STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555792	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyvale Post-Acute Center	1291 S Bernardo Avenue Sunnyvale, CA 94087

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure respect and dignity was maintained for three of four residents (Resident 83, 91, and 249) when: 1. Registered nurse F (RN F) addressed Resident 83 and 91, mama; and 2. Certified nursing assistant G (CNA G) addressed Resident 249, mama. These failures had the potential to affect the emotional and psychosocial well-being of the residents. Findings: 1. Review of Resident 83's face sheet (summary page of a patient's important information) indicated, Resident 83 was admitted to the facility with diagnoses including dementia (a progressive state of decline in mental abilities) with other behavioral disturbance (a pattern of persistent, inappropriate behaviors or emotions that can cause problems in person's life) and unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). Review of Resident 83's quarterly minimum data set (MDS , a federally mandated resident assessment tool), dated 8/27/24, indicated Resident 83's brief interview for mental status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 3 (a score of 00 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Further review of the MDS indicated, Resident 83 had the ability to understand others. During an observation inside Resident 250's room on 10/14/24 at 8:48 a.m., Resident 83 was observed trying to enter Resident 250's room. RN F was overheard talking to Resident 83 to stop her from going inside Resident 250's room. RN F stated, Mama, that's not your room. RN F continued to convinced Resident 83 that Resident 250's room was not her room and addressed Resident 83, mama two more times at the facility hallway. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 91's face sheet indicated, Resident 91 was admitted to the facility with diagnoses including low back pain, and malignant neoplasm (a cancerous tumor, or abnormal growth of tissue that can spread to other parts of the body) of unspecified part of left bronchus (a large airway that leads from the trachea [windpipe] to a lung) or lung. Review of Resident 91's admission MDS dated [DATE], indicated Resident 91's BIMS score was 8. Further review of the MDS indicated, Resident 91 had the ability to understand others. During an observation inside Resident 91's room on 10/14/24 at 9:14 a.m., RN F was heard speaking to Resident 91. RN F addressed Resident 91, mama three times during her conversation with Resident 91. During an interview with RN F on 10/14/24 at 9:14 a.m., RN F confirmed she addressed both Resident 83, mama at the hallway and Resident 91 inside the room. RN F stated, she got used in calling the residents mama. RN F further stated, staff should address residents with their first names or with use of mister or miss, to provide some dignity. 2. Review of Resident 249's face sheet indicated, Resident 249 was admitted to the facility with diagnoses including Parkinson's disease (a neurologic disease that significantly affects mobility) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar type (mood swings that range from the lows of depression to elevated periods of emotional highs). Review of Resident 249's admission MDS dated [DATE], indicated Resident 249's BIMS score was 11. Further review of the MDS indicated, Resident 249 had the ability to understand others. During an observation inside Resident 249's room on 10/14/24 at 9:22 a.m., CNA G was heard talking to Resident 249 and addressed Resident 249 mama two times. During an interview with CNA G on 10/14/24 at 9:30 a.m., CNA B confirmed she called Resident 249, mama. CNA G stated she should have addressed Resident 249 with her name. During an interview with the director of nursing (DON) on 10/17/24 at 9:52 a.m., the DON confirmed staff should not label or addressed residents with the use of mama, honey or [NAME]. The DON stated staff should address their residents with their first names or they should use Mister or Miss. Review of the facility's undated policy and procedure titled, Dignity, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure needs were accommodated for five of 20 sampled residents (Residents 250, 249, 39, 25 and 48) when call light devices were not within reach of the residents. This failure had the potential for a delayed response and not meeting the resident's needs. Findings: 1. Review of Resident 250's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 250 was admitted at the facility with diagnoses including sepsis (a life-threatening blood infection), pneumonia (an infection/inflammation in the lungs), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a concurrent observation and interview with Resident 250 on 10/14/24 at 8:48 a.m., inside Resident 250's room, Resident 250 was lying in bed and his call button (also called call light, a red or white button used to request assistance) was hanging at the head of bed, in between the mattress and the bed's headboard. Resident 250 tried to reach for the call button and stated, I can't. Resident 250 was unable to reach for his call button. 2. Review of Resident 249's face sheet indicated, Resident 249 was admitted to the facility with diagnoses including Parkinson's disease (a neurologic disease that significantly affects mobility) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar type (mood swings that range from the lows of depression to elevated periods of emotional highs). Review of Resident 249's admission minimum data set (MDS, a federally mandated resident assessment tool) dated 9/30/24, indicated Resident 249's brief interview for mental status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 11 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Further review of the MDS indicated, Resident 249 had the ability to understand others. During an observation inside Resident 249's room on 10/14/2024 at 9:22 a.m., Resident 249 was seated at the right edge of bed and her call button was hanging at the lowered left bed rail. During a concurrent observation and interview with certified nursing assistant G (CNA G) on 10/14/24 at 9:30 a.m., inside Resident 249's room, CNA G confirmed the location of Resident 249's call button was not within Resident 249's reach for use. CNA G stated call lights or call buttons should always be placed within residents' reach for use. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident 39's face sheet indicated Resident 39 was admitted to the facility with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following cerebral infarction (also called stroke) affecting right dominant side, aphasia (a disorder that makes it difficult to speak), and vascular dementia (a condition that occurs when blood vessels in the brain are affected, resulting in changes to memory, thinking, and behavior). Review of Resident 39's admission MDS dated [DATE], indicated Resident 39 had memory problem with short term and long-term memory. During an observation on 10/14/24 at 9:49 a.m., inside Resident 39's room, Resident 39 as lying in bed, and her call button was attached to the handle of the bedside drawer. During a concurrent observation and interview with certified nursing assistant I (CNA I) on 10/14/24 at 10 a.m. , inside Resident 39's room, CNA I confirmed Resident 39's call button was not within Resident 39's reach for use. CNA I stated the call button should not be placed at the handle of the bedside drawer. 4. Review of Resident 25's face sheet indicated Resident 25 was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, psychotic disorder with delusions (having false or unrealistic beliefs) and post-traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). Review of Resident 25's admission MDS dated [DATE] indicated Resident 25's BIMS score was 15. During an observation on 10/14/24 at 9:58 a.m., inside Resident 25's room, Resident 25 was lying in bed and her call button was located on the floor. Resident 25 tried to look for her call button and was not able to locate it. During a concurrent observation and interview with CNA I on 10/14/24 at 10:02 a.m., inside Resident 25's room, CNA I confirmed Resident 25's call button was on the floor. CNA I stated Resident 25's call button should be placed within Resident 25's reach for use. During an interview with the director of nursing (DON) on 10/17/24 at 10:10 a.m., the DON stated residents' call lights or call buttons should always be placed within resident's reach for use. 46001 5. A review of Resident 48's clinical record indicated she was admitted to the facility on [DATE] with diagnoses including spinal stenosis (the narrowing of one or more spaces within your spinal canal). During an observation in Resident 48's room on 10/14/24 at 3:50 p.m., she was in bed, and her call light was on the oxygen concentrator. Resident 48 was moving her hand but was not able to reach the call light, and stated she wanted to drink water. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with CNA A on 10/14/24 at 3:55 p.m., he confirmed the above observation and stated that Resident 48 could not reach the call light on the oxygen concentrator and the call light should be placed within her reach all the time. A review of the facility's undated policy and procedure (P&P) titled, Answering the call light indicated, .when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident .

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. 36044 Based on observation, interview, and record review, the facility failed to provide the Ombudsman's (a government employee who investigates, reports on, and helps settle complaints) contact information to all residents when the State Long-Term Care Ombudsman's contact information was not available in the resident's care and activity areas. This failure limited resident's rights to have a confidential avenue to talk about a concern and resolved issues at the lowest possible level. Findings: During a group interview on 10/15/24, at 11:30 a.m., with one of 20 sampled residents (6) and six non-sampled residents (20, 21, 27, 34, 43 and 68), Residents (6, 20, 21, 27, 34, 43 and 68) all stated, they did not have the Ombudsman's contact information in the facility. During a concurrent tour of the facility and an interview with the director of nursing (DON) on 10/15/24, at 1 p. m. to 1:09 p.m., the DON confirmed there was no Ombudsman contact information in any part of the facility. The DON stated the facility recently just had new paint put on the walls and that they forgot to place the Ombudsman contact information back on the wall. The DON further stated the facility should have provided the Ombudsman contact information to the residents. During a review of the facility's undated policy and procedure (P&P) titled, Resident Rights, 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 communicate with outside agencies (e.g. local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection, or advocacy organizations, etc.) regarding any matter.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 36044 Based on observation, interview, and record review, the facility failed to ensure the results of the most recent survey of the facility (the survey results in a binder) was readily accessible to residents, and family members and legal representatives of residents when one of 20 sampled residents (6) and six non-sampled residents (20, 21, 27, 34, 43 and 68) stated they could not access the facility's most recent survey results. This failure potentially limited resident's rights to examine and receive the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. Findings: During a group interview on 10/15/24, at 11:30 a.m., with one of 20 sampled residents (6) and six non-sampled residents (20, 21, 27, 34, 43 and 68), Residents (6, 20, 21, 27, 34, 43 and 68) all stated, they did not know where to find the survey binder of the facility's survey results for them to review it. During an observation on 10/15/24, at 12:53 p.m., in the facility's lobby area, the facility survey binder was nowhere to find. During a follow-up interview, on 10/15/24, at 12:55 p.m., with the front desk receptionist (FDR) at the front desk, the FDR stated the survey binder was stored inside the drawer cabinet. During an interview on 10/15/24, at 1:09 p.m., with the director of nursing (DON), the DON confirmed the above findings and stated, the survey results binder should be placed on the table readily for residents or family members' to review. During a review of the facility's undated policy and procedure (P&P) titled, Resident Rights, 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 examine survey results.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48935 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) for an advance directive (AD, a written instruction, such as a living will or durable power of attorney that authorizes another person to act on behalf of the resident) and completion of the Physician Order for Life-Sustaining Treatment (POLST, a document that specifies the medical treatments the residents wants to receive during serious illness) form for three out of five sampled residents (Residents 42, 16 and 26). These failures had the potential to lead to the delivery of unnecessary or inappropriate medical services against residents' goals and wishes. Findings: Review of Resident 42's admission record indicated Resident 42 was admitted to the facility on [DATE]. Review of Resident 42's POLST form dated 7/24/24 indicated section D for AD was not completed. Further review of Resident 42's clinical record indicated there was no documented copy of an AD signed by the resident or responsible party, or evidence that the facility offered assistance in establishing an AD prior to the survey period. Review of Resident 16's admission record indicated Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's POLST form dated 8/29/24 indicated section D for AD was not completed. Further review of Resident 16's clinical record indicated there was no documented copy of an AD signed by the resident or responsible party, or evidence that the facility offered assistance in establishing an AD prior to the survey period. Review of Resident 26's admission record indicated Resident 26 was admitted to the facility on [DATE]. Review of Resident 26's POLST form dated 9/20/24 indicated section D for Ad was not completed. Further review of Resident 26's clinical record indicated there was no documented copy of an AD signed by the resident or responsible party, or evidence that the facility offered assistance in establishing an AD prior to the survey period. During a concurrent interview and record review with the facility's Social Services Director (SSD) on 10/17/24 at 8:50 AM, the SSD confirmed section D was not filled out for Residents 42, 16 and 26. The SSD stated the role of social services was to ensure the POLST form was filled out completely and to verify if there was an existing AD for the resident. The SSD stated social services also offer help in completing an advanced directive if the resident or responsible party needs help. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's undated policy and procedure (P&P) titled Advance Directives indicated If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives and If the resident or the residents representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff.

