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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555866	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Sierra Vista Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1715 South Cedar Fresno, CA 93702	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 40641 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity in an environment that promotes and enhances quality of life for five of 21 sampled residents (Residents 68, 81, 245, 246, and 350,) when Residents 68, 81, 245, 246 and 350 waited up to 20 minutes for their lunch tray while watching other residents eat their meal while in the dining room. This failure violated Residents' 68, 81, 245, 246 and 350 the right to be offered a dignified dining experience. Findings: During an observation on 9/23/24 at 12:21 p.m. in the dining room, nursing staff passed out lunch trays to residents in the dining room except two residents, Resident 68 and Resident 81. Resident 68 and Resident 81 did not receive a lunch tray and watched other residents eat sitting at the same table. Resident 68 and Resident 81 were observed looking at other residents eating around them. Resident 68 and Resident 81 were served their lunch 15-20 minutes after other residents were served their lunch. During a concurrent observation and interview on 9/24/24 at 12:30 p.m., in the dining room, nursing staff was observed passing out lunch trays to residents in the dining room except for four residents, Residents 68, 245, 246 and 350. Residents 68, 245, 246 and 350 sat on the same table and did not receive their lunch trays and watched other residents eat in the dining room. Residents 68, 245, 246 and 350 were observed looking around and looking at other residents eat around them. Residents 68, 245, 246 and 350 were served their lunch 25-30 minutes after other residents were served their lunch. Family Member (FM) 1 was seated next to Resident 350 stated, it was not the first time Resident 350 ate in the dining room, and she did not understand why staff send Resident 350's lunch tray to his room. FM 1 stated it was uncomfortable watching other residents eat while Residents 68, 245, 246 and 350 waited for their lunch tray. During a review of Resident 68's Admission Record [AR-document which contain patient personal information], dated 9/26/24, the AR indicated Resident 68 was admitted to the facility on [DATE] with diagnoses which included unspecified psychosis ( ), anemia (low red blood cell) and muscle weakness. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 68's Minimum Data Set (MDS-an assessment tool used to identify resident cognitive [pertaining to reasoning, memory and judgement] and physical function level), assessment dated [DATE], indicated Resident 68's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was six out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 68 had severe cognitive deficit. During a review of Resident 81's Admission Record dated 9/26/24, the AR indicated Resident 81 was admitted in the facility on 6/13/24 with diagnoses which included psychosis (mental health disorder) and fracture (break in bone). During a review of Resident 81's MDS assessment dated [DATE], indicated Resident 81's BIMS score was nine out of 15 indicating Resident 81 had moderate cognitive deficit. During a review of Resident 245's AR dated 9/26/24, the AR indicated Resident 245 was admitted to the facility on [DATE] with diagnoses which included embolism and thrombosis, muscle weakness. During a review of Resident 245's MDS dated [DATE], indicated Resident 245's BIMS was 14 out of 15 indicating Resident 245 had no cognitive deficit. During a review of Resident 246's AR, dated 9/26/24, the AR indicated Resident 246 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection (bladder infection) and anemia. During a review of Resident 246's MDS dated [DATE], indicated Resident 246's BIMS was four out of 15, indicating Resident 246 had severe cognitive deficit. During a review of Resident 350's AR dated 9/26/24, the AR indicated Resident 350 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection and heart failure. During a review of Resident 350's MDS dated [DATE], indicated Resident 350's BIMS was 14 out of 15, indicating resident 350 had no cognitive deficit. During an interview on 9/23/24, at 12:35 p.m. with Certified Nursing Assistant (CNA) 3 in the dining room, CNA 3 stated the practice was to serve one table at a time then move on to the next table. CNA 3 stated it was not right for Resident 68 and 81 to wait for their food while they watched other residents eat. During an interview on 9/24/24 at 12:46 p.m. with CNA 4 in the dining room, CNA 4 stated Residents' 68, 81, 245, 246 and 350 waited a long time for their meals because they did not usually eat in the dining room. CNA 4 stated, .Therapist brought residents in the dining room after they finished working with them CNA 4 stated, dietary staff sent Residents' 68, 81, 245, 246 and 350's lunch trays in their rooms. CNA 4 stated they should have let the kitchen staff know to send Residents' 68, 81, 245, 246 and 350's in the dining room so they did not have to watch other residents eat while they wait for their lunch trays. (continued on next page)

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	555866	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Vista Healthcare	1715 South Cedar Fresno, CA 93702

