STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555796	A. Building B. Wing	02/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Care Center	4800 Delta Avenue Rosemead, CA 91770

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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 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** 42854 Based on interview and record review the facility failed to ensure one of one sampled resident ' s (Resident 37) Advance Directive (living will, legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) was obtained and readily available in the resident ' s records (medical chart). This deficient practice had the potential to result in misinformation of medical care and treatment and not honoring resident ' s wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: During a review of Resident 37 ' s Admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included urinary tract infection (UTI- an infection in the bladder/urinary tract), difficulty walking, and hypertension (high blood pressure). During a review of Resident 37 ' s History and Physical (H&P), dated 1/8/2025, the H&P indicated the resident had decision making capacities. During a review of Resident 37 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/14/2025, the MDS indicated the resident had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 37 ' s Physician Orders for Life Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatment that can or cannot be done at the end-of-life) dated 1/7/2025, the POLST indicated the resident had an Advance Directive. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 37 ' s medical chart and resident ' s electronic records on 2/16/2025 at 10:33 AM, the Quality Assurance Nurse (QAN) confirmed that resident ' s Advance Directive was not in the medical chart or resident ' s electronic records. The QAN stated the Social Services Director (SSD) and Medical Records Director (MRD) should follow up with the medical chart. The QAN stated the importance of having the Advance Directive in the chart was to know what the resident wishes are and how to to provide the care to them in case of an emergency. During an interview with the SSD on 2/16/2025 at 3:05 PM, the SSD stated she had been requesting for Resident 37 ' s Advance Directive but had not been able to obtain it from the resident ' s family member. The SSD stated the importance of having resident ' s Advance Directive in the chart to follow the resident ' s wishes in case they do not have the capacity to make their own decisions. During an interview with the Director of Nursing (DON) on 2/16/2025 at 5:45 PM, the DON stated the Advance Directive was important to make sure the facility honors the resident and family ' s wishes. The DON stated during the admission process, facility staff will ask the resident or family if they have an Advance Directive. The DON stated if the resident had an Advance Directive, the facility staff would encourage the family to provide it as soon as possible. During a review of the facility ' s policy and procedure (P&P) titled Advance Directives and Associated Documentation revision dated 12/2024 indicated if an Advance Directive was completed prior to admission and at the time of admission the resident is no longer capable of independent decision-making, the Advance Directive will be accepted. The P&P indicated to obtain copy of the Advance Directive and conservatorship/guardianship documents and place in the resident health record.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview, and record review, the facility failed to ensure one of three Certified Nurse Assistants (CNA 1) was checked for background screening and criminal history prior to employment at the facility in accordance with the facility ' s policy and procedure (P&P) titled, Pre employment Investigation. This failure increased the risk of applicants and employees with possible criminal convictions to have direct access to all patients in the facility and the potential not to be protected from abuse and place the residents at risk of abuse and feelings of intimidation. Findings: A review of CNA 1 ' s Offer of Employment indicated CNA 1 ' s offer of employment dated as of 11/4/2024. The form indicated the offer described above is contingent upon the results of your reference checks, criminal background check and the completion of a drug screening with negative results. A review of Facility provided document titled Memo indicated the document was from Operations Manager with facility Administrator name observed printed, dated November 6, 2024, including a subject: Background check contingency. The document further indicated Due to the national public health emergency declared on March 13, 2020, due to COVID-19 (is a contagious disease caused by the coronavirus SARS-CoV-2) pandemic, we are temporarily experiencing delays in the return of these results of criminal background checks in certain jurisdictions across the country. A review of CNA 1 ' s Notice to Employee indicated CNA1 ' s name and start date 11/07/2024. The notice was observed to include CNA 1 ' s name handwritten and signature dated 11/7/2024 A review of CNA 1 ' s background check record with an order date of 11/06/2024, indicated the background check was ordered on 11/06/2024 timed at 10:34 PM by