STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555801	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Creek Care Center	1139 Cirby Way Roseville, CA 95661

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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 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** 40214 Based on observation, interview, and record review, the facility failed to ensure accurate assessments for two residents (Resident 15 and Resident 301) of 24 sampled residents when: 1. Resident 15's Minimum Data Sheet (MDS, an assessment tool) indicated one side lower extremity impairment; and, 2. Resident 301's MDS indicated intermittent catheterization (a catheter used drain urine from the bladder on a temporary basis). These failures resulted in inaccurate assessments that did not reflect the residents' status and care needs. Findings: 1. A review of an admission record indicated Resident 15 was admitted to the facility in late 2022 with multiple diagnoses including hemiplegia and hemiparesis (body paralysis and weakness) after stroke and general muscle weakness. During an observation during the initial tour and concurrent interview on 4/16/24 at 9:50 a.m., in Resident 15's room, Resident 15 was in bed lying facing the right side of the room with both knees contracted. Resident 15's left knee was bent and positioned over his bent right knee. Resident 15 reported a pain intensity level of 8 out of 10 and confirmed both his legs were contracted. During a concurrent observation and interview on 4/16/24 at 9:55 a.m., in Resident 15's room, the Certified Nursing Assistant 3 (CNA 3) was repositioning Resident 15 to face the left side of the room. Resident 15's face grimaced and he verbalized pain during the repositioning. The CNA 3 confirmed both Resident 15's knees were contracted. During an interview on 4/16/24 at 10:08 a.m., with Licensed Nurse 4 (LN 4), the LN 4 confirmed both Resident 15's knees were contracted. During a concurrent interview and record review on 4/18/24 at 11:42 a.m., with the MDS Coordinator (MDSC), Resident 15's MDS dated [DATE] was reviewed. The MDS indicated, (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Lower extremity (hip, knee, ankle, foot) - impairment on one side . The MDSC confirmed the MDS assessment was inaccurate and should have indicated impairment on both sides. The MDSC further stated an inaccurate assessment could affect the resident's plan of care. 48140 2. A review of Resident 301's admission record indicated Resident 301 was admitted to the facility in January 2024, with diagnoses which included muscle weakness, fracture of the left lower arm and chronic respiratory failure. During a review of Resident 301's MDS dated [DATE] and 2/3/24, the bladder and bowel section indicated Resident 301 was receiving intermittent catheterization. A review of Resident 301's Order Summary Report (OSR, physician orders) indicated there was no order for intermittent catheterization. During a concurrent interview and record review on 4/18/24 at 1 p.m. with the MDSC and LN 5, Resident 301's MDS and OSR were reviewed. The MDSC and LN 5 confirmed the MDS was inaccurate and there were no orders for intermittent catheterization for Resident 301. The LN 5 stated, There needs to be an accurate assessment to be able to provide the proper care for the resident. The MDSC additionally stated, That's incorrect coding on the MDS. During an interview on 4/19/24 at 2:36 p.m. with the Director of Nursing (DON), the DON stated the expectation was resident assessments should be accurate. During a review of the facility's policy and procedure titled, Resident Assessments, revised October 2023, indicated, A comprehensive assessment of each resident is completed .the resident assessment coordinator is responsible for ensuring .appropriate resident assessments .attesting to the accuracy of such information .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48140 Based on observation, interview, and record review the facility failed to develop and implement an accurate baseline care plan for three residents (Resident 297, Resident 301 and Resident 307) out of 24 sampled residents when: 1. Resident 297's and Resident 301's did not have a care plan for their urinary catheter; and, 2. Resident 307 did not have a care plan for his urinary catheter, peripherally inserted central catheter (PICC, a long, thin tube inserted through a vein in the upper arm and passed through to the larger veins near the heart, used for long term fluids or treatments), abdominal binder (a wide compression belt that encircles the abdomen) and thrombo-embolic deterrent hose (TED hose, stockings used to help prevent blood clots and swelling in the legs). These failures decreased the facility's potential to implement effective, person-centered care for residents. Findings: 1. A review of Resident 297's admission record indicated admission to the facility on [DATE], with diagnoses which included fracture of the left hip, fracture of the left ankle and muscle weakness. During a concurrent observation and interview on 4/16/24 at 9:50 a.m. in Resident 297's room, Resident 297 was sitting up in bed and a urinary catheter was observed hanging from the side of the bed. Resident 297 was aware she had the urinary catheter in place but was not sure how long she would need it. A review of Resident 297's Order Summary Report (OSR, physician orders) dated 4/14/24 indicated Resident 297 had a urinary catheter in place due to urinary retention. During a review of Resident 297's care plan, initiated on 4/14/24, there was no documented evidence the resident had a care plan for a urinary catheter. A review of Resident 301's admission record indicated she was readmitted to the facility on [DATE] with diagnoses which included muscle weakness, fracture of the left lower arm and chronic respiratory failure. A review of Resident 301's OSR, dated 1/25/24, indicated Resident 301 had a urinary catheter. During a review of Resident 301's care plan initiated on 1/25/24 there was no documented evidence the resident had a care plan for a urinary catheter. 