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44583

Based on observation, interview, and record review, the facility failed to provide an orderly, comfortable, and homelike environment for one of five sampled residents (Resident 69) when Resident 69's closet door did not latch to remain close. This failure had the potential to result for Resident 69's decreased sense of well-being and an uncomfortable environment.

Findings:

During an observation and interview on 10/14/24 at 11:18 a.m., inside Resident 69's room, Resident 69 was observed walking inside the room and was about to change clothing. Resident 69 complained about her closet door, located behind the bedroom door. Resident 69 stated her closet door was broken and did not remain close. Resident 69 further stated she complained about it to the facility's housekeeper but instead of fixing or having someone to fix it, the housekeeper placed a surgical tape at the edge of the closet door to temporarily closed it. Resident 69's closet door was observed to have a surgical paper tape to leave the door closed. Resident 69 stated the closet door was broken for a while.

During a review of Resident 69's quarterly minimum data set (MDS, a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 69's brief interview for mental status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 14 (a score of 0 to 7 indicates severe cognition impairment; 8 to 12 moderate impairment; 13 to 15 patient is cognitively intact).

During a concurrent observation, and interview with maintenance director L (MD L) on 10/15/24 at 09:34 a.m. , inside Resident 69's room, MD L confirmed Resident 69's door did not latch to keep it closed. MD L confirmed nobody reported Resident 69's closet door was broken.

During an interview with licensed vocational nurse J (LVN J) on 10/16/24 at 9:21 a.m., LVN J was assigned to Resident 69. LVN J stated she was not aware about Resident 69's broken closet door. LVN J further stated, if something was broken inside resident's room, they would call maintenance right away. LVN J stated housekeeper M (HK M) was available in the evening shift to also help in fixing anything.

During an interview with certified nursing assistant K (CNA K) on 10/16/24 at 9:34 a.m., CNA K confirmed she was assigned to Resident 69 and she was not aware about the broken closet door. CNA K stated she would call maintenance if something was broken inside resident's room.