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/24 at 9:19 a.m. with Dietary Service Manager (DSM), the DSM stated the practice was to serve one table at a time then move on to the next table. The DSM stated it was not right for residents to wait a long time for their lunch tray to be served while they watched other residents eat around them eat; it was a dignity issue. The DSM stated the nursing staff in the dining room should have let dietary staff know when a resident who do not usually eat in the dining room decided to eat in the dining room. During an interview on 9/26/24 at 9:35 a.m. with Minimum Data Set Coordinator (MDSC) 1, MDSC 1 stated she usually helped in the dining room during meals. MDSC 1 stated she checked the food trays making sure residents received their diets as ordered. MDSC 1 stated Residents 68, 81, 245, 246 and 350's lunch trays were not served until later because their lunch trays were sent out to the floor. MDSC 1 stated they had to watch other residents eat while they waited for their lunch trays. MDSC 1 stated nursing staff working in the dining room should have communicated with the dietary staff of Residents' 68, 81, 245, 246 and 350 eating in the dining room. MDSC 1 stated the practice was to served everyone at the same table at a time. During an interview on 9/26/24 at 10:15 a.m. with Director of Staff Development (DSD), the DSD stated the practice was for the nurse to check the trays first then the CNAs distributes the trays. The DSD stated, . Staff needed to serve one table at a time before moving on to the next table . The DSD stated it was a dignity issue for residents watching other residents eat while they waited for their food. During an interview on 9/27/24 at 2:10 p.m. with the Director of Nursing (DON), the DON stated, .CNAs working in the dining room should have communicated with the dietary staff . The DON stated the expectation was for residents to be served their food one table at a time then moved on to the next table. During a review of facility's policy and procedure (P&P) titled, Quality of Life-Dignity dated 8/09, the P&P indicated, . Residents should be treated with dignity and respect at all times . During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated, 8/22, the P&P indicated, .be treated with respect, kindness and dignity . be free from corporal punishment or involuntary seclusions, and physical or chemical restraints not required to treat the resident's symptoms .