Facility Human Resources (HR) and completed on 11/20/2024 at 4:25 PM. During an interview and record review on 2/16/2025 at 11:23 AM with Director of Staff Development (DSD) CNA 1 ' s employee file, DSD stated CNA 1 began employment at the facility on 11/7/2024. DSD stated CNA 1 first day working in the facility was on 11/7/2024 completing the facility ' s comprehensive clinical competency which can take a couple of days before the staff is allowed to work on their own resident assignment. DSD stated he was told by HR CNA 1 was cleared and allowed to work. During an interview on 2/16/2025 at 12:24 PM with facility ' s HR staff stated the facility was using the Memo allowing staff to begin employment before completing their background check during Covid and had not had a chance to update. HR stated she did not have an updated Memo that exempts the facility from following their policy of completing background checks prior to commencing employment. HR stated she thought it was still ok to use in November 2024 since she put in the request for CNA 1 ' s background check and did not receive results right away. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/16/2025 at 12:32 PM with Director of Nursing (DON), DON stated it is the facility ' s policy when they hire any staff member to complete the interview and plication process first then offer employment based on the background check process. DON stated the background check should be completed before starting the orientation process. During a review of Center of Disease Control and Prevention guidelines titled End of the Federal COVID-19 Public Health Emergency (PHE) Declaration updated [DATE] indicated May 11, 2023, marks the end of the Federal Covid-19 Public Health emergency declaration obtained via https://archive.cdc.gov/www_cdc_gov/coronavirus/2019-ncov/your-health/end-of-phe.html During a review of the facility ' s policy and procedure (P&P) titled Pre employment Investigations California -Skilled Nursing Facilities with a revision date of January 2022 indicated Reasonable and prudent pre-employment investigations, including reference checks, applicable licensing and certification verification, criminal background checks and other necessary or desirable pre-employment checks are conducted on applicants for employment. The policy further indicated Post employment offer procedures 1. Employment many not commence unless the Accurate Background Check disposition is Pass.

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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** 42878 Based on observation, interview, and record review, the facility failed to ensure one of 3 sampled residents (Resident 150) received oxygen therapy (treatment that provides supplemental, or extra, oxygen) as ordered by the attending physician. This deficient practice has the potential for Resident 150 not to receive enough oxygen to meet the body ' s demand and place the resident at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) which can lead into serious injury or death. Findings: A review of Resident 150 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated the resident was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body following a cerebral infraction (a condition where blood flow to the brain is interrupted) , Chronic kidney disease(a gradual loss of kidney function) During a review of Resident 150 ' s Minimum Data Sets (MDS - a federally mandated resident assessment tool), dated 2/13/2025, indicated Resident 150 ' s cognition (ability to think, remember, and reason with no difficulty) was severely impaired. The MDS further indicated Resident 150 was receiving continuous oxygen therapy. A review of Resident 150 ' s Order Summary Report indicated an order on 2/11/2025, a physician ordered the resident to receive continuous oxygen at 2 Liters (L- unit of measurement) via nasal cannula (a small plastic tube, which fits into the person ' s nostrils for providing supplemental oxygen) to keep oxygen saturation (an oxygen blood level normal range 90%-100%) above 90% every shift for shortness of breath (SOB). During an observation in Resident 150 ' s room on 2/14/2025 at 5:51 PM, Resident 150 ' s was observed sitting in bed watching television without using a nasal cannula in nose. Resident 150 ' s nasal cannula was observed hanging from the oxygen concentrator (a medical device that gives oxygen). During a concurrent interview and observation with the Infection Preventionist Nurse (IPN) on 2/14/2025 6:02 PM, Resident 150 ' s nasal cannula hanging from the oxygen concentrator. The IPN stated Resident 150 ' s nasal cannula should never be hanging off the oxygen concentrator as Resident 150 should receive continuous oxygen therapy and the oxygen concentrator was considered dirty if removed it should be stored in a clean bag. A review of the facility ' s policy and procedure titled Use of Oxygen with a revision date of May 2007, indicated It is the policy of this facility to promote resident safety in administering oxygen.