2. A review of Resident 307's admission record indicated admission to the facility on [DATE], with diagnoses which included lymphoma (cancer that begins in cells of the lymph system), benign prostatic hyperplasia (enlarged prostate gland) and muscle weakness. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/16/24 at 12:30 p.m. in Resident 307's room, Resident 307 was sitting in the wheelchair next to his bed after having physical and occupational therapy sessions. A urinary catheter bag was observed hanging off the side of the bed and a PICC line was observed in Resident 307's upper right arm. When asked if he had an abdominal binder and TED hose for use when he was out of bed, Resident 307 stated the abdominal binder was on the shelf in his closet; however, he did not know what or why he would wear the TED hose. Resident 307 confirmed he was not wearing an abdominal binder or TED hose nor had staff offered them to him. A review of Resident 307's OSR indicated the following orders: - an indwelling urinary catheter with a start date of 4/8/24; - for staff to change the PICC dressing on the right arm with a start date of 4/9/24; and, - for the use of TED hose and an abdominal binder when out of bed during every shift for orthostatic hypotension (low blood pressure which occurs when changing position from sitting or lying down to standing up) with a start date of 4/11/24. A review of Resident 307's Care Plan, initiated 4/8/24, indicated there was no documented evidence the resident had a care plan for a urinary catheter, PICC, abdominal binder or TED hose. During a concurrent interview and record review on 4/19/24 at 9:23 a.m. with Director of Nursing (DON), Resident 297's, Resident 301's, and Resident 307's care plans were reviewed. The DON confirmed the missing care plans for Resident 297, Resident 301 and Resident 307. The DON stated, The baseline care plan needs to include the resident's primary diagnoses and seven basic topics; including the resident's bowel and bladder status and skin conditions or concerns. These care plans need to be completed within the first 24-48 hours of a resident's admission. A request for the facility's policy and procedure (P&P) regarding Baseline Care Plans was requested on 4/18/24 and 4/19/24. The facility was unable to provide a P&P for Baseline Care Plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48140 Based on observation, interview and record review the facility failed to revise a care plan for one resident (Resident 310) out of 24 sampled residents when Resident 310's care plan was not updated to reflect the placement of an elopement management bracelet (a bracelet that triggers alarms on doors to prevent the resident leaving unattended). This failure decreased the facility's potential to provide consistent nursing interventions for residents. Findings: A review of Resident 310's admission record indicated admission to the facility on [DATE], with diagnoses which included left hip fracture, dysphagia (difficulty swallowing), and dementia without behavioral disturbance (memory loss and difficulty with communication, reasoning, and problem solving). During a concurrent observation and attempted interview on 4/16/24 at 11:08 a.m. in Resident 310's room, Resident 310 was observed laying in her bed wearing a facility gown, watching television. When questioned about her stay at the facility Resident 310 responded with mumbled incoherent speech. During an observation on 4/17/24 at 8:19 a.m. in Resident 310's room, Resident 310 was observed laying in bed wearing a facility gown. At 11:43 a.m. Resident 310 was observed laying in bed under the covers. During an observation on 4/18/24 at 9:37 a.m. in Resident 310's room, Resident 310 had a elopement management bracelet on the left ankle. During a concurrent observation and interview on 4/18/24 at 9:53 a.m. with Certified Nursing Assistant 5 (CNA 5) in Resident 310's room, CNA 5 stated, That's news to me, when asked what the bracelet on Resident 310's ankle was for. During a concurrent interview and record review on 4/18/24 at 11:44 a.m. with the Assistant Director of Nursing (ADON), Resident 310's care plan dated 4/4/24 - 4/18/24 was reviewed. The ADON confirmed Resident 310's care plan was not updated to reflect the use of the elopement management bracelet. The ADON stated, It [care plan] should have been updated yesterday. During a concurrent interview and record review on 4/19/24 at 9:23 a.m. with the Director of Nursing (DON), Resident 310's care plan dated 4/4/24 - 4/18/24 was reviewed. The DON confirmed Resident 310's Care Plan was not updated to reflect the use of the elopement management bracelet. The DON stated, Care plans need to be updated as soon as possible, if there's a change or update to the treatment plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Care Plan Revision, revised April 2023, indicated, Care plans shall be reviewed/revised to incorporate goals and objectives to meet resident's individual needs.

