of cranberry juice is only good for a day. The EC further stated, There's no way on making an error on printing the labels or stickers . technically, you should stick to the sticker, they are supposed to discard it at the end of the date, no matter if it's correct or not. Better safe than sorry .they should always serve a new one. During an interview on [DATE] at 1:06 p.m. with the Director of Dining Services (DDS), when showed a photo of the pitcher of cranberry juice, the DDS stated, That should have not been served or stored .not supposed to just change the label and still serve it .it is past the date, it would affect the taste and the flavor but mostly the safety. During a review of the facility's policy and procedure (P&P) titled, Data Code Genie (DCG) Food Labeling Standard, revised ,d+[DATE], the P&P indicated, Food date marking should incorporate identified standards and criteria to ensure all food items are kept safe for consumption within a specific amount of time to minimize bacteria growth and spoilage .1. All DCG labels used for food item date marking must include the following: .c. Must Use By Date (Expiration date pre-loaded into the DCG labeling platform).