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview, and record review, the facility failed to prevent unnecessary medication by ensuring one (1) of three (3) residents (Resident 42) was administered Timolol Maleate Ophthalmic Solution (a medication used to treat high pressure in the eyes) to the left eye only as ordered by the physician reviewed for pharmacy services. This deficient practice had the potential for Resident 42 to have high pressure in the eyes that could lead to blindness. Findings: A review of Resident 42 ' s Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), primary open-angle glaucoma (an eye disease that causes slow symptomless vision loss) bilateral, stage unspecified. A review of Resident 42 ' s undated History & Physical (H&P) dated 1/26/2025, indicated the resident has limited decision-making capabilities. A review of Resident 42 ' s record, titled Order Summary Report (a physician ' s order), ordered on 1/25/2025, indicated to administer Timolol Maleate Ophthalmic Solution 0.5 %, instill 1 drop on left eye one time a day for glaucoma. During a medication pass observation, on 2/15/2025, from 10:06 AM to 10:25 AM, Licensed Vocational Nurse (LVN 1), LVN 1 was observed administering Timolol Maleate Ophthalmic Solution to both Resident 42 ' s left and right eyes. During a concurrent interview on 2/15/2025 at 10:26 AM with LVN 1, LVN 1 stated he did not read the medication bottle label or the order part where it said to administer medication to left eye only. During an interview with the Director of Nursing (DON) on 2/16/2025 at 5:47 PM, the DON stated all nurses should always check and follow the doctor ' s orders before administering medications to ensure they are giving the correct medication and for resident safety to prevent any complications. A review of the policy and procedure (P&P) titled Medication administration, six rights with a revision date of 12,2024, indicated, The six rights of medication administration are as follows in order to ensure safety and accuracy of administration, the right medication-medications are checked against the order before they are given.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to ensure that two (2) medications were in accordance with prescription label in two out of three Medication Carts at the facility. 1. In Medication Cart #1, no open date label found for an opened package of Albuterol (medication used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases) for Resident 203. 2. In Medication Cart #2, an open package of Albuterol with open date of 2/4/2025, was not discarded. This deficient practice had the potential for residents not to receive full strength of the medications and receive ineffective medication dosages. Findings: 1. During a review of the facility ' s Admission Record (AR), the AR indicated Resident 15 was admitted on [DATE] with diagnoses that included urinary tract infection (UTI- an infection in the bladder/urinary tract), dysphagia (difficulty swallowing), and Chronic Obstructive Pulmonary Disease (COPD). During a review of Resident 15 ' s History and Physical Assessment (H&P) dated 1/19/2025, the H&P indicated Resident 15 had decision making capacities. During a review of Resident 15 ' s Order Summary Report dated 2/6/2025, the Report indicated Ipratropium-Albuterol Inhalation Solution 0.5-2.5 milligrams (mg- unit of measure) per 3 milliliters (ml- unit of measure) 1 unit inhale orally via nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) every 4 hours as needed for shortness of breath (SOB)/wheezing. During a concurrent observation of Medication Cart #2 and interview with Quality Assurance Nurse (QAN) on 2/16/2025 at 11:21 AM, an open package of Albuterol Inhalation Solution for Resident 15 was observed with an open date of 2/4/2025. The QAN stated an unopened package of Albuterol Inhalation Solution contained 5 plastic vials. The QAN stated the opened package of Albuterol Inhalation Solution contained 1 plastic vial left. The QAN stated on the prescription label indicated the Albuterol Inhalation Solution had an expiration date of seven days after opening the package. At 11:42 AM, the QAN stated she would discard the opened package of Albuterol Inhalation Solution so it would not be used. 2. During a review of facility ' s AR indicated Resident 203 was admitted on [DATE] with diagnoses that included acute respiratory failure (condition when the lungs cannot release enough oxygen into the blood) with hypoxia (low levels of oxygen in the body tissues), reduced mobility, and pleural effusion (a buildup of fluid between the layers of tissue that line the lungs and chest cavity). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 203 ' s H&P dated 2/10/2025, the H&P indicated Resident 203 did not have decision making capacities. During a review of Resident 203 ' s Order Summary Report dated 2/6/2025, the Report indicated Ipratropium-Albuterol Inhalation Solution 0.5-2.5 mg per 3 milliliters ml, 1 unit inhale orally via nebulizer every 4 hours as needed for SOB/wheezing. During a concurrent observation of Medication Cart #1 and interview with the QAN on 2/16/2025 at 12:28 PM, an opened package of Albuterol Inhalation Solution for Resident 203 was observed with no open date and 4 out of 5 plastic vials left. The QAN stated the prescription label indicated the Albuterol Inhalation Solution also had an expiration date of seven days after opening the package. At 12:35 PM, the QAN stated it was important for staff to review all medications to have an open and expiration date to make sure the staff does not give expired medications to the residents. During an interview with the Director of Nursing (DON) on 2/16/2025 at 5:47 PM, the DON stated all medications should have a label of when it was opened, if there was no label, the medication should be discarded. The DON stated medications would not be as effective if given after the expiration date. During a review of the facility ' s policy and procedure (P&P) titled Medication Administration, Six Rights of revision dated 12/2024 indicated it was the policy of the facility to ensures that the six rights of medication administration are followed in order to ensure safety and accuracy of administration. The P&P indicated the right time- medications are administered within prescribed time frames.