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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** 48140 Based on observation, interview and record review the facility failed to ensure services provided met nursing professional standards for two residents of 24 sampled residents when: 1. Resident 307's physician's order was not implemented for the use of thrombo-embolic deterrent hose (TED hose, stockings used to help prevent blood clots and swelling in the legs) and an abdominal binder (a wide compression belt that encircles your abdomen) to prevent orthostatic hypotension (low blood pressure which occurs when changing position from sitting or lying down to standing up); 2. Resident 307's peripherally inserted central catheter (PICC, a long, thin tube inserted through a vein in the upper arm and passed through to the larger veins near the heart, used for long term fluids or treatments) was not assessed for patency and covered with an appropriate dressing; and, 3. An elopement management bracelet was applied to Resident 310 without a physician's order. These failures decreased the facility's potential to ensure physician's orders were carried out for residents. Findings: 1. A review of Resident 307's admission record indicated admission to the facility on [DATE] with diagnoses which included lymphoma (cancer that begins in cells of the lymph system), benign prostatic hyperplasia (enlarged prostate gland) and muscle weakness. During a concurrent observation and interview on 4/16/24 at 12:30 p.m. in Resident 307's room, Resident 307 was sitting in the wheelchair next to his bed. Resident 307 stated his abdominal binder was on the shelf in his closet and he did not know what TED hose were or why he would wear them. Resident 307 confirmed he was not wearing an abdominal binder or TED hose when out of bed. A review of Resident 307's Order Summary Report (OSR) indicated the following orders: -change PICC dressing on right arm by cleansing site using dressing kit with a chlorhexidine patch (a disinfectant used to prevent infection) and waterproof transparent dressing as needed starting on 4/9/24 -apply TED hose and abdominal binder when out of bed every shift to prevent orthostatic hypotentsion starting on 4/11/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/18/24 at 11:44 a.m. with the Assistant Director of Nursing (ADON), Resident 307's OSR and treatment record, dated April 2024, was reviewed. The ADON stated the floor nurse was responsible for ensuring the resident had the abdominal binder and TED hose on when out of bed. The ADON also stated the treatment was expected to be documented in the resident's TAR (Treatment Administration Record). The ADON reviewed Resident 307's TAR and confirmed there were six of 13 shifts which were not documented as executed for the order of TED hose while out of bed. The ADON stated, We have to follow the MD [physician] orders as is and of course, document appropriately. 2. During a concurrent observation, interview, and record review on 4/19/24 at 12:21 p.m. with the Licensed Nurse 8 (LN 8), Resident 307's PICC dressing was observed. The LN 8 stated she spoke to LN 7 about changing Resident 307's PICC dressing because changing the dressing was not within her scope of practice. The LN 8 stated there should be a physician order to monitor the PICC dressing every shift but there was not. The LN 8 confirmed there was only a physician's order to change the dressing as needed. During a concurrent observation, interview, and record review on 4/19/24 at 12:24 p.m. with LN 7, the LN 7 confirmed Resident 307's PICC dressing was not intact and needed to be changed. The LN 7 stated PICC dressings should be changed every seven days or if soiled or displaced. The LN 7 stated the PICC should be checked for patency daily. During a review of the facility's policy and procedure (P&P) titled, Central Venous Catheter/Peripherally Inserted Central Catheter Dressing Changes, revised April 2023, stipulated, Change transparent semi-permeable membrane (TSM) dressings at least every 7 days and PRN (when wet, soiled or not intact). 3. A review of Resident 310's admission record indicated admission to the facility on [DATE] with diagnoses which included left hip fracture, dysphagia (difficulty swallowing), and dementia without behavioral disturbance (memory loss and difficulty with communication, reasoning, and problem solving). During a concurrent observation and attempted interview on 4/16/24 at 11:08 a.m. in Resident 310's room, Resident 310 was observed laying in her bed wearing a facility gown, watching television. When questioned about her stay at the facility Resident 310 responded with mumbled incoherent speech. During an observation on 4/17/24 at 8:19 a.m. in Resident 310's room, Resident 310 was observed laying in bed wearing a facility gown. At 11:43 a.m. Resident 310 was observed laying in bed under the covers. During an observation on 4/18/24 at 9:37 a.m. an elopement management bracelet was observed on Resident 310's left ankle. During a concurrent observation and interview on 4/18/24 at 9:53 a.m. with Certified Nursing Assistant 5 (CNA 5) in Resident 310's room, CNA 5 stated, That's news to me, when asked what the bracelet on Resident 310's ankle was for. When questioned about Resident 310's behaviors, CNA 5 stated, [Resident 310] never attempts to get out of bed, but she will attempt to stand up when she's in the wheelchair .If you watch her in the wheelchair, she doesn't really go anywhere. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 310's elopement risk observation and assessment, dated 4/4/24, indicated Resident 310 was not at risk for elopement. A review of Resident 310's psychiatry diagnostic interview note, dated 4/12/24, showed no indication Resident 310 displayed any behavioral problems. A review of Resident 310's progress notes between 4/15/24 and 4/18/24 were reviewed and indicated the following: -On 4/17/24 at 3:56 p.m. indicated, [Resident 310] was trying to get out of bed unassisted .