During a concurrent interview with MD L and document review on 10/16/24 at 9:46 a.m., MD L reviewed the maintenance log. MD L confirmed Resident 69's broken closet door was not written in the maintenance log. MD L stated staff should write anything that needed to be fixed in the maintenance log binder. MD L confirmed he always checked the maintenance log in the morning and fixed what needed to be fixed right away. MD L stated, staff are lazy, to write down what needed to be fixed in the maintenance log. MD L further stated staff would call him if something was broken.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the director of nursing (DON) on 10/17/24 at 10:10 a.m., the DON stated nurses and housekeepers should have called maintenance when resident's if there was something wrong with residents' equipments or when something was broken inside residents' rooms. During a review of the facility's undated policy and procedure titled, Maintaining Residents Room, indicated, The Maintenance Department is responsible for maintaining the buildings, always including residents' rooms and equipment in a safe and operable manner .Residents' rooms should be in good repair and free from hazards.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment and care screening tool) assessment was coded accurately for weight gain for one of 10 sampled residents (Resident 78). This failure compromised the facility's ability to develop and implement a resident-centered care plan and interventions for the resident's severe unplanned weight gain. Findings: Review of Resident 78's face sheet dated 10/15/24 indicated the resident was admitted on [DATE] and readmitted on [DATE] with multiple diagnoses including atrial fibrillation (an irregular heart rhythm which can lead to blood clots and stroke), Type 2 diabetes (elevated blood sugar), duodenal ulcer (a sore in the lining of part of the digestive tract), chronic venous hypertension with ulcer of bilateral lower extremities (end parts of the body- legs), and morbid obesity (having too much body fat). Review of Resident 78's three-month (August, September, and October 2024) Weight Summary indicated on 8/13/24, Resident 78's weight was 276 lbs. (lbs, symbol for pound), and on 10/13/24 his weight was 303 lbs. This was a severe weight gain of 9.78 % in three months. Review of Resident 78's quarterly MDS, section K0300, dated 9/12/24, indicated the question, Has the resident had weight loss of 5% or more in the last month or 10% or more in last 6 months? The answer to this question was coded 2. Yes to indicate that Resident 78 did have a weight loss of 5% or more in the last month or 10% or more in last 6 months. Section K0310 asked the question, Has the resident had weight gain of 5% or more in the last month or gain of 10% or more in last 6 months? The answer to this question was coded 0. No to indicate that resident did not have a weight gain of 5% or more in the last month or gain of 10% or more in last 6 months. During a concurrent interview and record review with the Minimum Data Set Coordinator (MDSC) on 10/16/24 at 1:30 p.m., the MDSC reviewed Resident 78's monthly weight summary and sections K0300 and K0310. The MDSC confirmed the above weight gain occurred within the last three months and stated Resident 78's MDS sections for weight gain were not coded accurately on the MDS dated [DATE]. She stated the MDS K0310 should have been coded 2. Yes and section K0300 should have been coded 0. No. The MDSC further explained the MDS section K dated 9/12/24 was completed by the Registered Dietitian. During an interview with the Registered Dietitian (RD) U on 10/16/24 at 2:02 p.m., RD U acknowledged Resident 78's weight gain was not coded accurately. The RD U stated the MDS assessment dated [DATE] section K0300 should have been coded as 0. No, and section K0310 should have been coded as 2. Yes. The RD U further stated it was important to have a correct MDS to accurately develop a nutrition plan for the resident. Review of the facility's policy dated November 2019, titled Certifying Accuracy of the Resident Assessment, indicated Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on observation, interview, and record review, the facility failed to implement care plan interventions for one of 20 sampled residents (Resident 13) regarding supervision with ambulation, continue encouraging to wear shirts or gowns while not in rooms, and ensure resident have non-skid socks/shoes while walking in the hallways . This failure had the potential to result in residents not receiving the appropriate care necessary to maintain their highest practicable level of health and well-being and result in Resident 13's continued behavioral issues. Findings: A review of Resident 13's face sheet (summary of resident's demographic and admitting information) indicated that Resident 13 was admitted on [DATE] with multiple diagnoses, including unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms), generalized weakness, and a history of falling. A review of Resident 13's minimum data set (MDS, a tool used to measure health status in nursing home residents) completed on 10/9/24 indicated a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 4 out of 15. A score of 0 to 7 indicates severe cognitive impairment (problems with memory and thinking). During an observation on 10/14/24 at 3:40 p.m. in the hallway, Resident 13 was observed walking bare footed, shirtless, and only wearing pants. Resident 13 went to a medication cart, poured a cup of juice, and drank it all. During an interview with licensed vocational nurse (LVN) P on 10/14/24 at 03:45 p.m., LVN P stated Resident 13 poured cranberry juice from the pitcher, and he should not pour the juice from the medication cart by himself, he should ask certified nursing assistants when he needs a drink. During a concurrent observation and interview with certified nursing assistant (CNA) R on 10/14/24 at 4:02 p.m. in the hallway, Resident 13 was observed walking bare footed, shirtless, and only wearing pants. CNA R confirmed the observation and stated Resident 13 should wear shirt for dignity and should wear sock or shoes for safety. A review of Resident 13's care plan dated 7/11/24 indicated Resident 13 needed behavior monitoring for behavior problems prefers to be shirtless while walking in the hallways and room. This care plan indicated interventions to encourage Resident 13 to wear a shirt or gown while not in the room and ensure Resident 13 had non-skid socks/shoes while walking in the hallways. (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 Resident 13's care plan implemented on 4/24/24 indicated that due to generalized weakness, Resident 13 required assistance in walking in the room, corridor, and required assistance for dressing. This care plan indicated intervention to supervision with ambulation. During a concurrent interview and record review with the director of nursing (DON) on 10/18/24 at 9:56 a.m., the DON reviewed Resident 13's care plan and confirmed that the care plan indicated that he needed supervision for ambulation, assistance with dressing and eating, and monitoring of his behavior. The DON further stated that Resident 13 should be supervised when walking in the hallway, should not pour juice from the medication cart alone, should wear a sock or shoe for safety, and should wear a shirt or gown for dignity. A review of the facility's undated policy, Care Plans, Comprehensive Person-Centered, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on observation, interview and record review, the facility failed to provide care and service in accordance with professional standards of practice for two of six sampled residents (Resident 15 and 92) when: 1. The licensed nurses did not apply a Lidocaine patch (eases pain by numbing the nerves and making them less sensitive to pain) as ordered by the physician; and 2. The licensed nurses stored Resident 92's custom jewelry in a narcotic box (NB, a locked medication compartment inside a medication cart) in the medication cart (MC) 2. These failures had the potential to compromise residents' health and well-being. Findings: 1. A review of Resident 15's medical record indicated he was admitted on [DATE] and had diagnoses including fracture of unspecified lumbar vertebra (a break in a bone or bones of the spine). A review of Resident 15's Minimum Data Set (MDS, a tool used to measure health status in nursing home residents) completed on 9/23/24 indicated a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 10 out of 15. A score of 8 to 12 points suggests moderate cognitive impairment (problems with memory and thinking). A review of Resident 15's physician order dated 7/16/24 indicated applying Lidocaine External Patch 4% topically to his lower back one time a day for pain: on at 9 a.m. and off at 9 p.m.; no lidocaine patch order for his left shoulder. During a medication pass observation on 10/16/24 at 9:47 a.m., in Resident 15's room, Licensed Vocational Nurse (LVN) Q applied the Lidocaine patch to Resident 15's left shoulder when Resident 15 pointed the left shoulder as the pain area. During an interview with LVN Q on 10/16/24 at 1:40 p.m., LVN Q confirmed the above observation and stated that, according to the physician's order, she should have applied the Lidocaine patch to Resident 15's lower back instead of the left shoulder. During a follow-up interview with LVN Q on 10/16/24 at 02:15 p.m., LVN Q stated that she reported to the physician that Resident 15 complained left shoulder pain and got a new order to apply Lidocaine to his left shoulder starting 10/16/24. A review of the facility's policy titled Administering Medications, dated 2001, indicated that medications are administered in accordance with prescriber orders, including any required time frame . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a medication cart inspection with Registered Nurse (RN) D on 10/15/24 at 2:15 p.m., 5 bags of custom jewelry were stored in the NB in MC 2. RN D stated that the custom jewelry was made by Resident 92 and given to staff as gifts. The staff did not accept those and kept them in the NB in MC 2, and they wanted to return to Resident 92's family. RN D further stated she did not remember when Resident 92 gave those and that the nurse should not kept those items in the NB. During an interview with the Social Service Director (SSD) on 10/18/24 at 12:21 p.m., the SSD stated that Resident 92 had a habit of giving staff fake jewelry as gifts. The SSD further stated that he did not know how long those items were stored there. The nurse should not keep those items in the NB of MC 2 and should give them to social services once they receive them. During an interview with the Director of Nursing (DON) on 10/18/24 at 1:15 p.m., the DON stated that she was not sure how long those items had been stored in the NB. The nurse should lock the items there only overnight to keep them safe and then submit them to social service the next day. During an interview with the nurse supervisor (NS) on 10/18/24 at 2:33 p.m., the NS stated that Resident 92 gave the custom jewelry to staff as a gift on Sunday 10/13/24. The staff planned to return to Resident 92's family. The NS further stated that the staff should not keep those in the NB of MC 2 and submit them to social service on Monday 10/14/24. A review of the facility's policy titled medication labeling and storage dated 2001, indicated, controlled substances (listed as schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments . A review of the facility's policy titled Gifts, Gratuities, and payments, dated 2001, indicated that in certain situations, when a resident is attempting to give a gift, it may be acceptable to receive the gift due to resident diagnosis, behavior, or extenuating circumstances, but the employee must store the item in a safe location and attempt to return the items to the resident, responsible party, or family in a timely manner .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to provide care and services for effective communication when the facility did not provide language assistance or other communication aid and did not develop a baseline care plan to one of three sampled residents (Resident 254) with language barrier (speaking in foreign language). These failures had the potential to affect the psychosocial well-being of Resident 254 and a decline in the activities of daily living. Findings: 1a. Review of Resident 254's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 254 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (also called stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following cerebral infarction affecting left non-dominant side and dysphagia (difficulty in swallowing). Review of Resident 254's admission/5-day minimum data set (MDS, a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 254's preferred language was [foreign language]. Further review of the MDS indicated Resident 254's brief interview for mental status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 12 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During a concurrent observation and interview with family member N (FM N) on 10/14/24 at 8:37 a.m., inside Resident 254's room, Resident 254 was in bed and FM N was standing at bedside. FM N stated Resident 254 could understand English but unable to spoke the language. There was no communication aid posted or around Resident 254's surroundings. FM N confirmed there was no communication aid provided since Resident 254's admission. FM N stated staff did not use any communication aid to communicate with Resident 254. During an interview with registered nurse F (RN F) on 10/15/24 at 9:40 a.m., RN F confirmed Resident 254 did not have a communication aid in the room and needed a communication aid for staff to used to communicate with him. RN F stated activities staff were the ones who provided the communication aids to residents who could only speak foreign language. Review of the facility's policy and procedure titled, Translation and/or Interpretation of Facility Services, date revised November 2020, indicated, This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility .This facility shall provide written translation of vital information pertaining to health services . (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1b. During a concurrent interview and record review with the activities director (AD) on 10/16/24 at 11:27 a.m. , the AD reviewed Resident 247's list of baseline care plan. The AD confirmed Resident 247's language barrier baseline care plan was not developed and implemented. The AD stated the language barrier baseline care plan should have been developed within 24 hours of admission. The AD confirmed activities staff were the ones responsible in providing the communication aids to residents with language barrier. The AD stated nurses should also provide the communication aid to residents who needed communication aid because they have the communication aids at the nurse station. Review of the facility's undated policy and procedure titled, Care Plans - Baseline, indicated, A baseline plan of care to meet resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan .The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to update the fall care plan, provide new intervention, and provide a resident centered care plan interventions to prevent the falls for one of two sampled residents (Resident 6) who was high risk of falling. These failures resulted in Resident 6's four falls since admission and had a potential to result in major injuries (broken bones, joint dislocation, head trauma or even death). Findings: Review of Resident 6's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 6 was admitted to the facility with diagnoses including polyneuropathy (a condition that affects many nerves in different parts of the body, causing them to malfunction altogether), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), pulmonary fibrosis (a serious lung disease that causes scarring in the lungs, making it difficult to breathe), and unspecified asthma (inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath). Review of Resident 6's quarterly minimum data set (MDS, a federally mandated resident assessment tool) dated 9/2/24, indicated Resident 6's brief interview for mental status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 12 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Further of the review of the MDS indicated Resident 6 required supervision with bed mobility (roll left and right, sit to lying and from lying to sitting), chair/bed to chair transfer, and with walking/wheeling self on a wheelchair. Review of Resident 6's Admission Fall Risk Observation/assessment dated [DATE], indicated, Resident 6's score was 18 (0-8 low risk; 9-15 moderate risk; 16-42 HIGH RISK). Review of Resident 6's clinical record titled, Change in Condition Evaluation, dated 6/12/24, indicated Resident 6 had an unwitnessed fall. Further review of the Change in Condition Evaluation indicated Resident 6 tried to walk to the bathroom, slipped on a piece of food and fell on her knees. There was no injury after the fall. Review of Resident 6's progress notes titled, IDT [interdisciplinary team, a group of health care professionals from diverse fields who work toward a common goal for residents] - Fall, dated 6/13/24, indicated to address the 6/12/24 fall. The current interventions in the IDT indicated, Reoriented to the call and to use the light and agreed to call the staff before standing up. Frequent checks to prevent falls. Call light within easy reach. Frequent checks with the nurses to prevent falls. Reminded the resident not to pick up anything from the floor and ask someone to do it for her. Referred to rehab (physical therapy and occupational therapy) for post-fall check. The IDT deemed that the fall was considered unavoidable, related to .generalized weakness and diagnosis . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's clinical record titled, Change in Condition Evaluation, dated 8/15/24, indicated Resident 6 was found seated on the floor next to bed. Further review of the Change in Condition Evaluation indicated, Resident 6 told staff she tried to turn but slid down to the floor. There was no injury from the fall. Review of Resident 6's progress notes titled, IDT-Fall, dated 8/16/24, it indicated to address the 8/15/24 fall. Further review of the IDT-Fall indicated the current interventions were the same as above interventions and there were no possible contributing factors of the fall except for generalized weakness and Resident 6' diagnoses. Review of Resident 6's clinical record titled, Change in Condition Evaluation, dated 9/3/24, indicated Resident 6 slid down from the wheelchair down to the floor. Further review of the Change in Condition Evaluation indicated, Resident 6 sustained a skin tear on the right knee. Review of Resident 6's progress notes titled, IDT-Fall, dated 9/6/24, indicated to address the 9/3/24 fall. Further review of the IDT-Fall indicated the current interventions were the same as the first fall interventions and there were no possible contributing factors of the fall except for Resident 6's generalized weakness and diagnosis. Review of Resident 6's clinical record titled, Change in Condition Evaluation, dated 9/6/2024, indicated Resident 6 was found seated on the floor in between her wheelchair and bed. Further review of the Change in Condition Evaluation indicated Resident 6 did not sustain any injury. Review of Resident 6's progress notes titled, IDT-Fall, dated 9/9/24, indicated to address Resident 6's 9/6/24 fall. There were no new interventions developed except for the frequent checks every 2 hours. During an observation on 10/14/24 at 9:11 a.m., inside Resident 6's room, Resident 6 was observed seated on a wheelchair with oxygen in placed and was able to wheel herself from the bed side to the room's door to talked to registered nurse F (RN F). During a concurrent observation and interview with Resident 6 on 10/15/24 at 9:50 a.m., Resident 6 was found at the facility's hallway, seated on her wheelchair and in front of the medication cart. Resident 6 was not wearing any footwear. Resident 6 stated she wanted to go to the bathroom and staff just left her seated in front of the medication cart. During a concurrent observation and interview with the director of nursing (DON) on 10/17/24 at 9:16 a.m., the DON reviewed Resident 6's change in condition evaluation, IDT-Fall and care plans related to falls. The DON confirmed Resident 6 was high risk for fall and had fallen four times since admission. The DON stated Resident 6 was non-compliant with fall risk interventions. The DON confirmed the IDT did not identify the possible contributing factors of each fall. The DON further confirmed they did not develop new interventions to prevent future falls and fall care plan was not updated or revised. The DON stated the fall care plan should have been updated or revised for every fall incidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated policy and procedure titled, Falls and Fall Risk, Managing, indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling .If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, date revised March 2022, indicated, .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents 'conditions change. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in resident's condition; b. when the desired outcome is not met; .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38924 Based on observation, interview, and record review, the facility failed to ensure implementation of a comprehensive systematic approach for effective monitoring for one sampled resident (78) who experienced a severe unplanned weight gain of a 9.78% in three months and did not maintain acceptable parameters of nutrition. This failure had the potential to result in additional unintentional weight gain for Resident 78, which could lead to further weight gain and decline in health and nutrition status. Cross reference F641 Findings: According to an article in the Cardiovascular Diabetology journal titled Extremes of Both Weight gain and Weight loss are associated with Increased Incidence of heart failure and cardiovascular death: Evidence from the CANVAS Program and CREDENCE.Obesity is an independent risk factor for cardiovascular disease (CVD) in patients with type 2 diabetes (T2D). Extremes of weight gain or loss were independently associated with a higher risk of the composite of congestive heart failure (CHF) and Cardiovascular (CV) death. In patients with Type 2 Diabetes and high CV risk, large changes in body weight should be carefully assessed in view of individualized management. Ferrannini, G., [NAME], C., [NAME], A. et al. Cardiovasc Diabetol 22, 100 (2023). https://doi.org/10.1186/s12933-023-01832-5 Per the facility's Admission Record dated 10/16/24, Resident 78 was admitted on [DATE] with diagnoses which included cellulitis (inflammation and swelling) in the lower right and left limbs, morbid obesity (body mass index greater than 40) due to excess calories, type 2 diabetes mellitus (inability to manage blood sugar) and anemia (low iron in the blood). Review of Resident 78's Weight Summary report dated 10/21/24 indicated: June 2024 - 290 pounds July 2024 - 273 pounds August 2024 - 276 pounds September 2024 - 294 pounds October 2024 - 303 pounds Resident 78's three-month (August, September, and October 2024) weight summary indicated Resident 78 experienced a 9.78% severe weight gain in three months. Review of Resident 78's physician ordered diet dated 7/21/24 indicated .cardiac, no added sodium, regular texture, thin liquid consistency . (continued on next page)

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an observation and interview with Resident 78 on 10/14/24 at 12:40 p.m.,, Resident 78 received his lunch meal tray. The resident stated he liked to eat the facility's food and he had not spoken with the Dietitian department about concerns related to his food, snacks, or meals.