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48424 Based on observation, interview, and record review the facility failed to post the results of the most recent survey in a place readily accessible to 91 of 91 residents, families, and their legal representatives. This failure had the potential to violate the rights of residents and their representatives to be informed of previous survey deficiencies. Findings: During an observation on 9/24/24 at 10:30 a.m., a binder labeled CDPH Survey Results was located in a holder in the hallway east of the main entrance. During a review of the facility's, CDPH Survey Results binder, undated, the binder did not contain results for the facilities last recertification survey on 9/22. During an interview on 9/24/24 at 10:35 a.m. with the Director of Nursing (DON), the DON stated the facility had their last survey 9/22. The DON stated the results of that survey were not included in the CDPH Survey Results binder. During a concurrent interview and record review on 9/24/24 at 10:42 a.m. with the Administrator (ADM), the facility's CDPH Survey Results binder, undated, was reviewed. The CDPH Survey Results binder did not contain the facility's previous survey results from 9/22. The ADM stated the facility's last survey was in 2022 and the results of the survey were not in the binder. The ADM stated he thought only results from the previous year needed to be stored in the binder and since the survey was in 2022 it did not need to be included. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 8/22, the P&P indicated, .the resident has the right to be informed of his or her rights and of all rules and regulations . 1. 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** 49949 Based on interview and record review the facility failed to ensure one of six sampled residents (Residents 351), had their code status (resident's instructions to a medical team about the type of treatment they want if their heart or breathing stops) documented upon admission on the Physician Order for Life Sustaining Treatment (POLST). Resident 365's POLST form was not completed and signed by the physician for more than eleven days after admission and not in accordance with the facility policy and procedure. This failure had the potential to result in Resident 351's wishes not being honored and unnecessary medical interventions administered. Findings: During a review of Resident 351's electronic medical records (EMR) on [DATE] at 10:10 a.m., the EMR indicated, no POLST was in the (EMR). A copy of the printed POLST form was requested on [DATE]. During a review of Resident 351's Physician Orders for Life-Sustaining Treatment (POLST) dated prepared [DATE], the POLST indicated, .Box A Cardiopulmonary Resuscitation (CPR) .[check mark] Do not Attempt Resuscitation/DNR .Box B Medical Interventions . [check mark] Selective-Treatment .Box C Artificially Administered Nutrition .[check mark] no artificial means of nutrition, including feeding tubes .Box D Information and Signatures .[box] Signature of Physician/Nurse Practitioner /Physician Assistant . [physician signature] .Date [DATE] .[box] Signature of Patient or legal Recognized Decisionmaker . [Resident 361 signature] .Date: [DATE] . The POLST form indicated Resident 351 signed the POLST form on [DATE]. During an interview on [DATE] at 3:15 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, the POLST form should have been completed upon admission. LVN 1 stated, the physician and or Nurse Practitioner had 72 hours to sign the POLST form after Resident 351 was admitted . LVN 1 stated, It is important to have a signed POLST form to let the staff know when residents wanted CPR (emergency treatment that's done when someone's breathing or heartbeat has stopped) or did not want one. LVN 1 stated, residents without a POLST had CPR performed and when they did not want it. During an interview on [DATE] at 3:19 p.m. with Minimum Data Set Coordinator (MDSC) 1, MDSC 1 stated the admission nurse was responsible for completing the POLST form upon admission. MDSC 1 stated the admission nurse should have asked Resident 351 what her wishes were and should have completed the POLST upon admission. MDSC 1 stated, Medical Record should have followed up to ensure if the POLST form was or was not completed after admission. MDSC 1 stated, Medical Record should have completed POLST form within 72 hours of admission. MDSC 1 stated, Resident 351's was considered a full code (term that means a patient's health care team will do everything possible to save their life in a medical emergency) because the POLST form was not completed and signed by the physician within 72 hours. MDSC 1 stated, the POLST form was not considered completed without a physician signature. MDSC 1 stated, she was not sure how often the physician came to the facility. MDSC 1 stated, a Nurse Practitioner was also able to sign the POLST form, and the Nurse Practitioner came to the facility daily. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:41 a.m. with the Director of Nursing (DON), the DON stated the POLST form should have been initial by the admission nurse and communicated to the physician regarding Resident 351's wishes. The DON stated, the physician should have signed the POLST form the next day after admission. The DON stated, the physician had three to five days to sign the POLST form after Resident 351 was admitted to the facility. The DON stated, the physician had the POLST form in his inbox and did not sign it until [DATE]. The DON stated, the physician should have signed the POLST the same day it was placed in his inbox. The DON stated, Medical Records should have followed up with the POLST form when it was not signed. The DON stated, The POLST form was not completed without the physician signature and was not acceptable. The DON stated, Resident 351 was automatically considered full code because the POLST form was not completed. The DON stated, and it was important to get the POLST form completed to honor Resident 351's wishes. The DON stated, the POLST form notified staff about Residents wishes when the Resident health condition was unstable. The DON stated, Resident 351 did not have an advance directive (a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) and the POLST form had her wishes. During an interview on [DATE] at 10:54 a.m. with Medical Records (MR) 1, MR 1 stated the admission nurse was responsible for completing the POSLT form and should had done so upon admission. MR 1 stated, Once the POLST from is completed I will do follow up. MR 1 stated the POLST needed to be signed by the physician for it to be considered valid. MR 1 stated, The residents are automatically full code, that is why it was important to get the POLST signed in time. MR 1 stated, If something would have happened, we need to follow what the resident's wishes were. During a review of Resident 351's Admission Record (AR-document containing resident demographic information and medical diagnosis dated [DATE], the AR indicated Resident 351's was admitted to the facility on [DATE]. The AR indicated Resident 351 had diagnoses of Covid 19 (disease caused by the SARS-CoV-2 virus) polyneuropathy (the nerves that are located outside of the brain and spinal cord are damaged) Depression, Hypertension (high blood pressure when the pressure in your blood vessels is too high [, d+[DATE] mmHg or higher], and constipation. The AR indicated: Resident 351 was her own responsible party (the person who is responsible for making the medical decision). During a review of Resident 351's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS, indicated Resident 351 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of ,d+[DATE]) score of 9 (a score of ,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired, ,d+[DATE] suggests cognitively intact) indicating Resident 351 was moderately cognitively impaired. During a review of the facility's Policy and Procedure (P&P) titled, Administrative Manual dated revision [DATE], the P&P indicated, Physician Orders for Life Sustaining Treatment (POLST) .Policy .the facility will advise residents about their rights to make health care decisions and the facility will honor those wishes .The POLST will be honored if received on admission and signed by both the resident and a physician in accordance with the guidelines .The POLST form is not valid until it is signed by the resident (or the designated decision-maker) AND physician .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 40641 Based on observation, interview and record review, the facility failed to protect the privacy of personal information for one of three sampled residents (Resident 34) when Licensed Vocational Nurse (LVN) 2 left her workstation computer open and unattended with Resident 34's information exposed to public view. This failure resulted in violation of Resident 34's right to confidentiality and the potential for unauthorized access to Resident 34's personal information. Findings: During a concurrent observation and interview on 9/25/24 at 3:40 p.m. with LVN 2, outside of Resident 34's room, LVN 2 entered Resident 34's room and left her computer screen open with Resident 34's information open. LVN 2 stated she should not have left her computer screen open. LVN 2 stated any residents, staff and visitors walking by could have seen Resident 34's private information violating her privacy. During a review of Resident 34's Admission Record [AR-document which contain patient personal information], dated 9/26/24, the AR indicated Resident 34 was admitted in the facility on 11/22/23 with diagnoses which included unspecified dementia (loss of cognitive functioning like thinking, remembering and reasoning), and Hemiplegia(severe of complete loss of strength or paralysis on one side of the body) and hemiparesis (mild loss of strength or weakness on one side of the body). During an interview on 9/26/24 at 9:50 a.m. with the Assistant Director of Nursing (ADON), the ADON stated computer screen should always be closed as soon as the licensed nurses turned their back on the computer to safeguard the privacy of residents. During an interview on 9/26/24 at 10:23 a.m. with the Director of Staff Development (DSD), the DSD stated the practice was to never leave the computer screen open to protect residents' information. The DSD stated it was a Health Insurance Portability and Accountability Act (HIPAA- a federal law that was passed in 1996 to protect sensitive health information. HIPAA establishes national standards for the privacy and security of health information, and gives individuals certain rights over their health records) violation. During an interview on 9/27/24 at 2:40 p.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses to close their computer screen when they turned their back on the computer and not within their sight. The DON stated there are always other residents, staff and visitors walking by that did not need to know residents' information. The DON stated residents information needed to be protected. During a review of facility's policy and procedure (P&P) dated 8/22, the P&P indicated, . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to: . privacy and confidentiality .