[nurse] transfer [sic] the pt [patient]to wheelchair and brought to nursing station to keep pt busy. Pt has an anxiety and agitated [sic]. NP [Nurse Practitioner] was notified about pt's behavior. -On 4/17/24 at 5:19 p.m. indicated, New order for pt to put [elopement management bracelet] placed to Left Ankle .monitor functioning and intactness due to confusion. Order carried out. -On 4/17/24 at 5:25 p.m. indicated, .observed a patient trying to enter rooms and walking down the hallway unassisted .CNA did keep her up in WC [wheelchair] with her in the hall while she charted .Also let nursing supervisors know that she would likely need [elopement management bracelet] as well, which was obtained and placed on resident. During a concurrent interview and record review on 4/19/24 at 9:38 a.m. with LN 6, the staff and physician communication binder was reviewed. The LN 6 stated verbal or telephone orders were not accepted, everything needed to be written down for the physician to review and sign. The LN 6 confirmed there was no communication documented between nursing staff and the physician in the communication binder regarding Resident 310 between 4/15/24 and 4/18/24. During a concurrent interview and record review on 4/19/24 at 12:14 p.m. with the NP, the communication binder was reviewed. The NP stated, If a verbal or telephone order is given there must be written documentation of that order for the provider to sign, that document is then placed in the communication binder for us to review. The NP confirmed there was no documentation or communication regarding Resident 310 in the communication binder. During an interview on 4/19/24 at 2:43 p.m. with the Medical Doctor (MD) stated he was unaware of an order for Resident 310's elopement management bracelet. The MD confirmed phone orders were rare and were always followed up with a written order. A review of the facility's P&P titled, Physician Services, revised April 2023, indicated, The resident's attending physician participates in the resident's assessment and care planning, monitoring changes in a resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident.

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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. 47563 Based on observation, interview and record review, the facility failed to ensure one resident (Resident 28) of 24 sampled residents was assisted to an upright position while eating lunch. This deficient practice decreased the facility's potential to prevent food aspiration (breathing food and fluid into the lungs) and aspiration pneumonia (severe infection of the lungs) for Resident 28. Findings: A review of Resident 28's admission record indicated admission to the facility in November of 2023 with diagnoses that included history of stroke (when the blood supply to the brain is reduced and causes brain cells to die), dysphagia (difficulty swallowing), and generalized muscle weakness. A review of Resident 28's Minimum Data Set (MDS, an assessment tool), dated 3/9/24 indicated Resident 28 had moderately impaired cognition and required set up assistance for meals. A review of Resident 28's ADL (Activities of Daily Living)/Mobility care plan, dated 3/29/24, indicated, . Resident has .ADL/mobility decline and requires assistance .Goal: Will have needs anticipated and met by staff . During a concurrent observation and interview on 4/16/24 at 12:53 p.m. in Resident 28's room, Resident 28 was lying in bed while eating a bowl of soup during lunch. When asked if resident chose to eat in a lying down position, Resident 28 shook her head no and stated, It is not the best position to eat. During a concurrent observation and interview on 4/16/24 at 12:57 p.m. in Resident 28's room, the Certified Nursing Assistant 2 (CNA 2) acknowledged Resident 28 was, laying back too much and should be sitting up to eat. The CNA 2 raised the head of the bed (HOB) until Resident 28 was in an upright seated position. Resident 28 did not express any discomfort with sitting upright in bed. The CNA 2 stated it was important to ensure the resident was sitting up while eating so the resident did not choke. In an interview on 4/19/24 at 7:48 a.m., the Director of Staff Development (DSD) stated residents who eat in bed should have the HOB raised so the resident is sitting upright. The DSD added if a resident is laying back while eating, they could choke. The DSD stated when staff deliver the meal trays to residents in their rooms, she expected them to also ensure the resident is in a position ready to eat safely. In an interview on 4/19/24 at 8:08 a.m., the Restorative Nursing Assistant Supervisor (RNAS) stated it is important for staff to ensure the HOB is up and the resident is fully sitting up. The RNAS added a resident could choke if she is not sitting up while eating. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/19/24 at 12:21 p.m., the Director of Nursing (DON) stated residents should be sitting up as tolerated for eating and added a resident who is lying back when eating would be at risk for choking. A review of facility policy and procedure titled, Activities of Daily Living (ADLs), supporting, revised March 2018, indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with .Dining (meals and snacks) . A review of a BioMed Central research article titled, Interventions to prevent aspiration in older adults with dysphagia living in nursing homes: a scoping review, published 7/17/21, indicated, Dysphagia is highly prevalent condition in older adults living in nursing homes. There is also evidence indicating that aspiration is one of the major health risks for these older adults, which is more likely to result in respiratory infection, aspiration pneumonia .The aim of this scoping review is to describe the current spread of interventions to prevent or reduce aspiration in older adults with dysphagia with a specific focus on those who reside in nursing homes .Appropriate posture .For those who can get out of bed, caregivers should help them sit upright when eating .For those who are not able to get out of bed, it is important to raise the head of the bed by at least 30 degrees .