Review of the facility's Weight variance committee note dated 7/10/24 indicated the resident's weight was 273 pounds and the recommendation by RD T was for the resident to receive prostat (protein supplementation), and a CMP (comprehensive metabolic panel) lab assessment.

During an interview on 10/16/24 at with Resident 78, the resident stated he knows he lost weight after returned from the hospital when he had an infection in his lungs and stomach. But he was unaware of a recent significant weight gain. He stated he was able to walk inside his room back and forth for physical activity.

During an interview on 10/16/24 at 2:02 p.m., with RD U about Resident 78's weight gain, RD U stated she should have interviewed the resident about his weight gain and food intake from meals and snacks he gets from outside the facility.

During an interview on 10/16/24 at 5:19 p.m., with the Director of Nursing (DON), the DON stated Resident 78 was not on a physician ordered weight gain program. The DON also stated Resident 78's care plan should have addressed a plan for the resident's unintentional weight gain, and the food brought in from the outside.

During an interview on 10/17/24 at 2:51 p.m., with RD T about Resident 78's weight gain. RD T stated in her nutrition assessment dated [DATE], she recommended protein (prostat) and zinc to address the resident's wound healing from weight loss from his recent hospitalization in July 2024. RD T stated she made a recommendation for the resident to have a CMP lab report completed to evaluate the resident's nutrition status, but she did not follow up to verify if the recommendations were carried out.

Review of Resident 78's lab report dated 6/27/24 indicated the following: Vitamin D = 8 ng/L (low level) (normal= 30-100); calcium = 7.5 mg/dL (low level) (normal= 8.5-10 mg/dL); and albumin 2.8 g/dL (normal= 3. 2 - 5.5 g/dL).

Review of Resident 78's Nutrition Risk Review Quarterly report dated 9/9/24, completed by the Registered Dietitian indicated .Resident noted with weight gain 18lbs/6.5% x 1month. Currently at 294lbs/ BMI 41- morbidly obese weight status .PO (oral intake) has been excellent with overall 75-100%meals intake +snacks. Suspect rt is meeting estimated needs with current intake. Would benefit from weight stability or gradual weight loss for improved nutrition status. Resident already on appropriate therapeutic diet restriction. For now, continue with current plan of care . Goal: weight stability or gradual weight loss, PO>75% Monitor: PO intake, wt, labs, and adjust prn .

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sunnyvale Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1291 S Bernardo Avenue Sunnyvale, CA 94087	

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/24 at 10:15 a.m., with the PHYS (Physician), the PHYS stated he did not restrict Resident 78's food or fluid intake because the resident did not have renal disease or congestive heart failure (CHF), and because he had recent hospitalization s. The PHYS stated he only would consider making dietary restrictions if a resident's BMI exceeded 35 or 40 and they were morbidly obese. The PHYS stated then he would recommend the resident be educated on not eating as much food and snacks from outside. The PHYS stated he was not aware Resident 78's BMI was greater than 35 when he last checked and spoke with him. The PHYS stated he routinely checked regular lab values for residents based on their health status, but he acknowledged the labs were not ordered for Resident 78 because he was unaware, they were requested by the weight variance committee. The PHYS stated the CMP labs recommended by the RD may have helped in the resident's nutrition assessment and could have prevented the resident's unintentional weight gain. Review of the facility's Policy & Procedure (P&P) titled Weight Intervention dated 2001, the policy indicated . Residents weights are monitored undesirable or unintentional weight loss or gain .Weight Assessment- Residents are weighed upon admission and at intervals established by the interdisciplinary team. 1.) Weights are recorded in each unit's weight record chart and in the individual's medical record. 2.) Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a) If the weight is verified, nursing will immediately notify the dietitian in writing. 3.) Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. 4.) The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss= (usual weight- actual weight}/(usual weight} x 100]: a). 1 month - 5% weight loss is significant; greater than 5% is severe, b.) 3 months - 7.5% weight loss is significant; greater than 7.5% is severe; c.) 6 months -10% weight loss is significant; greater than 10% is severe .Evaluation .1. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example .a.) poor digestion or absorption; b.) fluid and nutrient loss; and/or c.) inadequate availability of food or fluids . Review of the facility's Policy & Procedure (P&P) titled Nutrition Assessment the policy indicated .The dietitian, 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. 1). As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. 2). the nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components: Nursing: .Usual body weight; .A description of the resident's usual intake and appetite; .A history of reduced appetite or progressive weight loss or gain prior to admission; .Current clinical conditions and recent events that may have affected a resident's nutritional status and risk factors'. Advance directives that may influence decision-making regarding nutrition support; .General appearance - a description of the resident's overall appearance; .The resident's usual route(s) of intake (e.g., oral, enteral, parenteral); .Usual meal and snack patterns; .Food preferences and dislikes (including flavors, textures, and forms); .Food restrictions, including food allergies and cultural or religious practices affecting food choices; and Preferred portion sizes .Physicians and Practitioners: Current clinical conditions and recent events that may have affected a resident's nutritional status and risk factors; Current laboratory results related to fluid and electrolyte status (BUN, creatinine, serum osmolality) . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50135

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview and record review, the facility failed to ensure that proper care and treatment services for oxygen (O2, a colorless, odorless gas) use was provided for two of two sampled residents (Resident 6 and 10) when: 1. Registered nurse F (RN F) failed to ensure the oxygen was on and at 3 liters per minute (L,metric unit of capacity, P, M) as ordered, when Resident 6's oxygen tubing was transferred from the oxygen concentrator (a medical device that provides a safe source of oxygen-enriched air) to an E-tank (a portable 3-foot-tall aluminum tank that contains oxygen), and staff did not develop a care plan related to Resident 6's oxygen use; and 2. Staff did not post an Oxygen in use/No Smoking sign at Resident 10's room entrance door and staff did not develop a care plan related to Resident 10's oxygen use. Findings: 1a. Review of Resident 6's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 6 was admitted to the facility with diagnoses including polyneuropathy (a condition that affects many nerves in different parts of the body, causing them to malfunction altogether), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), pulmonary fibrosis (a serious lung disease that causes scarring in the lungs, making it difficult to breathe), and unspecified asthma (inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath). Review of Resident 6's clinical record titled, Order Summary Report, dated 6/3/24, indicated there was an order for oxygen use at 3 LPM with a goal to maintain Resident 6's oxygen saturation (O2 sat, the amount of oxygen circulating in the blood) greater than 90%. Review of Resident 6's quarterly minimum data set (MDS, a federally mandated resident assessment tool) dated 9/2/24, indicated Resident 6's brief interview for mental status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 12 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Further review of the MDS indicated Resident 6 was on oxygen therapy at the facility. During a concurrent observation and interview on 10/14/24 at 9:11 a.m., inside Resident 6's room, Resident 6 was observed seated on a wheelchair with oxygen thru nasal cannula (NC, a device used to deliver supplemental oxygen or airflow) connected to an E-tank behind Resident 6's wheelchair. It was observed that the E-tank was off. Resident 6 wheeled herself from the bed side to the room's door. Resident 6 complained of not getting air for 15 minutes. Resident 6 stated the restorative nursing assistant (RNA, a healthcare professional who helps patients regain and maintain their independence and mobility) transferred her to the wheelchair and the oxygen tubing to the E-tank. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with RN F on 10/14/24 at 9:15 a.m., inside Resident 6's room, RN F confirmed Resident 6's E-Tank was not on. RN F confirmed the RNA was the one who transferred Resident 6 to the wheelchair and transferred the oxygen tubing to the E-tank. RN F stated the oxygen should have been turned on at 3 LPM as ordered by the physician. During an interview with the director of nursing (DON) on 10/17/24 at 9:45 a.m., the DON confirmed the nurse should have turned on Resident 6's oxygen when the RNA transferred Resident 6 to the wheelchair. Review of the facility's policy and procedure titled, Oxygen Administration, date revised October 2010, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure .Turn on the oxygen. 1b. During a concurrent interview with the DON and record review on 10/17/24 at 9:47 a.m., the DON reviewed Resident 6's list of active care plans. The DON confirmed Resident 6's care plan for oxygen use was not developed. The DON stated Resident 6 used the oxygen due to her diagnosis of COPD. The DON further stated Resident 6's oxygen use should have been care planned. 2a. Review of Resident 10's face sheet indicated Resident 10 was admitted to the facility with diagnoses including Parkinsonism (a neurologic disease that significantly affects mobility), chronic bronchitis (a lung condition that causes inflammation of the bronchial tubes, the airways in the lungs) and COPD. Review of Resident 10's clinical record titled, Order Summary Report, dated 9/19/24, indicated Resident 10 had an order for oxygen use at 2 LPM thru NC with a goal to maintain O2 sats greater than 90%. Review of Resident 10's quarterly MDS assessment dated [DATE], indicated Resident 10's BIMS score was 15. Further review of the MDS indicated Resident 10 was on oxygen therapy. During an observation on 10/14/24 at 10:45 a.m., inside Resident 10's room, Resident 10 was seated on a wheelchair with oxygen in placed thru NC at 2 LPM which was connected to an oxygen concentrator. There was no Oxygen in use/No Smoking sign posted at Resident 10's room entrance door. During a concurrent observation and interview with licensed vocational nurse J (LVN J) on 10/14/24 at 12:27 p.m., in Resident 10's room entrance door, LVN J confirmed Resident 10 was on oxygen and there was no Oxygen in Use sign posted at his room entrance door. LVN J stated their maintenance staff and infection preventionist (IP) nurse were supposed to provide and post the Oxygen in Use sign. LVN J stated the Oxygen in Use sign should have been posted. During an interview with the DON on 10/17/24 at 10 a.m., the DON stated the Oxygen in Use sign were stored in the facility's oxygen room and nurses should have taken one to post it at Resident 10's room entrance door. During a review of the facility's policy and procedure titled, Oxygen Administration, date revised October 2010, indicated, Place an 2. Oxygen in Use sign on the outside of the room entrance door .3. Place an Oxygen in Use sign in a designated place . (continued on next page)