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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** 40641 Based on observation, interview and record review, the facility failed to maintain a clean and homelike environment for two of six sampled residents (Resident 16 and Resident 39) when Resident 16 had the following at bedside: 1. A plastic bag of fresh onions, tomatoes and avocados on the floor. 2. On a shelf were multiple cans of soup, bananas, cookies, ramen noodle soup, bottles of spices with broken lids, individual packets of sugar, pepper, mayonnaise and loaves of bread. 3. The sink area had kitchen utensils and under the sink was a small ice chest, loaf of bread and small bottles of spices. These failures provided an unclean and un-homelike environment for Resident 16 and Resident 39 (Resident 16's roommate) and placed them at risk for cross contamination from improper storage of personal food. Findings: During a review of Resident 16's Minimum Data Set (MDS-an assessment tool used to identify cognitive [pertaining to reasoning, memory and judgement] and physical function level), assessment dated [DATE], indicated Resident 16's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 15 out of 15 (,d+[DATE] scale[,d+[DATE] severe cognitive deficit, , d+[DATE] moderate cognitive deficit, ,d+[DATE] no cognitive deficit]) indicating Resident 16 had no cognitive deficit. During a review of Resident 39's MDS dated [DATE], indicated Resident 39's BIMS assessment score was 15 out of 15 indicating Resident 39 had no cognitive deficit. During a concurrent observation and interview on [DATE] at 8:15 a.m. in room [ROOM NUMBER] during the initial tour. Resident 39 was lying in bed A watching TV and covered with blanket. Resident 39 stated he did not mind Resident 16's (roommate in bed B) clutter. Resident 39 stated when he was first admitted in the facility, he was told he could use the sink too but Resident 16 had too much clutter, it was impossible to use the sink. Resident 39 stated he was used to the clutter on Resident 16's side including the clutter, on top of the sink. During an observation on [DATE] at 8:20 a.m. in room [ROOM NUMBER] during initial tour, Resident 16 was not in the room. Observed food clutter on the floor between Resident 16's bed and the window. Open shelves by the window was observed overflowing with dry goods and fresh produce. During a concurrent observation and interview on [DATE] at 3:30 p.m. in the hallway leading out to the patio, Resident 16 was observed sitting up in his wheelchair and propelled self out in the patio. Resident 16 stated he did not have any concerns and did not answer any more questions. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:19 a.m. with Infection Preventionist (IP), the IP stated the facility staff talked to Resident 16 and family and explained the risks of hoarding food, but they continued to bring food in the facility. The IP stated it was difficult talking to Resident 16 and had explained the consequences of his hoarding of food. The IP stated food hoarding attracts pest which could result in infestation of the whole facility. The IP stated foods past their expiration dates could cause food borne illness. During a concurrent observation and interview on [DATE] at 3:10 p.m. in Resident 16 and Resident 39's room, housekeeping (HK) 3 was observed moping Resident 16's side of the room and cleaning and wiping the sink area. HK 3 stated her only job was to clean the room, mop the floor and clean the sink, it was not her job to pick up the food off the floor and check the expiration dates of food. HK 3 stated Resident 16 did not like facility staff touched his food. During an interview on [DATE] at 10:30 a.m. with the Director of Staff Development (DSD), the DSD stated Resident 16 liked to bring foods and keep it at his bedside. The DSD stated she tried talking to Resident 16 about the hoarding of food and the family but they continue to bring food. The DSD stated the food hoarding could result in a pest problem and affect the whole facility. During an interview on [DATE] at 10:55 a.m. with Registered Dietitian (RD), the RD stated she goes in the facility once or twice a week and explained repeatedly to Resident 16 about the potential for food borne illness as a result of hoarding food but he never listened. The RD stated the facility staff checked the expiration dates of Resident 16's food and throw away food past its expiration dates. RD stated Resident 16 refused to throw expired foods out at times and had insisted the food was still good. RD stated nursing staff offered to store his food in the resident's refrigerator but he refused. During an interview on [DATE] at 11:57 a.m. with the Director of Nursing (DON), the DON stated Resident 16 was alert and oriented and independent with most of his activities of daily living (ADL- everyday task to care for self like bathing or showering, dressing, toilet use). The DON stated the facility offered to find him a place where he can be more independent, but he refused, stating he had friends in the facility. The DON stated Resident 16 goes to his sister's house to cook and brings the finished product in the facility. The DON stated nursing staff are making sure they are checking the expiration dates of Resident 16's food and throw away expired foods. The DON stated the facility is making sure Resident 16's room and bedside is kept clean to prevent pest infestation. During an interview on [DATE] at 8:55 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated she was familiar with Resident 16. CNA 5 stated Resident 16 likes to bring lots of food including fresh produce and fruits into the facility. CNA 5 stated nursing staff had to make sure the food was to checked to make sure it was not rotten or expired. CNA 5 stated she report to the charge nurse when Resident 16 refused to throw away expired or rotten food. During an interview on [DATE] at 9:21 a.m. with Social Service Assistant (SSA), The SSA stated, .It has been a while since I went to his room, I think I have done everything I possibly could . The SSA stated Resident 16 was offered alternate placement so he could be more independent but he refused saying he has friends in the facility and did not want to move. The SSA stated the IP nurse is following up on Resident 16. (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:45 p.m. with the Administrator (ADM), the ADM stated He talked to Resident 16 constantly and discussed his hoarding of food and he would agree to stopped hoarding which he did for a few days then went back to his usual ways. The ADM stated Resident 16 was alert and oriented with a BIMS of 16. The ADM stated the staff was making sure they put dates on the food when he brings it into the facility and put it in the resident refrigerator or in the ice chest he kept under the sink. Staff made sure there was ice in the ice chest. During a review of the facility's policy and procedure (P&P) titled, Quality of Life-Homelike Environment, dated ,d+[DATE], the P&P indicated, . The facility staff and management shall maximize, to the extent possible,the characteristic of the facility . Clean, sanitary and orderly environment . During a review of facility's policy and procedure (P&P) titled, Resident Outside Food, dated ,d+[DATE], the P&P indicated, It is the policy of this facility to educate the families of our residents about their family members diet order . Prepared food brought in for the resident should be consumed within two (2) hours . Unused food will be dated and stored in a Resident Refrigerator . Opened food must be sealed and consumed by the indicated manufacturer's expiration date . Any suspicious or obviously contaminated food will be discarded immediately During a review of the facility's policy and procedure (P&P) titled, Personal Property, dated ,d+[DATE], the P&P indicated, . The resident is encouraged to maintain his/her room in a home-like environment . A representative of the admitting office will advise the resident, prior to or upon admission, as to the types and amount . the resident may keep in his room .