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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. 40214 Based on observation, interview, and record review, the facility failed to ensure all drugs were properly labeled for a census of 91 residents when a medication stored in a medication cart did not have an identification label. This failure reduced the facility's potential to ensure safe medication administration. Findings: During a concurrent observation and interview on 4/17/24 at 3 p.m., at the nursing station 1 with Licensed Nurse 3 (LN 3), at the medication cart 1, an aerosol medication used to treat breathing problems was observed inside a disposable plastic cup without identifying labels. The LN 3 confirmed the medication did not have identification labels on it and she was unable to determine which resident the medication belonged to. The LN 3 stated all medications were expected to be labeled. During an interview on 4/17/24 at 3:19 p.m., with Regional Nurse Consultant (RNC) 1, RNC 1 confirmed the [brand name] inhalation aerosol medication placed in a disposable plastic cup did not have identification labels. When asked if the medication should have been labeled, RNC 1 stated, Yes. During an interview on 4/18/24 at 3:59 p.m. with the Assistant Director of Nursing (ADON), the ADON stated nurses would not be able to identify which resident a medication was to be used for if the medication was not labeled. The ADON stated she expected medication without a label to be discarded due to safety issues. A review of the facility's policy and procedure titled Medication Labeling, revised February 2023, indicated, Medications are labeled in accordance with .federal and state requirements and .includes, at a minimum . resident's name .medication name .prescribed dose .route of administration; and .appropriate instructions and precautions .

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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. 47563 Based on observation, interview, and record review, the facility failed to meet food storage and service practices that met professional standards for food service safety when: 1. There were opened food packages found with no opened date label; 2. There were foods found removed from their original packaging without labels; 3. There was food stored in unsealed packaging; and, 4. The sanitizer solution was below the effective range. These failures decreased the facility's potential to prevent food borne illness for 89 residents who ate facility prepared foods. Findings: 1. During a concurrent observation and interview on 4/16/24 at 8:20 a.m. with the Food and Nutrition Assistant (FNA) during the initial kitchen tour, in the walk in refrigerator a bottle of barbecue sauce found opened with no label indicating what date it had been opened. The FNA acknowledged the barbecue sauce did not have an opened date labeled. The FNA stated she expected opened packages of food items should be labeled with the date they were opened to determine when they should be thrown away based on storage guidelines. The FNA pointed to documents posted in kitchen titled Dry Goods Storage Guidelines. During a concurrent observation and interview on 4/16/24 at 8:56 a.m. with the Food and Nutrition Director (FND) during the initial kitchen tour, containers of: dried basil, Italian seasoning, and Hungarian paprika found opened without labels indicating the date each seasoning was opened. The FND acknowledged the seasonings were not labeled and he expected the seasonings to have a label to indicate the opened date. During a review of the facility's policy and procedure titled, Labeling and Dating Foods, revised 5/30/23, indicated, .all food items in the storeroom, refrigerator, and freezer need to be labeled and dated .Dry storage guidelines are to be used to determine the .opened on shelf and opened and refrigerated use by date . During a review of a facility document titled, Dry Goods Storage Guidelines, dated 2023, indicated, .BBQ [barbecue] sauce .opened, refrigerated .4 months .Spices, ground .opened on shelf .2 years .spices, whole . opened on shelf .3 years . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent observation and interview on 4/16/24 at 8:20 a.m. with the FNA during the initial kitchen tour, three packs of frozen waffles, one bin of bulk white granular substance, and two bins of brown grain substance had been removed from their original packaging and were missing labels which indicated what the items were. The FNA acknowledged three packs of waffles had no labels, a bin of white granular substance was sugar and was missing a legible identification label, and two bins of brown grain substance were brown rice which were also missing identifying labels. The FNA stated foods removed from their original packaging should be labeled to indicate what the product was. A review of the facility's policy and procedure titled, Labeling and Dating Foods, revised 5/30/23, indicated, . all food items in the storeroom, refrigerator, and freezer need to be labeled and dated . A review of the U.S. Food and Drug administration's Food Code, dated 2022, indicated, .Preventing food and ingredient contamination .Food Storage Containers, Identified with Common Name of Food .working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT .shall be identified with the common name of the FOOD . 