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	555792	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2b. During a concurrent interview with the DON and record review on 10/17/24 at 10:05 a.m., the DON reviewed Resident 10's list of active care plans. The DON also confirmed Resident 10's care plan for oxygen use was not developed. The DON stated the oxygen use care plan should indicate the oxygen rate ordered by the physician. Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, date revised March 2022, indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44583 Based on interview and document review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis based on Staffing Data Report submitted to Centers for Medicare & Medicaid Services (CMS). This failure had the potential to affect resident's care, health, and psychosocial wellbeing. Findings: During a document review titled, Census and Direct Care Services Hours Per Patient Day (DHPPD), from April through July 2024, indicated the following dates with actual DHPPD were below 3.5 hours: 4/6 - 3.11; 4/13 -3.07; 4/14 - 3.32; 5/5 - 3.43; 5/6 - 3.46; 5/25 - 3.30; 6/16 - 3.48; 6/17: 3.48; 6/29 - 3.29; 6/30 - 3.24; 7/1 - 3.44; and 7/7 - 3.42. Further review indicated the following dates with actual certified nursing assistant (CNA) DHPPD were below 2.4 hours: 4/1 - 2.15; 4/2 - 2.31; 4/3 - 2.38; 4/4 - 2.36; 4/5 - 2.29; 4/6 - 2.05; 4/7 - 2.24; 4/8 - 2.20; 4/9 - 2.40; 4/10 - 2.35; 4/12 - 2.34; 4/13 - 2.03; 4/14 - 2.16; 4/15 - 2.11; 4/16 - 2.25; 4/17 - 2. 26; 4/18 - 2.37; 4/19 - 2.30; 4/20 - 2.39; 4/23 - 2.32; 4/24 - 2.22; 4/26 -2.32; 4/27 - 2.37; 4/29 - 2.35; 4/30 - 2. 39; 5/3 - 2.37; 5/4 - 2.38; 5/5 - 2.29; 5/6 - 2.33; 5/10 - 2.36; 5/11 - 2.38; 5/13 - 2.17; 5/14 - 2.17; 5/17 - 2.25; 5/18 - 2.30; 5/19 - 2.36; 5/24 - 2.28; 5/25 - 2.03; 5/26 - 2.32; 5/27 - 2.28; 6/1 - 2.28; 6/2 - 2.25; 6/7 - 2.39; 6/11 - 2.25; 6/16 - 2.34; 6/17 - 2.34; 6/18 - 2.33; 6/21 - 2.39; 6/24 - 2.28; 6/29 - 2.16; and 6/30 - 2,21. During an interview with the staffing coordinator (SC) on 10/16/24 at 5:05 p.m., the SC confirmed the actual DHPPD should not be below 3.5 and the actual CNA DHPPD should not be below 2.4. During an interview with the director of staff development (DSD) on 10/18/24 at 8:53 a.m., the DSD confirmed they had weekend low staffing in April to June 2024. The DSD further stated they were in transition with the staffing coordinator on those months. During an interview with the director of nursing (DON) on 10/18/24 at 9:11 a.m., the DON confirmed they had low staffing especially on weekends in April to June 2024. The DON stated they had some staff who called in sick and were on vacation in April - June 2024. During a review of the All Facilities Letter (AFL) 21-11 dated March 17, 2021, indicated, The 3.5 DHPPD staffing requirement, of which 2.4 hours per patient day must be performed by CNAs, is a minimum requirement for SNFs (Skilled Nursing Facility). SNFs shall employ and schedule additional staff and anticipate individual patient needs for the activities of each shift, to ensure patients receive nursing care based on their needs. The staffing requirement does not ensure that any given patient receives 3.5 or 2.4 DHPPD; it is the total number of actual direct care service hours performed by direct caregivers per patient day divided by the average patient census. During a review of the facility's Certified Nursing Assistant's (CNA) waiver from the California Department of Public Health (CDPH) dated, 7/12/2024, indicated, Your request is approved and valid from July 1, 2024 to June 30, 2025, under the following conditions: .2. The facility shall continue to provide a minimum of 3.5 direct care service hours per patient day .