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety and facility ' s policy and procedure (P&P) by having an expired Traditional Cinnamon Roll Dough (expired [DATE], 51 days after expiration date) in refrigerator number one and by not labeling: Two (2) bags of bell peppers with a use by date. Three (3) bags of carrots with a use by date. One (1) bag of tomatoes with a use by date. Five (5) lettuce heads with a use by date. Six (6) celery stalk with a use by date. Two bags of cucumbers with a use by date. One box of onions with a use by date. One box of oranges with a use by date. Four (4) cantaloupes with a use by date. Five pineapples with a use by date. These deficient practices had the potential to put 54 residents in the facility at risk for food borne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: During a concurrent observation and interview on [DATE] at 5:08 PM with Dietary Supervisor (DS) observed two bags of bell peppers, three bags of carrots, one bag of tomatoes, five lettuce heads, six celery stalk, two bags of cucumbers, one box of onions, one box of oranges, four cantaloupe, and five pineapples did not have a use by date. The DS stated contents in the refrigerator must have a Use by date, or else the food could go bad, and the residents could get sick. During a concurrent observation and interview on [DATE] at 5:15 PM with DS observed a box of Traditional Cinnamon Roll Dough that had a best if used by date of [DATE]. The DS stated this Traditional Cinnamon Roll Dough should not have been in the refrigerator otherwise a facility staff could cook the dough and that would not be okay. The DS stated if the dough was cooked, that could put the residents at risk of food bone illness, the residents could get sick, poisoned, or have stomach issues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of the facility ' s P&P titled Labeling and Dating of Foods dated 2023 with the DS on [DATE] at 11:35 AM, the P&P indicated, For foods that were commercially processed, read to eat, AND intended to be stored cold greater than 24 hours would be marked with a Use by date. The Use by date signifies the date in which food must be consumed or discarded. The DS stated the facility was not following the policy and foods must have a Use by date otherwise the facility staff would not know when to use the food by or the food could be expired. The DS stated if the facility did not follow the policy, that could affect all the residents in the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review, the facility failed to accurately document a resident ' s discharge disposition on the resident ' s discharge summary for one of one sampled resident (Resident 47). This deficient practice resulted in inaccurate documentation of Resident 47 ' s discharge disposition/location for accurate and appropriate tracking purposes of all residents discharged or transferred out of the facility. Findings: During a review of Resident 47 ' s Admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included fracture of nasal bones, abnormalities of gait and mobility, and type 2 diabetes mellitus (condition when the body cannot use insulin [hormone that turns food into energy] correctly and sugar builds up in the blood). During a review of Resident 47 ' s History and Physical (H&P), dated 10/18/2024, the H&P indicated the resident had decision making capacities. During a review of Resident 47 ' s Order Summary dated 11/13/2024, the Order Summary indicated a physician order for left knee skin graft surgery on 11/18/2024 (Monday) at 7:30 AM, resident will be NPO (nothing by mouth) after midnight 11/18/2024, resident needs to arrive at GACH at 5:45 AM. During a review of Resident 47 ' s Progress Notes on the following dates: On 11/14/2024 timed at 2:54 PM, the progress note type: discharge summary- nursing indicated Resident 47 was being discharged home. On 11/18/2024 timed at 5:06 AM, the progress note type: nursing indicated Resident 47 was being discharged to general acute hospital center (GACH) as scheduled. The progress note indicated Resident 47 was transferred onto a gurney (hospital bed with wheels that makes it easy to move patients around) and transportation arrived at 4:30 AM as scheduled. During a review of Resident 47 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/18/2024, the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 47 was discharged to the GACH. During a review of Resident 47 ' s Physician ' s Discharge Summary dated 11/18/2024, the discharge summary indicated resident was discharged home. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 47 ' s Physician Discharge Summary, MDS, and progress notes on 2/16/2025 at 4:50 PM, the MDS Nurse (MDSN) confirmed Resident 47 was discharged to the hospital. MDSN stated that the MRD was in charge auditing resident ' s chart upon discharge. MDSN stated it was important for information to match so that all resident ' s documents are documented accurately like the MDS, so it would be coded correctly. During a concurrent interview and record review of Resident 47 ' s Physician Discharge Summary and MDS on 2/16/2025 at 4:58 PM, MRD stated she was responsible for auditing resident charts. MRD stated the Physician Discharge Summary is sent to the physician ' s office for signature and she would check if all the information was correct and put it in resident ' s medical record. MRD confirmed Resident 47 ' s Physician Discharge Summary discharge location did not match with the MDS. MRD stated she did not know the importance of why all documentation should match. During an interview with the Director of Nursing (DON) on 2/16/2025 at 5:49 PM, the DON stated accuracy of documentation was important, so all parties are aware of resident updates and disposition. During a review of the facility ' s policy and procedure (P&P) titled Admission, Transfer, and Discharge revision dated 12/2023 indicated when the facility transfers or discharges a resident, the facility shall ensure that the transfer or discharge is documented in the resident ' s medical record and appropriate information is communicated to the receiving health care institution or provider. During a review of the facility ' s P&P titled Documentation, Principles of revision dated 12/2024 indicated Resident ' s health record shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each resident. The P&P indicated complete entries must be accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555796	A. Building B. Wing	02/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Care Center	4800 Delta Avenue Rosemead, CA 91770

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 48661 Based on observation, interview, and record review, the facility failed to maintain the walk-in freezer in good operating condition as indicated in the facility's policy and procedures by failing to: Document temperature readings of the freezers both in the morning and evening as indicated on the facility ' s P&P Procedure for Freezer Storage indicating freezer temperatures should have been recorded twice daily. The walk-in freezer ' s plastic curtain had water dripping down the curtain and had condensation (the process where water vapor becomes liquid) with visible water droplets on the ceiling. These deficient practices had the potential to affect 54 residents in the facility to be at risk for food borne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) or contamination (process of making something dirty or poisonous, or the state of containing unwanted or dangerous substances). Findings: During a review of the Refrigerator and Freezer Temperatures Log dated January and February 2025, the Refrigerator and Freezer Temperatures Log provided space to document the temperature for each refrigerator and freezer. The Refrigerator and Freezer Temperature Logs indicated there were three refrigerator ' s and three freezers. The walk-in freezer was considered freezer number three. Under freezer number three, there was only one (1) slot to input a temperature reading. The Refrigerator and Freezer Temperatures Log indicated for the month of January and February; freezer number three ' s temperature ranged from negative six to zero degrees Fahrenheit. The Refrigerator and Freezer Temperatures Log did not indicate which thermometer was being used to document the temperature and did not include the two other thermometers used for freezer number three. During a review of the Direct Supply Work Order dated 2/13/2025 at 2:12 PM, the Work Order indicated there was freezer (unknown which freezer) and ice buildup in the kitchen freezer. During a review of the Heating & Air Conditioning Invoice dated 2/13/2025 at 3:15 PM, the Invoice indicated a request to inspect ice buildup and a request to repair a pipe leak. The invoice indicated the pipe leak repair would be scheduled. During a concurrent observation and interview on 2/14/2025 at 5:25 PM, the Dietary Supervisor (DS) observed the walk-in freezers with outside thermometer that read 19 degrees Fahrenheit, the inside thermometer closest to the walk-in freezer ' s door read 20 degrees Fahrenheit, and the thermometer at the back of the freezer read negative two (2) degrees Fahrenheit. Upon opening the walk-in freezer ' s door there were clear plastic curtain ' s that had water drops dripping down the curtain. On the ceiling of the walk-in freezer, a visible water droplets and condensation was observed. To the right side of the walk-in freezer contained frozen vegetables, to the left side of the walk-in freezer contained frozen meats, and the back side of the walk-in freezer contained frozen baked goods and ice cream. The DS stated the facility documents the temperature log every morning only. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/15/2025 at 5:59 PM, the DS stated at 4 PM the walk-in freezer resets and turns back on but the build up of water droplets and condensation should not have been in the freezer. During an interview on 2/15/2025 at 7:39 AM, the Kitchen Manager (KM) stated the facility only checks the temperature readings once a day only in the morning and reads the temperature from the outside thermometer or the thermometer closest to the door, only the thermometer in the back of the walk-in freezer. The KM stated the facility only logs the temperature in the back of the walk-in freezer because the other thermometer was broken and the thermometer in the back of the walk-in freezer was more accurate. During an interview on 2/15/2025 at 8:38 AM, the Air Conditioning Technician (AC Tech) stated when the walk-in freezer was running, the walk-in freezer builds up ice on the coils which was part of the cycle and the reason why the walk-in freezer had a defrost mode. The AC Tech stated thermometers by the door was not going to be a true reading because there were heaters along the door to prevent ice from building up on the door. The AC Tech stated the thermometer on the outside of the walk-in freezer was true because the walk-in freezer door was closed but that the freezer temperature should have been at zero. The AC Tech stated the issue right now was that the walk-in freezer had a cracked condensate line (a damaged section of the pipe that carried water condensation away from an air conditioning unit, where the crack had formed in the pipe, causing water to leak out instead of draining properly) and someone would come Monday to fix the problem. During a concurrent interview and record review of the facility ' s policy and procedure (P&P) titled Procedure for Freezer Storage dated 2023 with the Administrator (ADM) on 2/16/2025 at 9:35 AM, the P&P indicated, Freezer temperatures should be recorded twice daily. Temperatures were to be recorded upon opening and closing of kitchen by a designated employee and logged in the Cold Storage Temperature Log. The ADM stated the facility was not following the P&P. During a concurrent interview and record review of the facility ' s P&P titled Procedure for Freezer Storage dated 2023 with the DS on 2/16/2025 at 11:35 AM, the P&P indicated The freezer should be maintained at a temperature of zero degrees Fahrenheit or lower and Each freezer much have two thermometers that were easily visible. The P&P indicated, Freezer temperatures should be recorded twice daily. Temperatures were to be recorded upon opening and closing of kitchen by a designated employee and logged in the Cold Storage Temperature Log. The DS stated the facility was not following the P&P. The DS stated the residents could be at risk if the facility was not following the P&P because if the facility did not know the temperatures before leaving the kitchen the facility would not know if the freezer was working properly.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 48661 Based on observation, interview, and record review, the facility failed to post a designated No Smoking sign in the patio used by the residents to smoke and have a fireproof blanket available for use in care of fire per the facility ' s policy and procedure (P&P). These deficient practices had the potential to place the residents at risk for burns and the facility at risk for fire hazards. Findings: During an observation of the designated Smoking Patio on 2/15/2025 at 3:28 PM, the Smoking Patio had one (1) ash receptacle (place to put cigarette ashes and butts), one metal container for cigarettes, one apron, and a sign for Fire Extinguisher Inside posted on a window. The Smoking Patio did not have a sign indicating the area was a designated Smoking Patio. The Smoking Patio did not have a sign indicating No Oxygen to be used or permitted in the designated Smoking Patio. The Smoking Patio did not have a fire blanket as indicated in the facility ' s policy and procedure (P&P). During an interview on 2/16/2025 at 10:30 AM, the Activities Assistant (AA) stated there should have been a sign indicating the designated Smoking Patio and a sign for No Oxygen. The AA stated if there was No Smoking sign for the designated Smoking Patio, residents may not know where the designated Smoking Patio was and residents on oxygen might be around and would not know they should not have been there. The AA stated residents with oxygen could get burned if a cigarette was not out, the smoke could be bad for residents ' lungs and affect their breathing. During the same observation and interview on 2/16/2025 at 10:30 AM, the AA stated there was no fireproof blanket in the patio smoking area, AA stated there should have been a fireproof blanket in the designated Smoking Patio because if something was wrong with the fire extinguisher, the fire blanket would be a backup. The AA state if a fire blanket was not available the residents could get burned. During a concurrent interview with the AA and record review of the facility ' s policy and procedure (P&P) titled Smoking and Safety Measures dated December 2023 with the AA on 2/16/2025 at 10:30 AM, the P&P indicated Safety Measures included a fire extinguisher was available to the designated smoking area, along with a fire blanket. The AA stated the facility was not following the P&P because the fire blanket was not at the designated smoking area which could put Resident 1 in danger because the facility would not be able to protect the resident if the fire blanket were not there.