3. During a concurrent observation and interview on 4/16/24 at 8:20 a.m. with the FNA during the initial kitchen tour, opened boxes which had opened and unsecured packages of meatless meatballs, meatless breaded wings, and oatmeal cookie dough were found inside the freezer. The FNA acknowledged the boxes were opened and the plastic bags inside the box were not sealed. The FNA stated she expected the bags to be sealed to prevent cross contamination. In an interview on 4/16/24 at 8:56 a.m., the FND stated bags of food stored in boxes in the freezer need to be securely closed. The FND added if the bags were not securely closed, the food could become freezer burned and the food could be, ruined. A review of the facility's policy and procedure titled, Food Receiving and Storage, undated, indicated, .all foods stored in the refrigerator or freezer will be covered, labeled, and dated .Wrappers of frozen foods must stay intact until thawing . A review of U.S. Food and Drug administration's Food Code, dated 2022, indicated, .Preventing food and ingredient contamination .Packaged and Unpackaged Food - Separation, Packaging, and Segregation . FOOD shall be protected from cross contamination by .storing the food in packages, covered containers, or wrappings . 4. During a concurrent observation and interview on 4/16/24 at 8:56 a.m. with the FND during the initial kitchen tour, the FND stated the kitchen uses quaternary ammonium (chemical used to kill bacteria, viruses, and mold) sanitizer soaked towels for sanitizing surfaces throughout the kitchen. The FND pointed out the red buckets found at food preparation areas in the kitchen with towels fully submerged in the sanitizer solution. The FND stated kitchen staff is expected to change the sanitizer solution in the red buckets every two hours or as needed when the sanitizer solution becomes cloudy or is below the 200 to 400 parts per million (ppm, a unit of measure for concentration of solution) of sanitizer solution. At the three compartment sink, the FND retrieved a sanitizer solution test strip from a dispenser mounted to the wall, the FND dipped the test strip into the red bucket of sanitizer solution and compared the color of the test strip to the test strip packaging. The FND stated the test strip color indicated the sanitizer solution was at 100 ppm and added, we need to change it. The FND added when the solution is too low it is not effective at sanitizing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 4/17/24 at 10:51 a.m., the FND stated kitchen staff including the cooks and dietary aides are responsible for changing the sanitizer solution every 2 hours or as needed. The FND denied there is a schedule or a timer to trigger when the sanitizer solution should be checked and changed. During a concurrent observation and interview on 4/17/24 at 10:56 a.m., the Dietary Aide 1(DA 1) tested the sanitizer solution in the red bucket at the three compartment sink. The DA 1 removed a test strip from the dispenser mounted on the wall, dipped the test strip in the red bucket of sanitizer solution and compared the color of the test strip to the test strip packaging. The DA 1 stated the test strip color indicate the sanitizer solution was between 100 and 200 ppm. The DA 1 looked at the sanitizer solution log on the wall and stated the sanitizer solution needed to be changed every two hours or as needed and the sanitizer solution should be at 400 ppm. An interview on 4/17/24 at 10:57 a.m., the FND confirmed the sanitizer solution should have been between 200 and 400 ppm and the solution needed to be changed. The FND added the DA was too nervous to recite the expected range of the sanitizer solution. During a concurrent observation and interview on 4/19/24 at 9:13 a.m. at the dishwashing area, the FNA retrieved a sanitizer solution test strip, dipped it in the red bucket sanitizer solution, removed the test strip and compared it to the test strip packaging, and stated the sanitizer solution reading was at 150 ppm. FNA stated the sanitizer solution needed to be changed as it should be between 200 and 400 ppm. During a review of the facility's policy and procedure titled, Quaternary Ammonium Log Policy, undated, indicated, The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution .the solution will be replaced when the reading is below 200 ppm [parts per million] .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46242 Based on observation, interview and record review, the facility failed to follow infection control standards of practice when: 1. A shower chair with brown substance on its surface was observed stored in the hallway, and staff did not follow recommended minimum disinfectant contact time for sanitation of the chair; 2. Staff did not sanitize the exterior surface of the washing machine including the door handle after loading dirty laundry; 3. Staff did not perform hand hygiene prior to donning and after doffing personal protective equipment (PPE, example: gowns, gloves, mask) during medication administration; 4. Staff did not disinfect the vital signs (VS, example: blood pressure, pulse, etc.) machine in between resident use and after use; 5. Oxygen tubing (used for oxygen delivery) was not labeled with a date for Residents 6, 36, and 95; 6. Nebulizer (a device that changes medication from liquid to a mist for inhalation) equipment not labeled with a date or stored in anti-microbial bag for Resident 6; and, 7. Urinal (a container used to collect urine) was not labeled with resident identifiers for Resident 6 and 7. These failures decreased the facility's potential to prevent