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 44583 Based on observation, interview, and record review, the facility failed to ensure the nurse staffing information was posted clearly visible in a prominent place that was readily accessible to residents and visitors. This failure had the potential to result in nurse staffing misinformation about resident's care. Findings: During an observation on 10/14/24 at 9:33 a.m., in nurse station AA and BB (NS AA/BB), there was no nurse staffing information posted. During an observation on 10/15/24 at 1:05 p.m., in nurse station CC (NS CC), the nurse staffing information was not seen posted. During an observation on 10/15/24 at 1:06 p.m., at the lobby area, the nurse staffing information was located behind the receptionist desk, in a frame stand. The location of the nurse staffing information was not easily visible to family members, visitors, or residents. During an additional observation on 10/15/24 at 1:08 p.m., in NS AA/BB, the nurse staffing information was not seen posted. During a concurrent observation and interview with the front desk receptionist (FDR) on 10/15/24 at 1:10 p.m. , at the lobby area, the FDR confirmed the location of the nurse staffing information was not visible to visitors and residents. The FDR stated they did not post the nurse staffing information anywhere and confirmed it was just placed behind the receptionist desk. The FDR further stated the nurse staffing information should be posted in an area visible to all visitors and residents. During an interview with the staffing coordinator (SC) on 10/18/24 at 1:23 p.m., the SC confirmed she updated the projected nurse staffing information and placed in a frame stand behind the receptionist desk. The SC stated the nurse staffing information should be placed in front of the receptionist desk to be visible to all visitors.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46001 Based on interview and record review, the facility failed to ensure one of 20 sampled residents (Resident 18) was free from unnecessary psychotropic drugs (medication capable of affecting the mind, emotions, and behavior) when Resident 18's physician order of Lorazepam (used to treat anxiety) as needed (PRN) was not limited to use up to 14 days. Findings: A review of Resident 18's clinical record indicated she was admitted on [DATE] with diagnoses including depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). A review of Resident 18's physician order dated 10/14/24 indicated administering Lorazepam 0.5 milligram (mg, a metric unit of mass) by mouth every four hours as needed for anxiety. During a concurrent interview and record review with the director of nursing (DON) on 10/17/24 at 4:12 p.m., the DON reviewed Resident 18's physician order and confirmed that Resident 18's Lorazepam use was not limited to up to 14 days. A review of the facility's undated policy Psychoactive/Psychotropic Medication Use indicated, PRN psychotropic drug orders (other than PRN antipsychotics) are limited to 14 days. If it is appropriate to extend the order beyond 14 days, the attending physician or prescribing practitioner shall document the rationale in the medical record and indicate a duration for the PRN 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** 46001 Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when: 1. Multiple expired medications were stored in medication refrigerators (REF) 2 and 1; 2. Two insulin (injectable medication to lower blood sugar) pens identified in REF1 were not labeled with resident-specific information; 3. An oral inhaler was expired and identified in the active stock in the medication room (MR) 2; 4. Discontinued and expired and controlled medication in Medication carts 1 and 2; and 5. Licensed nurses left the medication on the medication cart unattended and the medication cart key on the top of the medication cart unattended. These deficient practices had the potential for residents to receive medications with unsafe and reduced potency from being used past their discard date, medication errors due to medications not being labeled, which could lead to unsafe and ineffective medications for the residents. Findings: 1. During a visit to Med room [ROOM NUMBER] with the Nurse Supervisor (NS) on 10/14/24 at 9:10 a.m., an inspection of a MRF 2 identified: a. Two small bottles of latanoprost eye solution (a prescription medication to treat glaucoma) labeled expiration date of 8/9/24 and 6/8/24 prospectively. b. A bottle of Augmentin (a medication used to treat many types of bacterial infections) labeled to be used before 7/9/24. c. A bottle of vancomycin (medications used to treat and prevent various bacterial infections caused by gram-positive bacteria) labeled expiration date 8/6/24. d. A Pneumovax 23 (Pneumococcal polysaccharide vaccine can prevent pneumococcal disease) intramuscularly one time only for immunization labeled expiration date 6/8/24. During a visit to Med room [ROOM NUMBER] with the Nurse Supervisor (NS) on 10/14/24 at 10:24 a.m., an inspection of a medication refrigerator (MRF 1) identified: b. A bottle of Lorazepam (medication used to treat anxiety) oral concentrate 2 mg/ml expired on 10/6/24, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. A bottle of Lorazepam 2 mg/ml oral concentrate expired on 7/29/24, d. A bottle of Lorazepam oral concentrate 2 mg/ml expired on 10/6/24, e. A bottles of Amoxicillin and Clavulanate potassium (used to treat bacterial infection) for oral suspension 250 mg/62.5mg expired on 1/28/24, f. A bottle of Acidophilus probiotic dietary supplement 100 capsules open date 1/22/23 and expired in 8/24, g. A bottle of [NAME] Fluconazole (an antifungal) 40 mg/ml labeled discard date 8/11/24. The NS confirmed the above observation and stated that expired items should not be in MRF 1 but placed in the discard box to prevent medical errors. 2. During the same inspection of MRF 1 with the NS, two insulin pens without labels containing resident-specific identification information were identified. The NS confirmed the above observation and stated that they should be labeled with the resident's name and room number. 3. During a visit to Med room [ROOM NUMBER] with the Nurse Supervisor (NS) on 10/14/24 at 9:48 a.m., one bottle of inhalation (powder) with an expiration date of 2/13/24 During an interview with the NS on 10/14/24 at 09:51 a.m., the NS confirmed the above observation and stated the expired inhaler should be discarded. 4. During a medication cart inspection with Registered Nurse (RN) EE on 10/14/24 at 10:47 a.m., the following items were identified in MC 1: a. A bottle of morphine (controlled pain medication) inside a box labeled expiration date was 7/29/24. b. Three discontinued controlled medications locked in the narcotic box in MC 1. b 1). Hydro/ Apap 10-325mg 55 tablets left in the bottle and the last administeration date was 9/23/24. b 2). Morphine 20mg/ml 29.75 ml left in the bottle and the last administeration date was 9/23/24. b 3). Oxycodone tab 5mg 9 tabs left in the bottle and the last administeration date was 10/6/24. RN EE confirmed the above obervation and stated that residents with the above medications had already been discharged , and she should give the above-controlled medications to the DON immediately after the patient's discharge. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation and concurrent interview on 10/16/24 at 10 a.m., in the hallway, seven medication pills in three medication cups and two inhalation medications were left unattended on the top of the medication cart. RN D came out from Resident's 60's room, confirmed the above observation, and stated she should have locked all the medication in the medication cart when she was not there. During an observation on 10/16/24 at 1:58 p.m., in the hallway, a box of Morphine oral solution and the medication cart key were on top of a medication cart, unattended, while four residents were near the cart. LVN J came out from Resident 36's room after administering medication, confirmed the above observation and stated that she should not have left the key and medication on the medication cart while four patients were nearby the cart. A review of the facility's policies and procedures (P&P) titled Administering Medications, dated 2001, indicated that Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the Nurse verifies that the correct pen is used for that patient. A review of the facility's P&P titled Medication labeling and, dated 2001, indicated in part, Discontinued, outdated, or deteriorated drugs and biologicals are . destroyed. A review of the facility's P&P titled Medication labeling and, dated 2001, indicated in part, compartments(including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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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. 50135 Based on observation, interview, and record review, the facility failed to ensure the kitchen staff competently carried out the functions of the food and nutrition services department according to facility policy and standards of practice when: 1. A dietary staff member did not demonstrate the correct technique for testing the sanitation level on the dish machine or maintaining the correct wash temperature. 2. Two Dietary Aides did not know how to properly test the sanitizer in the red bucket. These failures in staff competency had the potential to result in improperly sanitized resident dishes and food contact surfaces that could expose residents to food-borne illness in a highly susceptible population of 97 residents. Findings: 1. On 10/14/24 at 8:22 a.m., an observation and interview were conducted with the Dietary Director (DD), and Dietary Aides (DA S and DA Z) about dish washing procedures. DA S stated the dish machine was a low-temp dish machine. DA S was asked to describe how he checked whether the dishwasher was working properly. DA S stated he runs the wash cycle 4-5 times every morning to get the dishwasher hot. Then he writes the temperature on the dish machine log sheet. DA S ran one wash cycle and verified the dish machine thermometer gauge reading with the surveyors. The temperature reading ranged from 110 degrees Fahrenheit (F, unit of measurement for temperature)-115 F. DA S stated the wash cycle temperature should be 120 F but it had only reached 115 F for the last two months. DA S stated it was reported to the dietary manager. DA S then used a test strip to check the dish machine sanitizer solution in the dish machine. DA S stated the test strip was dark purple and equal to 100-200 on the test strip container. DA S stated the sanitizer should be 100-200. A review of the Dietary Department's document dated October 2024 titled Dish Machine Temperature Log, indicated wash temperatures recorded by DA S from October 1-14, 2024, was 120 F. DA S verified his initials were next to the wash temperatures on the log sheet. During an interview on 10/14/24 at 11:06 a.m., with the DD, the DD stated she was aware the dish machine wash temperature was not reaching 120 F, and they were waiting for a water heater booster that would raise the dishwasher temperature. The DD verified the dishwasher temperature reached 110 F at time of interview and acknowledged the wash temperature needed to be between 120-150 F and the chlorine sanitizer should have been 50 ppm. On 10/14/24 at 11:22 a.m., an interview was conducted with the Maintenance Director (MD) L. The MD L stated the dishwasher had not been working correctly for six weeks and he called the manufacturer for a heat booster but had not received it. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/14/24 at 11:26 a.m. an observation and interview were conducted in the kitchen with the administrator (ADM). The ADM acknowledged the dish machine wash temperature was 110 F. The ADM stated, A representative from the dish machine company is coming to install a part to make it hotter. During an interview with the RD U on 10/16/24 at 4:12 p.m., the RD U stated she expected the kitchen staff to operate the dish machine correctly. The RD U further stated she expected the kitchen staff to perform their job functions and duties accurately. A review of the facility's document dated February 2024 titled Job Description: Dietary Aide indicated the Dietary Aides essential duties are to Observe the water temperatures of dishwasher during dishwashing cycles . A review of the manufacturer's operating requirements on the dishwasher indicated Water Temp. 120 F Minimum . A review of the dishwasher's label titled Sanitizer Check Procedures indicated .compare strip with chart on vial. Minimum 50-100 ppm . Review of the facility's policy dated November 2022 titled Sanitization indicated Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitization are: .b. Low-Temperature Dishwasher (Chemical Sanitization): (1) Wash temperature (120 F); 2) Final rinse with 50 parts per million (ppm) hypochlorite (chlorine) on dish surface in final rinse; and the chemical solution is maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines . 2. During an interview on 10/15/24 at 11:58 a.m., with DA Z in the kitchen, DA Z stated he did not know how to test sanitizer in red bucket. During an interview on 10/15/24 at 12 p.m., with the DD, the DD stated she trained the kitchen staff on how to test the sanitizer in the red buckets. The DD stated DA Z may have missed the in-service for testing the sanitizer solution because he works part-time. On 10/16/24 at 9:37 a.m., an observation and interview were conducted with DA S. DA S used a yellow cloth from the red sanitizer bucket containing sanitizer solution to wipe down the meal trays and food preparation counter next to the three-compartment sink. DA S stated he checks the red bucket sanitizer strength every morning. DA S tested the sanitizer in the red bucket with a test strip and the reading was 300-400 ppm, a dark teal green color. DA S stated, It kind of looks like 200 ppm on the test strip container. The DD and RD U acknowledged the DA S did not know how to correctly test the sanitizer solution. The DD stated the sanitizer strength should be 200 ppm but was a lighter teal green color on the strip container. During an interview on 10/16/24 at 4:12 p.m. with RD U, RD U stated she expected kitchen staff to perform their job functions and duties correctly. Review of the facility's document dated February 2024 titled Job Description: Dietary Aide indicated Essential Duties- To leave the kitchen in a clean and sanitary manner and . Clean work surfaces and . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the manufacturer's label on the sanitizer bottle for the sanitizer used in the red buckets, the effective concentration to sanitize should be at 150-400 PPM. According to section 4-701.10, titled Food-Contact Surfaces and Utensils, Effective sanitization procedures destroy organisms of public health importance that may be present on wiping cloths, food equipment, or utensils after cleaning .It is important that surfaces be clean before being sanitized to allow the sanitizer to achieve its maximum benefit. Review of the facility's policy dated November 2022 titled Sanitization indicated .9. Service area wiping cloths are cleaned and dried or placed in a chemical sanitizing solution of appropriate concentration .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on observation, interview and record review, the facility failed to ensure safe and sanitary conditions were maintained for food storage according to standards of practice and facility policy when: 1. Two bins with thawed, soft mighty health shake cartons were stored in a reach-in refrigerator with expired dates. 2. A 3-door reach-in refrigerator and a walk-in refrigerator did not have internal thermometers to monitor temperature. 3. A large yellow onion with 3 dark grayish green colored spots resembling mold on it was found in case of yellow onions in the dry storage room. 4. A plastic container half full of tuna salad stored was stored inside the walk-in refrigerator and did not have a use by date. 5. The ice machine air filter had black and dark gray debris on it, and the inside ice making parts were not cleaned and maintained according to manufacturer's instructions. 6. A water filter attached to the ice machine, and one attached to the coffee maker machine were expired and not changed according to manufacturer's guidelines. 7. A medium grease trap floor hole space near the food production area was uncovered and had sticky brown dirt and black debris. 8. Ten large plastic bins were stacked wet in the dish machine area. These deficient practices exposed facility residents who consume food from the kitchen to potentially harmful substances which could have led to widespread foodborne illness. Findings: 1. During the initial kitchen tour on [DATE] at 8:30 a.m., an observation and interview was conducted with the Dietary Director (DD). There were two bins containing mighty health shakes stored in the reach-in refrigerator and thawed. One bin contained about 22 chocolate mighty health shakes was labeled In: [DATE], UB (Use By): [DATE]. The second bin contained about five vanilla mighty health shakes and was labeled In: [DATE], UB: [DATE]. On [DATE] at 9:30 a.m., during an interview with the DD, the DD acknowledged the mighty health shakes were thawed and stored in the refrigerator past their use date. She stated the shakes should have been good to use 2 weeks after the date they were placed in the refrigerator. She stated the labels on the bins were incorrect and acknowledged the bin with 22 mighty shakes dated [DATE] were past the 14 days and were not good because their nutritional value was lowered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Certified Nursing Assistant (CNA) V on [DATE] at 11:12 a.m., CNA V stated Resident 67 receives mighty shakes three times a day with meals. She stated Resident 67 drank the mighty shake in the morning with his breakfast and typically drinks the entire shake. Review of the health mighty shakes manufacturers label indicated the Store Frozen and to Thaw and serve within 4 days. https://www.hormelhealthlabs.com/wp-content/uploads/ProductFactSheet_26337_[DATE].pdf. 2. During the initial tour of the kitchen on [DATE] at 8:17 a.m., the three-door reach-in refrigerator and walk-in freezer did not have thermometers. During a concurrent interview on [DATE] at 8:59 a.m., the DD verified there were no thermometers in the refrigerator of the walk-in freezer and stated there should be thermometers in both the refrigerator and walk-in freezer to keep the food at an adequate temperature. According to the 2019 California Retail Food Code, section 113928, titled Temperature measuring device, TEMPERATURE MEASURING DEVICE means a thermometer, thermocouple, thermistor, or other device that indicates the temperature of FOOD, air, or water . 3. On [DATE] at 10:59 a.m., an observation and interview were conducted with [NAME] (CK) X and DD. CK X was cutting onions during meal preparation. One onion was discolored inside after it was cut in half. CK X stated he was still going to use the onion even though it had some discoloration. He stated, I'm just going to cut that part off. The DD verified the discoloration on the cut onion and stated, it's rotten. According to the 2022 Federal Food and Drug Administration (FDA) Food Code, section ,d+[DATE].11, Food Products which are damaged, spoiled, or otherwise unfit for .use in a food establishment may become mistaken for safe .and cause contamination of other foods . 4. During an observation on [DATE] at 8:21 a.m. in the main dry storage room, an opened case with six 12-ounce cans each of tuna were on a shelf. During an observation on [DATE] at 8:25 a.m. of the walk-in freezer in the kitchen a container with tuna salad on shelf was labeled [DATE]. On [DATE] at 11:45 a.m. an observation and interview were conducted with the Dietary Aide (DA) Y. DA Y explained the procedure for making tuna salad. DA Y stated she makes tuna salad sandwiches by taking a can of tuna from the dry storage and adding one tablespoon of mayonnaise then mixes it together. She then places it in the refrigerator with a label for the date it was made. She stated the tuna was good for 4 days. She also stated she does not write a cool down temperature on the log before making the tuna sandwiches. According to the 2022 Federal Food and Drug Administration (FDA) Food Code, Section ,d+[DATE].14 titled Cooling, Time/Temperature control for Safety (TCS) Food shall be cooled within 4 hours to .41F or less if prepared from ingredients at ambient temperature, such as .canned tuna . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. During an observation and interview with the DD and Maintenance Director (MD) L on [DATE] at 3:52 p.m. of the facility's ice machine in the kitchen. The MD L stated he does deep internal cleaning and bin cleaning of the ice machine every month. During a concurrent observation and interview on [DATE] at 3:30 p.m. in the kitchen with DD, and MD L, the ice machine was checked for cleanliness. The MD L opened the ice machine cover and described how he followed the manufacturer's guidelines for cleaning the ice machine. The ice machine's air filter screen was covered with black debris material and had a dead brown bug on it. The DD and MD L acknowledged the black debris on the filter screen and stated it should be clean and without any pest. Review of the ice machine cleaning log schedule indicated the ice machine was last cleaned on [DATE]. According to the 2017 Federal Food Code, section ,d+[DATE].11, Equipment Food-Contact Surfaces and Non-Food Contact Surfaces, .equipment food-contact surfaces shall be clean to sight and touch, effectively washed to remove or completely loosen soils .; Non-Food Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris . 6. On [DATE] at 3:40 p.m. an observation and interview were conducted with the DD and MD L in the kitchen. The water filter for the ice machine was dated [DATE] and the water filter for the coffee machine was dated [DATE]. The DD and MD L acknowledged both filters were outdated and should have been changed. Review of the kitchen ice machine manufacturer's cleaning instructions dated [DATE], titled Ice Machine Maintenance and Cleaning Instructions for Filters, indicated The air filter . will capture airborne dust during operation. As the dirt builds up, it begins to restrict air flow and causes the refrigeration system to work less effectively. Clean air filter regularly. 2. Remove dust and dirt by washing the filter . 3. Reinstall filter . 7. During the initial tour of the kitchen on [DATE] at 8:30 a.m., an observation and interview was conducted with the DD. A medium sized grease trap floor hole space near the food production area was uncovered and had sticky brown dirt and black debris. The DD verified the grease trap looked dirty and should be covered with a lid. According to the 2022 Federal Food and Drug Administration (FDA) Food Code, Section ,d+[DATE].16, Nonfood-Contact Surfaces Nonfood-contact surfaces shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance. According to the 2022 Federal Food and Drug Administration (FDA) Food Code, Section ,d+[DATE].11, Floors, Walls, and Ceilings floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. 8. An observation and interview were conducted on [DATE] at 9 a.m. with the DD in the kitchen. There were twelve clear plastic bins stored wet on top of a wire shelf. The DD stated the bins should not be stacked and stored wet. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the Food and Drug Administration (FDA) Food Code 2017, Section ,d+[DATE].11 Equipment and Utensils, Air-Drying Required, After cleaning and sanitizing, equipment and utensils: shall be air-dried . On [DATE] at 4:08 p.m. an interview was conducted with the Administrator (ADM) and RD U. Concerns with kitchen findings were discussed. RD U stated she checks on the DD regularly to ensure tasks are carried out correctly and expects the kitchen staff to perform their functions and duties according to standards of practice. The ADM stated he expects the dish washer to always function properly and tasks to be appropriately completed. Review of the facility's policy dated 2023, titled General Cleaning of Food & Nutrition Services Department, indicated Floors and Floor Mats- Floors, floor mats, and walls must be scheduled for routine cleaning and maintained in good condition. 1. Floors must be mopped at least once per day. Review of the facility's policy dated, [DATE] titled Food Receiving and Storage, indicated, Refrigerated/Frozen Storage . 7. Refrigerated foods are labeled, dated, and monitored so they are used by their use -by date, frozen, or discarded. Review of the facility's policy dated [DATE] titled, Sanitization, Filters, indicated All ice machines, water dispensers, and other units containing filters are to be kept clean, free from debris and serviced regularly. Ice machines, water dispensers . are recommended to be changed every six (6) months or as needed. Review of the kitchen ice machine manufacturer's cleaning instructions dated [DATE], titled Ice Machine Maintenance and Cleaning Instructions for Filters, indicated The air filter . will capture airborne dust during operation. As the dirt builds up, it begins to restrict air flow and causes the refrigeration system to work less effectively. Clean air filter regularly. 2. Remove dust and dirt by washing the filter .