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F 0645

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

PASARR screening for Mental disorders or Intellectual Disabilities

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40641

Based on interview and record review, the facility failed to ensure the Level l Preadmission Screening and Resident Review (PASRR-The State is required to ensure that every person entering a Medicaid certified Nursing Facility [NF] receives a Level I screening and if necessary a Level II evaluation to ensure that their NF residence is appropriate and to identify what specialized services they may need) was completed accurately for one of two sampled residents (Resident 68) when Resident 68 was admitted to the facility on [DATE].

This failure had the potential for Resident 68 not to receive the necessary and appropriate psychiatric level of treatment and evaluation in the facility.

Findings:

During a review of Resident 68's Admission Record (AR), dated 9/26/24, the AR indicated, Resident 68 was admitted to the facility on [DATE] with diagnoses which included unspecified psychosis (collection of symptoms that cause a person to lose touch with reality and have difficulty distinguishing reality) and depression (sadness).

During a review of Resident 68's Order Summary Report, [OSR] dated 9/26/24, the OSR indicated, . Citalopram Hydrobromide [brand name- medication used to treat depression] Oral Tablet 20 MG [milligram-unit of measurement] . Order date 8/27/24 . risperiDONE Oral [brand name- medication used to treat the symptoms of schizophrenia [a mental illness that causes disturbed or unusual thinking, loss of interest on life, and strong or inappropriate emotions] oral Tablet . Order Date 8/27/24 .

During a concurrent interview and record review on 9/26/24 at 11:45 a.m. with the Director of Nursing (DON), Resident 68's PASRR dated 8/27/24 was reviewed. The DON stated the PASRR was completed at the general acute care hospital (GACH) and a copy was sent to the facility when Resident 68 was admitted to the facility on [DATE]. The DON stated the PASRR indicated Resident 68 did not require Level ll screening (person-centered evaluation completed for anyone as having, or suspected of having seriou mental illnessm intellectual disability, developmental disabilityor related condition). The DON stated Resident 68 was admitted with diagnosis of unspecified psychosis and depression and was also on psychotropic medications when admitted to the facility. The DON stated she did not review the assessment part of the PASSR which indicated Resident 68 did not have a diagnosis of mental illness and was not prescribed psychotropic medications. The DON stated Resident 68's PASRR assessment dated [DATE] was not accurate. The DON stated she should have reviewed the PASRR assessment when Resident 68 was admitted to the facility and resubmitted an updated PASSR assessment to indicate Resident 68's diagnosis of mental disorder. The DON stated PASSR was important in order for the facility to identify and meet residents mental issues or developmental delay and to refer resident out to other facilities to appropriately provide for their mental care needs.

During a review of facility's policy and procedure (P&P) titled, PREADMISSION SCREENING & RESIDENT REVIEW (PASRR), dated 11/30/23, the P&P indicated, . Confirm that the PASRR process was completed by the hospital . and reviewing the PASRR documentation submitted by the hospital . Review PASRR documentation .