the spread of infection. Findings: 1. During an observation on 4/17/24 at 8:50 a.m. in facility's hallway near room [ROOM NUMBER], a shower chair with a few brown chunky splatters was observed stored against the wall directly next to an ice chest. There were no staff observed in or around the hallway and there were no residents in the shower room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/17/24 at 9:52 a.m. with Certified Nursing Assistant 4 (CNA 4) in the hallway near room [ROOM NUMBER], CNA 4 confirmed the presence of brown splattered substance on the shower chair and stated all equipment should be cleaned after use and prior to storage in the hallway. The CNA 4 took the shower chair back to the shower room and used water and a wash rag to remove the splattered brown substance from the surface of the chair. After the stains were removed, she wiped down the chair using a bleach-containing product and rinsed the rag with water for approximately 30 seconds. After rinsing the rag, she immediately used the rag to wipe the bleach-containing product off of the surface of the chair. The CNA 4 then pushed the shower chair back into the hallway for storage. The CNA 4 was asked how long the bleach-containing product was supposed to be on the surface in order for it to properly disinfect. The CNA 4 confirmed the bleach-containing product was supposed to be left on the surface for at least 3 minutes. The CNA 4 admitted she wiped it off with water before the required 3 minutes. In an interview on 4/19/24 at 12:21 p.m. the Director of Nursing (DON) stated equipment stored in the hallway should be clean, and staff should follow manufacturer's recommended treatment time for sanitation depending on the product used. Storing dirty equipment in the hallway and not following recommended treatment time increases the risk of cross-contamination. A review of facility's policy titled Cleaning and Disinfection of Resident-Care Items, Surfaces and Equipment, revised October 2021, indicated, Reusable items, including environmental surfaces will be cleaned and/or disinfected between residents and when surfaces are visibly soiled .Reusable resident care equipment will be cleaned and disinfected between residents according to manufacturer's instructions. 2. During a concurrent observation and interview on 4/17/24 commencing at 10:24 a.m. in the facility's laundry room with the laundry attendant (LA), the LA put on a gown and gloves to handle dirty laundry and loaded it into the washing machine. After completing the loading process, she closed the washer door, removed the gloves and gown, and washed her hands at the sink located in the room. The LA then placed her back against the door of the washer to speak with the surveyor and she touched the washer door handle with her elbow. The LA then moved to the clean side of the room to fold clean linens. The LA was not observed to sanitize the exterior surface of the washing machine including washer door handle. The LA stated she usually cleans the laundry room and the equipment at the end of her shift. In an interview on 4/17/24 at 10:48 a.m. the LA acknowledged she should have disinfected the outside surface of the washing machine after handling dirty laundry but she forgot to do it. The LA confirmed the exterior surface of the washing machine needed to be cleaned in-between loads. In an interview on 4/19/24 at 12:21 p.m. the DON stated her expectation was for staff to clean the outside surface of the washing machine after the dirty laundry has been loaded; not cleaning it would increase the risk of cross contamination. A review of the facility's policy titled Departmental (Environmental Services)- Laundry and Linen, revised January 2024, indicated, Separate soiled and clean linen at all times .Wash hands after handling soiled linen and before handling clean linen . Handle linen using standard precaution. 40214 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, revised October 2023, indicated, Hand hygiene is performed to prevent the spread of .infections .Personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors .Hand hygiene is indicated .prior to care .before .handling an invasive medical device . after care .after touching the resident's environment .Use an alcohol-based hand rub .was hands with soap and water . During a review of an undated facility's policy and procedure titled, CONTINUOUS ADMINISTRATION OF SOLUTION VIA CENTRAL VENOUS CATHETER, indicated, .To provide guidelines for the safe administration of prescribed solution intravenously through a central line catheter .Wash hands . During a review of the facility's policy and procedure titled, Cleaning and Disinfecting of Resident-Care Items, Surfaces and Equipment, revised October 2021, indicated, Resident-care equipment, including reusable items and durable medical equipment .including environmental surfaces will be cleaned and/or disinfected between residents and .before reuse by another resident . 