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 44583 Based on observation, interview and document review, the facility failed to comply with Federal and State laws, and regulations when the approval letter for staffing waiver was not posted where visitors and residents could easily read. This failure had the potential to result in nurse staffing misinformation about resident's care. Findings: During an observation on 10/14/24 at 8:30 a.m., in front of the facility's glass covered cork board, the approval letter for the staffing waiver was not posted. During an interview on 10/15/24 at 1:34 p.m. with the staffing coordinator (SC), the SC stated the facility had a staffing waiver. During a concurrent interview with the director of nursing (DON) and record review on 10/15/24 at 1:54 p.m., the DON reviewed the approval letter for staffing waiver. The DON confirmed the staffing waiver was not posted. During a concurrent observation and interview with the clinical consultant (CC) 10/15/24 at 1:56 p.m., in front of the facility's glass covered cork board, the CC confirmed the approval letter for staffing waiver should have been posted in the board. Review of the staffing waiver's approval letter dated 7/12/2024, it indicated, Your request is approved and valid from July 1, 2024 to June 30, 2025, under the following conditions: 1. This approval letter shall be posted immediately adjacent to the facility's license. The facility shall provide written notice of the approved waiver to all residents prior to the execution of an admission agreement. The notice shall be a true copy of the approval letter.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36044

Based on observation, interview, and record review, the facility failed to follow infection control practices when:

1. One certified nursing assistant (CNA) did not wash hands after providing care between two residents (Residents 96 and 52) who were on transmission-based precautions (are used to help stop the spread of germs from one person to another);

2. One resident (Resident 149)'s nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) oxygen tubing was not changed after seven days according to facility policy;

3. The facility failed to ensure there was a plan in place to prevent the growth of Legionella (a bacteria that is found in water and can cause illness) in the facility's water supply;

4. One resident (Resident 6)'s oxygen filter was not changed according to facility policy;

5. The Licensed Nurses did not perform hand hygiene before putting on a new pair of gloves and after removing gloves, and wearing double gloves during medication administration; and

6. An unlabeled urinal was found in one resident (Resident 42)'s bathroom that was shared by more than one resident room.

These failures had the potential to result in cross-contamination and the spread of infection throughout the facility.

Findings:

1. During an observation on 10/14/24, at 10:32 a.m. and 12:52 p.m., Resident 52 and 96's room door showed a sign posted for transmission-based precautions.

During an observation on 10/16/24, at 8:43 a.m., in the hallway, Certified Nursing Assistant (CNA) B wore a personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) facemask, gown and gloves entering Resident 52's room to check to check Resident 52's vital signs. After performing the task, CNA B removed her gown and gloves inside the room and then performed hand hygiene using a hand sanitizer outside the room. At 8:45 a.m., CNA B walked to door side of Resident 96's room and put on a gown and new pair of gloves then walked inside of Resident 96's room to check his vital signs. After performing the task, CNA B removed her gown and gloves then she washed her hands at inside of resident's shared restroom.

During a follow-up interview on 10/16/24, at 9:22 a.m., with CNA B, CNA B stated she should washed her hands between Resident 52 and 96, because they were on contact precautions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/17/24, at 2 p.m., with the DON and the registered nurse consultant (RNC), both confirmed staff would need to wash hands between residents' care when residents were on transmission-based precautions. During an interview on 10/18/24, at 10:21 a.m., with the infection preventionist (IP), she stated Residents 52 and 96 were both infected with Methicillin-resistant Staphylococcus aureus (MRSA, a type of bacteria that is resistant to treatment with certain antibiotics). During a review of the facility's undated policy and procedure (P&P) titled, Handwashing/ Hand Hygiene, the P & P indicated, Wash hands with soap and water: when hands are visibly soiled; and after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and Clostridioides difficile (C.difficile). 2. Review of Resident 149's admission record indicated she was admitted to the facility on [DATE] and had diagnoses including shortness of breathing with congestive heart failure (a long-term condition that happens when your heart cannot pump blood well enough to give your body a normal supply). Review of Resident 149 physician's orders, dated 9/30/24, indicated she had oxygen 2 liters per minute via nasal cannula continuously and to change nasal cannula every Sunday during night shift. Review of Resident 149's October 2024 medication administration record (MAR) indicated the nasal cannula was marked changed on 10/6/24 and 10/13/24. During an observation on 10/15/24, at 9:58 a.m., with registered nurse (RN) D to check on Resident 149's oxygen filter. Resident 149 sat at bedside chair and with a nasal cannula connected to the oxygen concentrator in use. The nasal cannula oxygen tubing was labeled and dated 10/5/24. During a follow-up observation and interview on 10/16/24, at 8:36 a.m., with RN E, in Resident 149's room, RN E confirmed Resident 149's nasal cannula oxygen tubing was outdated, and it should have been changed. During an interview on 10/17/24, at 2 p.m., with the director of nursing (DON), the DON stated the nasal cannula oxygen tubing should be changed according to physician's orders. During a review of the facility's undated policy and procedure (P&P) titled, Department (Respiratory Therapy)- Prevention of Infection, the P&P indicated, Change the oxygen cannula and tubing every seven (7) days, or as needed. 44583 3. During a concurrent interview with the infection preventionist (IP), maintenance director L (MD L) and maintenance director O (MD O) on 10/18/24 at 10:30 a.m., all three disciplines could not answer about their water management program. MD O stated someone comes in to check their water and took the water sample to the laboratory. MD L stated he checked the water temperature on each resident's bathroom daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up interview with MD O on 10/18/24 at 10:58 a.m., MD O provided the daily checks of the water temperature in each resident's bathroom. MD O confirmed they only checked the water temperature in each resident's bathroom. MD O stated maintenance did not do any other checks or assessment in their water system. MD O who was the maintenance consultant for MD L stated he did not know what a water management program was. During a follow up interview with IP on 10/18/24 at 11:05 a.m., the IP confirmed they did not have a water management program. The IP stated, I missed that. The IP confirmed they used to have a water management program when the facility was under a different company. The IP stated, but now, we forgot about it. During a concurrent interview with the IP and record review on 10/18/24 at 11:14 a.m., the IP reviewed the water management program policy and procedure provided by MD O. The IP stated they used to have the program. IP further stated, we should have a system in placed to prevent the water borne infection . During a review of the facility's policy and procedure titled, Water Management Program, dated September 2022, indicated, The purpose of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The water management program used by our facility is based on the Centers for Disease Control and Prevention .The water management program includes the following elements .The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria .The identification of situations that can lead to Legionella growth .A system to monitor control limits and the effectiveness of control measures; A plan for when control limits are not met and/or control measures are not effective; and Documentation of the program. 4. Review of Resident 6's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 6 was admitted to the facility with diagnoses including polyneuropathy (a condition that affects many nerves in different parts of the body, causing them to malfunction altogether), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), pulmonary fibrosis (a serious lung disease that causes scarring in the lungs, making it difficult to breathe), and unspecified asthma (inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath). During an observation on 10/15/24 at 9:16 a.m., inside Resident 6's room, Resident 6 was seated at the edge of bed with oxygen thru nasal cannula (NC, a device used to deliver supplemental oxygen or airflow) at 3 liters per minute (LPM). The oxygen concentrator's filter located at the right side of the machine was observed to have grayish colored substance build up. During a concurrent observation and interview with registered nurse D (RN D) on 10/15/24 at 9:17 a.m., inside Resident 6's room, RN D did not know the location of the oxygen concentrator's filter. RN D did not know when and who should change the oxygen concentrator's filter. During a concurrent observation and interview with the director of nursing (DON) on 10/15/24 at 9:21 a.m., inside Resident 6's room, the DON confirmed there was a grayish substance build up in Resident 6's oxygen concentrator's filter. The DON stated the filter should have been changed weekly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with MD L on 10/15/24 at 9:31 a.m., MD L stated they changed the oxygen concentrator's filter every Friday. Review of Resident 6's clinical record titled, Order Summary Report, dated 6/3/24, indicated there was an order for oxygen use at 3 LPM with a goal to maintain Resident 6's oxygen saturation (O2 sat, the amount of oxygen circulating in the blood) greater than 90%. Further review indicated, there was an order dated 5/31/24 to change the oxygen filters on concentrator (a medical device that provides a safe source of oxygen-enriched air) every Sunday night. During a review of the facility's undated policy and procedure titled, Departmental (Respiratory Therapy) - Prevention of Infection, indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff . Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. 46001 5. During a medication pass observation and a concurrent interview with Licensed Vocational Nurse (LVN) Q on 10/16/24 at 9:45 a.m., in front of Resident 15's room, LVN Q was preparing the medication for Resident 15. She did not wash or sanitize her hands before putting gloves on or after removing the gloves and then wearing a new pair of gloves. LVN Q confirmed the above observation and stated that she should have washed or sanitized her hands before and after wearing gloves and between glove changes. During a medication pass observation and a concurrent interview with LVN J on 10/16/24 at 2:01 p.m., in front of Resident 36's room, LVN J was preparing the medication for Resident 36. She did not wash or sanitize her hand before wearing a glove and doubled the gloves before entering Resident 36's room. During an interview with the director of nursing (DON) on 10/18/24 at 1:27 p.m., the DON stated that staff should wash or sanitize their hands before wearing gloves and, after removing gloves, change gloves between tasks to prevent infections. The DON further stated staff should not wear double gloves. A review of the facility's undated policy, Handwashing/Hand Hygiene, indicated, All personnel shall follow the hand washing/ hand hygiene procedures to help prevent the spread of infections to other personal, residents and visitors .use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap and water for the following situations: before preparing and handing medications .after removing gloves . 48935 6. During an observation on 10/14/24 at 8:41 a.m., a urinal (a plastic container used to measure urine output) was seen in the resident room bathroom which was shared between two rooms (room [ROOM NUMBER] and 2) with no resident identifier or room or bed identifier. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with CNA H on 10/17/24 at 9:10 a.m., CNA H stated any basins or urinals that were used for residents should be labeled with the room number and either A or B for bed number. CNA H further stated the urinal in room [ROOM NUMBER] was used to empty the urinary catheter (a tube that drains the bladder) bag for Resident 42 and she should have a label now. During an interview with the DON on 10/18/24 at 10:58 a.m., the DON stated urinals and basins should be labeled by resident room number and bed number. Review of facility undated P&P titled Cleaning and Disinfecting Non-Critical Resident-Care Items indicated, Single resident use items are for single resident use only. [NAME] with the resident's room number and discard upon transfer or discharge.