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NAME OF PROVIDER OR SUPPLIER Sierra Vista Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1715 South Cedar Fresno, CA 93702	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40641 Based on observation, interview, and record review, the facility failed to develop and implement a resident centered care plan for three of 11 sampled residents (Resident 1, Resident 31, and Resident 53) when: 1. Resident 31 did not have a care plan for the use of clotrimazole (brand name-used to treat fungal infection) medication. This failure placed Resident 31 at risk for complications from not having care needs planned by licensed nurses to determine if nursing intervention needed to be added, changed, or completed. 2. The padding on Resident 1's left bedrail was not fully intact, and the metal bar was exposed This failure had the potential to result in Resident 1 sustaining an injury during a seizure (uncontrolled bursts of electrical activities that change sensations behaviors, awareness and muscle movements) episode. 3. Resident 53 did not have a care plan in place for the change in condition for diarrhea on 9/14/24. This failure had the to result in Resident 53's medical needs not to be met. Findings: 1. During a concurrent observation and interview on 9/23/24 at 7:33 a.m. Resident 31's room, Resident 31 was lying in bed, feet were dangling off the bed while his body was covered with blanket. Observed toenails were thick and long, Resident 31 stated staff cut his nails, and the foot doctor had seen him recently. During a review of Resident 31's Admission Record, dated 9/26/24, the admission record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses which included epilepsy (brain disease where nerve cells don't signal properly, which causes seizures[uncontrolled burst of electrical activities that changes sensations, behaviors and muscle weakness]), anemia (body does not produce enough healthy red blood cells) and dementia (loss of cognitive functioning, thinking, remembering and reasoning). During a review of Resident 31's Order Summary Report, dated 9/26/24, the Order Summary Report, indicated, . Clotrimazole External Cream one percent [1%] . Apply to toenails topically in the morning for onychomycosis [fungal infection that affects the nails, causing them to become discolored, thickened, and brittle] for four months . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 9/25/24 at 2:16 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 31's order summary was reviewed and LVN 3 stated Resident 31 was seen by podiatrist and was ordered ointment to be applied to his toenails for four months. LVN 3 stated she did not find a care plan for the new order and there should have been a care plan. LVN 3 stated a care plan should have been initiated by the licensed nurse who received the order. LVN 3 stated the care plan was very important to monitor the condition of residents whether there was progress or decline. LVN 3 stated care plan were the responsibility of all licensed nurses. During a concurrent interview and record review on 9/25/24 at 2:40 p.m. with Social Service Director (SSD), the SSD stated she arranged for podiatrist to come in the facility and they come in the facility to see residents every two months. The SSD stated the podiatrist saw Resident 31 on 7/17/24 and 9/17/24. During an interview on 9/27/24 at 2:25 p.m. with the Director of Nursing (DON), the DON stated Resident 31's care plan should have been initiated by the licensed nurse receiving the order. The DON stated care plans are important because it directs the staff on how to care and monitor progress of residents. Care plans are initiated immediately after an order was received. During a review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/16, the P&P indicated, . The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes . Identifying problem areas and their causes, and developing interventions that are targeted and meaningful . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions changes . 49949 3. During an observation on 9/23/24 at 11:50 a.m. in Resident 53's room, an enhanced barrier (infection control strategy to reduce the spread of bacteria) sign was next to the door. Resident 53 stated, he had diarrhea last week. During a review of Resident's 53 Admission Record dated 9/27/24, the admission record indicated, Resident 53 was admitted to the facility on [DATE] with diagnoses which included, Parkinson's Disease(a condition where a part of your brain deteriorates, causing more severe symptoms over time), Gastro-Esophageal Reflux Disease (GERD- condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach), Pain, Schizoaffective (chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors). During a review of Resident 53's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 8/2/24, the MDS, indicated Resident 53 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 53 was cognitively impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's document titled, SBAR [Situation, Background, Assessment, and Recommendation (or Request), is a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue your team needs to address] Communication Form and Progress Note for RNs/LPN/LVNs (SBAR) for Resident 53, dated 9/14/24, the SBAR indicated .Situation .the change in condition, symptoms, or signs observed and evaluated is/are: Diarrhea .This started on 09/14/2024 .since this started it has gotten .(box checked] stayed the same . This condition, symptoms, or sign has occurred before: [box checked] unknown .Review and Notify .primary physician: Yes .Date:9/14/24 .Time:2:30 PM .Testing .[box checked] blood test .[box checked]other .C.diff [a bacterium that can cause diarrhea other intestinal conditions] and stool culture .[box checked] other n/a . During a review of Resident 53's, [Facility Name] Progress Notes *NEW* dated 9/14/24, the progress note indicated, .Situation: The Change in Condition/s report on this CIC evaluate are/were: Diarrhea . During an interview on 9/27/24 at 10: 17 a.m. with the Director of Nurses (DON), the DON stated Resident 53 had diarrhea on 9/14/24 and an SBAR was done. The DON stated, the physician ordered C-Diff and stool culture (a lab test that examines a stool sample for the presence of bacteria or other germs that can cause infection). The DON stated Resident 53's lab results were negative for c-diff. The DON stated, Resident 53 did not have a recent care plan developed for his diarrhea. The DON stated, Resident 53's diarrhea was considered a changed in condition and a care plan for diarrhea should have been done. During an interview on 9/27/24 at 2:58 p.m. with Registered Nurse (RN) 2, RN 2 stated, Resident 53 had a changed in condition when he had diarrhea. RN 2 stated, there was no care plan for the diarrhea on 9/14/24. RN 2 stated, a care plan should have been developed due to a change in condition related to this new problem. RN 2 stated it was important to create a care plan to ensure the residents were getting the proper care. RN 2 stated, the care plan notified other disciples about the change in condition. During an interview on 9/27/24 at 3:06 p.m. with the Minimum Data Set Coordinator (MDSC) 1, the MDSC 1 indicated Resident 53 had a changed in condition when he had diarrhea. MDSC 1 stated, the staff should have done a care plan to reflect the changed in condition. MDSC 1 stated Resident 53 short term care plan. MDSC 1 stated, nurses and the DON were responsible for the short-term care plans. During a review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/16, the P&P indicated, . The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes . Identifying problem areas and their causes, and developing interventions that are targeted and meaningful . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions changes . 