47563 5. In an observation on 4/16/24 at 10:10 a.m., in Resident 36's room, Resident 36 wore an oxygen (O2) nasal cannula (NC, a device to deliver oxygen through the nose) with a label attached to the O2 tubing with illegible writing. During a concurrent observation and interview on 4/16/24 at 10:19, in Resident 36's room, the LN 9 inspected Resident 36's O2 tubing and label and confirmed the label was illegible. The LN 9 added resident equipment should be labeled with a date to know how long it has been used. In an observation on 4/16/24 at 10:32 a.m. in Resident 6's room, Resident 6 was wearing an O2 NC without a label attached to indicate the date it was placed. During a concurrent observation and interview on 4/16/24 at 10:35 a.m., in Resident 6's room, the LN 9 inspected Resident 6's O2 tubing and confirmed it was not labeled with the date it was placed. The LN 9 stated the tubing should be labeled with a date. In an observation and interview on 4/16/24 at 10:44 a.m., in Resident 95's room, Resident 95 was wearing an O2 NC without a label to indicate the date it was placed. During a concurrent observation and interview on 4/16/24 at 10:50 a.m., in Resident 95's room, the LN 9 inspected Resident 95's O2 tubing and confirmed it was not labeled with the date it was placed. The LN 9 stated the tubing should be labeled with a date. In an interview on 4/19/24 at 7:48 a.m., the Director of Staff Development (DSD) stated she expected O2 tubing to be replaced weekly and to be labeled with the date the tubing had been replaced for infection control purposes. In an interview on 4/19/24 at 9:18 a.m., the LN 10 stated O2 tubing should be changed weekly and should have a sticker indicating what date the tubing had been changed for infection control purposes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/19/24 at 12:21 p.m., the DON stated she expected O2 tubing should be changed weekly and labeled with the date it was changed. The DON stated undated O2 tubing could potentially cause the tubing to not be changed timely which could lead to a buildup of microorganisms (tiny living things such as bacterium, fungus, virus, and molds). A review of the facility's policy and procedure title, Oxygen administration, revised October 2023, indicated, . the oxygen tubing is changed at least weekly, labeled with the date it was changed, and stored in and Anti-microbial [kill or slow the spread of microorganisms] bag which is changed at least every 30 days . 6. In an observation on 4/16/24 at 10:32 a.m. in Resident 6's room, Resident 6's nebulizer mask was sitting on a stack of newspapers on top of the resident's nightstand and the nebulizer tubing did not have a label indicating the date it was placed. During a concurrent observation and interview on 4/16/24 at 10:35 a.m., in Resident 6's room, the LN 9 inspected Resident 6's nebulizer mask and tubing and confirmed the nebulizer tubing had no date indicated. The LN 9 stated the tubing should be labeled with a date. The LN 9 stated the nebulizer mask should also be stored in a bag to protect it. In an interview on 4/19/24 at 7:48 a.m., the DSD stated she expected the nebulizer tubing to be replaced weekly and to be labeled with a date the tubing had been replaced for infection control purposes. The DSD added the mask and tubing was expected to be placed in an anti-microbial bag when not in use for infection prevention purposes. In an interview on 4/19/24 at 9:18 a.m., the LN 10 stated nebulizer tubing should be changed weekly and should have a sticker indicating what date the tubing had been changed for infection control purposes. The LN 10 added nebulizer masks should be stored in an anti-microbial bag for infection control purposes. In an interview on 4/19/24 at 12:21 p.m., the DON stated she expected nebulizer tubing to be changed weekly and labeled with the date it was placed. The DON stated nebulizer tubing not labeled with a date could potentially cause the tubing to not be changed timely which could lead to buildup of microorganisms. The DON stated she expected nebulizer masks to be placed in a bacteriostatic (stops bacteria from growing) bag when not in use. 7. In an observation on 4/16/24 at 10:32 a.m. in room [ROOM NUMBER], there were two beds in the room. Resident 7's bed, Bed A (the bed closest to the door), had two urinals hanging off the side of the bed. Neither of the urinals was labeled to identify which resident the urinals belonged to. Resident 6's bed, Bed B (the bed closest to the window), had one urinal hanging off the side of the bed which was not labeled to identify which resident the urinal belonged to. During a concurrent observation and interview on 4/16/24 at 10:35 a.m., in Resident 6's room, the LN 9 inspected the urinals and confirmed the urinals did not have labels to indicate who they belonged to. The LN 9 added the urinals should be labeled with the room number and which bed to identify which urinal belongs to which resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/19/24 at 7:48 a.m., the DSD stated when two residents in the room use urinals, she expected staff to label the urinals with the resident's name to identify who the urinal belongs to. In an interview on 4/19/24 at 8:08 a.m., the Restorative Nurse Assistant Supervisor (RNAS) stated when there are multiple residents in a room using urinals, she expected the urinals to be labeled with the name of the resident it belongs to. The RNAS added urinals are labeled for infection control, [staff] wouldn't want A bed to use B bed's urinal .it could spread infections. In an interview on 4/19/24 at 12:21 p.m., the DON stated when residents share a room the urinals should be labeled with the resident's name on it. The DON added if the urinals are not labeled, it could cause the other resident to use the wrong urinal which would be a concern for cross-contamination. A review of the facility's policy and procedure titled, Urinal Assistance, revised April 2024, indicated, .ensure the urinal being used belongs to the resident .