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F 0908

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Keep all essential equipment working safely.

50135

Based on observation, interview, and record review, the facility failed to ensure the dish machine consistently provided accurate temperatures and properly function for cleaning and sanitizing dishes, according to manufacturer's guidelines and standards of practice. This failure had the potential to result in widespread foodborne illness for 97 residents consuming food in the facility.

(Cross Reference F802 and F812)

Findings:

During the initial kitchen tour on 10/14/24 starting at 8:22 a.m., the mechanical dishwashing process was observed. The dish machine did not reach the posted manufacturers' specifications of 120 F (degrees Fahrenheit) for both the wash and rinse cycles. The wash cycle on the machine was 110 F-115 F. Similarly, the rinse cycle was 110 F-115 F. Additional wash cycles revealed similar temperatures including 112 F and 108 F, respectively.

During an observation and concurrent interview on 10/14/24, at 8:22 a.m., with Dietary Aide (DA) S in the kitchen, the dish machine's wash water temperature gauge indicated 115 F (Fahrenheit-a unit of measurement). DA S verified the temperature gauge indicated 115 F. DA S stated the dish machine's wash water temperature should be 120 F. DA S ran another load of dirty dishes and the dish machine's wash water temperature continued with readings of 110 F-115 F. DA S verified the dish machine's water temperature only reached 115 F. DA S then stated he has to run the dish machine at least four times before getting a temperature reading of 120 F. DA S stated the dish machine temperature had not been reaching 120 F for the last two months and he notified the dietary manager. He also stated the dish machine was inspected by a technician when low temperature readings were initially noticed but it was still currently not working properly.

During a review of the data plate affixed on the dish machine, the manufacturer's instructions indicated, the wash water temperature is to reach a 120 F Minimum.

During a concurrent interview on 10/14/24 at 11:06 a.m., with the Dietary Director (DD), the DD verified the dish temperature reading of 115 and confirmed the temperature reading should be at 120 F. She stated she was aware of the low temperature reading of the dish washer and was waiting for the manufacturer to provide an additional mechanical part to raise the water temperature.

An interview on 10/14/24 at 11:22 a.m. was conducted with the Maintenance Director (MD) L. MD L stated the dish machine had not been working correctly for the last six weeks. He stated he phoned the dish machine manufacturer and requested placement of a heat booster that would increase the temperature of the water in the dish washer.

On 10/14/24 at 11:38 A.M. an interview was conducted with the Administrator (ADM) in the kitchen. The ADM stated he was aware of the dish machine not working properly over the past two months. The ADM stated they were waiting for a heat booster to be installed on the dish machine, which would increase the water temperature. The ADM further stated, We'll use disposable containers and paper goods for meals, and the three compartment sink until the dish machine is fixed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/14/24 at 11:44 a.m., an observation and interview were conducted in the kitchen at the dish machine with the Dish Machine Technician (DMT), ADM, and DD. The DMT stated the manufacturer's operating instructions state the wash temperature needs to reach 120 F to correctly wash dish the dishes. The DMT stated the water temperature tank gauge may need to be repaired before a heater booster could be installed. On 10/16/24 at 4:08 p.m. during an interview with Registered Dietitian (RD) U, RD U stated she noticed the dish machine not working properly one month ago and called the maintenance department for a repair. She stated the maintenance worker turned up the water temperature, but she did not personally check the dishwasher temperature reading afterwards. The RD U stated she expected the dish machine to wash and sanitize correctly according to the dish machine's manufacturer's operation guidelines. According to the 2022 Federal Food and Drug Association (FDA) Food Code section 4-501.11, titled, Good Repair and Proper Adjustment, Part (A) indicated Equipment shall be maintained in a state of repair and condition that meets requirements. Review of the facility's policy dated November 2022 titled, Sanitization indicated Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitization are: b. Low-Temperature Dishwasher (Chemical Sanitization): (1) Wash temperature (120 F).

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 50135 Based on observation, interviews, and record reviews the facility failed to ensure the Food and Nutrition Services Department, the kitchen, was free from pest and an effective pest control program maintained. This failure had the potential to contaminate food stored in the kitchen which could lead to widespread foodborne illness. Findings: During the initial kitchen tour on 10/14//24 at 8:26 a.m., an observation and interview was conducted with [NAME] (CK) W. A brown bug resembling a cockroach was observed moving across the floor in front of the tray line food preparation area. CK W tried to stomp the bug with her foot but was unsuccessful. CK W stated, I see one or two of them sometimes. On 10/14/24 at 12:01 p.m. an interview was conducted with the Administrator (ADM) about pest control maintenance. The ADM stated the kitchen was due for a quarterly fogging the end of October or the first of November to kill pests like roaches. During an interview on 10/14/24 at 12:05 p.m. with the Pest Company Technician (PCT), the PCT stated the facility's kitchen received a spray out treatment to remove the roaches a couple of months ago. The PCT further stated he did not do a fumigation treatment. On 10/14/24 at 12:51 p.m. during an concurrent interview with the PCT from the pest control company stated he does a Clean Out quarterly treatment. He stated he might need to do more treatments more often. During an observation and interview on 10/14/24 at 3:30 p.m. in the kitchen with Dietary Director (DD) and Maintenance Director (MD) L, the ice machine was checked for cleanliness. The MD L opened the ice machine air filter screen, and it was covered with black and gray debris. The air filter also had a dead brown bug that resembled a cockroach, on it. The DD and MD L acknowledged the air filter screen had black and gray debris and the dead brown bug carcass resembling a cockroach on it. The DD and MD L both stated the ice machine should not have any pests inside. A review of the outside company pest company invoice records from October 2023 through September 2024 indicated Findings- Insects, rodent droppings and pest activity. The invoices from July 2024 and August 2024 indicated Findings - German roach activity. The invoices indicated the technician made recommendations to Seal cracks, crevices and holes with grout as to mitigate potential harbor spots, empty out the trash at the end of the day or as often as possible, trash is possible source of pest food and to make sure to keep all work areas clean to not attract pest activity or create conducive conditions. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Centers for Disease Control and Prevention (CDC), the German cockroach is a known vector for diseases including: Salmonellosis - Salmonella food poisoning causes diarrhea, fever, and abdominal cramps within 12 to 72 hours. Symptoms are generally mild, but can be severe, especially for those with a compromised immune system . https://www.cdc.gov/healthypets/pets/wildlife/rodent-control.html According to the Food and Drug Administration, Insects and rodents are vectors of disease-causing microorganisms which may be transmitted to humans by contamination of food and food-contact surfaces. The presence of insects and rodents is minimized by protecting outer openings to the food establishment. (FDA 2022 Annex 3 - Public Health Reasons/Administrative Guidelines, 6-202.15 Outer Openings, Protected.) According to the 2022 Federal Food Code, section 6-501.111 .Controlling Pest .The premises shall be maintained free of insects, rodents, and other pests .by .routinely inspecting the premises for evidence of pests . A review of the facility's policy dated May 2008 titled, Pest Control, indicated . 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents .6. Maintenance services assist, when appropriate and necessary, in providing pest control services.