51271 2. During a review of Resident 1's Admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 9/25/24, the AR indicated Resident 1 has a history of epilepsy (a brain disease where nerve cells don't signal properly, which causes seizures). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 12 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 1 had moderate cognitive impairment. During an observation on 9/23/24 at 9:15 a.m. in Resident 1's room, the padding on residents left bedrail was not fully intact, and the metal bar was exposed. During a concurrent observation and interview on 9/25/24 at 10:30 a.m. with Certified Nursing Assistant (CNA) 7 in Resident 1's room, the padding on Resident 1's left bedrail was not fully intact, and the metal bar was exposed. CNA 7 stated Resident 1's bed rails were to be padded for easier turning and for Resident 1's protection. CNA 7 stated she was unsure of Resident 1's medical history that would indicate the use of padded rails and the nurses were responsible for communicating to the CNAs During a concurrent observation and interview on 9/25/24 at 10:45 a.m. with CNA 8 in Resident 1's room, the padding on Resident 1's left bedrail was not fully intact, and the metal bar was exposed. CNA 8 stated Resident 1's bedrails should have been fully padded for Resident 1's protection. During a concurrent interview and record review on 9/25/24 at 11:00 a.m. with Registered Nurse (RN) 1, Resident 1's Care Plan, dated 5/24/24 was reviewed. The Care Plan indicated at risk for recurrent seizure episode . padded side rails on bed as indicated . RN 1 stated she did not know why Resident 1's bedrail padding was not intact and properly maintained. RN1 stated both of Resident 1's bedrails should have been padded as indicated on her care plan. RN 1 stated it was the responsibility of the nursing staff to ensure the care plans were being followed. RN 1 stated Resident 1 had a diagnosis of seizures, and she could hurt herself if she hits her limbs on the unpadded rail. During an interview on 9/25/24 at 11:30 a.m. with House Keeping Supervisor (HKS), the HKS stated it was the expectation of nursing staff to log items that need repair in the maintenance log located at nurse's station. During a review of the facility's Maintenance Log dated 9/24, the maintenance log indicated no entries for bed rail padding repair was present for Resident 1's bed. During an interview on 9/27/24 at 9:32 a.m. with the Director of Staff Development (DSD), the DSD stated if a CNA was unsure whether Resident 1's torn siderail padding needed to be replaced, they could have asked the nurses. The DSD stated it was the nurse's responsibility to check the care plan to see if the side rail needed to be padded and then place a work order in the maintenance log. The DSD stated the nurses failed to communicate and implement the care plan's intervention for padded side rails for Resident 1. The DSD stated if Resident 1's siderails were not padded, Resident 1 may have injured herself if she hit the rail. During an interview on 9/27/24 at 11:15 a.m. with the Director of Nursing (DON), the DON stated she expected her staff to report damaged padding to the side rails and write the work order in the maintenance log to be fixed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/17, the P&P indicated, .comprehensive, person centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident . the comprehensive, person centered care plan will: .g. Incorporate identified problem areas h. Incorporate risk factors associated with identified problems . 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents condition change .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 40641 Based on observation, interview and record review, the facility failed to provide services which met professional standards of quality of care for one of five sampled residents (Resident 68) when Resident 68's fluid restriction order was not followed according to the physician order. This failure resulted in Resident 68 consuming more than the allowed fluid intake which could lead to fluid overload and could result in serious health condition. Findings: During a concurrent observation and interview on 9/23/24 at 7:45 a.m. during the initial tour, Resident 68 was sitting up in bed, with an over the bed table placed in front of her with a brown cup was on the bed table. Resident 68 was holding the brown cup and stated she wanted more coffee. During concurrent observation and interview on 9/23/24 at 12:55 p.m. in the dining room, Resident 68 was observed seated at a dining table with two other residents. Observed in front of Resident 68 was an eight-ounce cup (240 cc[cubic centimeter-unit of measurement]) of coffee, clear eight ounces (240 cc) cup containing reddish colored liquid, four-ounce cup (120 cc) containing clear liquid, four ounces (120 cc) two-handled mug with lid containing house shake and four ounces (120 cc) ice cream. The total amount of fluid was 840 cc or 28 ounces. During a review of Resident 68's meal ticket, meal ticket indicated, Notes: May have up to 10 oz [ounces] of fluid per meal . During a review of Resident 68's Admission Record (AR- document containing resident personal information), dated 9/26/24, the AR indicated, Resident 68 was admitted in the facility on 8/27/24 with diagnoses which included psychosis and muscle weakness. During a review of Resident 68's Order Summary Report, dated 9/26/24, the Order Summary Report indicated, .Regular diet Pureed texture, Thin liquids consistency, 1500 ml [milliliter-unit of measurement] fluid restriction in 24 hours . During an interview on 9/23/24 at 12:45 p.m. with certified Nursing Assistant (CNA) 4 in the dining room, CNA 4 checked Resident 68's fluids and stated Resident 68 received more fluid than ordered of 10 ounces. CNA 4 stated we should have followed her fluid restriction and not give her more than 10 ounces per meal. During an interview on 9/23/24 at 12:55 p.m. with Assistant Dietary Service Manager (ADSM) in the dining room, the ADSM stated Resident 68 received more than the ordered amount of fluids. During an interview on 9/26/24 at 9:05 a.m. with Dietary Service Manager (DSM), the DSM stated Resident 68 is on fluid restrictions. The DSM stated the kitchen staff was given the allowed amount of fluids for each meal and that had to be followed. The DSM stated not following the fluid restriction may lead to serious health conditions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/24 at 10:37 a.m. with Registered Dietitian (RD), the RD stated it was important to follow fluid restriction orders because it could lead to more serious health condition like fluid overload which could result in respiratory problems. During an interview on 9/27/24 at 2:20 p.m. with the Director of Nursing (DON), the DON stated the expectation was for staff including kitchen staff to comply with the fluid restriction order. The DON stated Resident 68 was confused and had a tendency to keep requesting more coffee. The DON stated staff needed to keep explaining to Resident 68 why she could not have more coffee. During a review of the facility's policy and procedure (P&P) titled, Tray Identification, dated 4/07, the P&P indicated, . The Food Service Manager or designee will check trays for correct diets before the food carts are transported to their designated areas . If there is an error, the Nurse Supervisor will notify the Dietary Department immediately . According to professional reference https://www.mkuh.nhs. uk/patient-information-leaflet/a-guide-to-fluid-restriction .Fluid retention can range in severity and can cause health problems, such as tissue and blood vessel damage, long-term swelling, and stress on the heart if left untreated. The symptoms of fluid retention will depend on the area it affects. Common areas include the lower legs, the hands, abdomen, and chest. Symptoms might include raised blood pressure, swollen ankles, legs, face or abdomen, and breathlessness. Your treatment team may suggest you follow a fluid restriction diet to help relieve your symptoms .

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424 Based on observation, interview, and record review the facility failed to ensure proper treatment and care to maintain good foot health was performed for one of six sampled residents (Resident 3) when Resident 3's toenails were long, thick, and crooked. This failure had the potential to cause Resident 3 to receive injuries from her toenails digging into her skin. Findings: During a review of Resident 3's Admission Record (AR, documents containing resident demographic information and medical diagnosis), dated 9/25/24, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (condition where the body has trouble controlling blood sugar levels), restless leg syndrome (condition which causes uncontrollable urge to move legs), and Parkinson's disease (a brain disorder which causes unintended or uncontrollable movements, such as shaking and stiffness). During a concurrent observation and interview on 9/25/24 at 11:10 a.m. with Registered Nurse (RN) 1 in Resident 3's room, Resident 3 toenails on both of her feet were long, thick, and crooked. RN 1 stated Resident 3's toenails were really long and not in an acceptable condition. RN 1 stated certified nursing assistants (CNA) should have reported the residents nail conditions to her but none of the CNAs ever had. During an interview on 9/25/23 at 11:50 a.m. with CNA 1, CNA 1 stated she was familiar with the condition of Resident 3's nails. CNA 1 stated Resident 3 had not received any nail care because she kept refusing. CNA 1 stated CNAs can report the condition of a patient's toenails to a nurse to make them aware. CNA 1 stated if Resident 3's toenails were not clipped they could have cut her skin which would be difficult to treat since she was a diabetic. During a concurrent interview and record review on 9/30/24 at 3:03 p.m. with the Social Services Director (SSD), Resident 3's podiatry notes, dated 5/15/24, 7/17/24, and 9/18/24, were reviewed. The podiatry notes indicated Resident 3 had refused all her podiatry visits. The SSD stated if staff had alerted her about Resident 3's toenail condition and frequent refusals she could have put in a referral for Resident 3 to be seen by a podiatrist in a private office or call the responsible party to try to get Resident 3 to comply with nail care. During a concurrent interview and record review on 9/27/24 at 9:13 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 3's podiatry visits, dated 5/15/24, 7/17/24, and 9/18/24, were reviewed. The Podiatry visits indicated Resident 3 had refused all visits. LVN 6 stated it was not ok for Resident 3 to continue refusing nail care, the facility should have taken steps to help trim her toenails. LVN 6 stated Resident 3 was diabetic and if her nails kept growing, she could get skin breakdown, an infection (when germs invade and multiply in the body), or ulcers (open sores that develop on the skin). LVN 6 stated staff should have called her responsible party after every podiatry refusal to try and get her to comply with toenail care. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/27/24 at 9:45 a.m. with the Director of Staff Development (DSD) the DSD stated CNAs should have been looking at Resident 3's feet and toenails during showers and reporting anything concerning to the nurse. The DSD stated CNAs were trained to report long jagged nails to the nurses for to ensure residents receive the care they needed. During an interview on 9/27/24 at 10:17 a.m. with the Infection Preventionist (IP) the IP stated her expectation was for CNAs to document residents nail condition and report to the nurses. The expectation for the nurses was to follow up on what was reported and try to act against the problem. The IP stated if Resident 3's nails kept growing they could have become ingrown and caused an infection. Resident 3 was diabetic, and diabetics were prone to foot infection issues. During a concurrent interview on 9/27/24 at 10:52 a.m. with the Director of Nursing (DON) and the Administrator (ADM), the ADM stated if Resident 3 refused podiatry visits multiple times the facility needed to do extra interventions to get the nail care done for Resident 3. The DON stated it was important for Resident 3 to receive their nail care because it helped maintain their skin integrity. The DON stated Resident 3 was diabetic and diabetics could get a cut that would have been difficult to heal due to their diabetes. During a review of the facility's policy and procedure (P&P) titled, Foot Care, dated 3/18, indicated, . Residents will receive appropriate care and treatment in order to maintain mobility and foot health . 1. Residents will be provided with foot care and treatment in accordance with professional standards of practice 2. Overall foot care will include the care and treatment of medical conditions associated with foot complications (e.g. diabetes .) 3. Residents will be assisted in making transportation appointments to and from specialists (podiatrist [doctor who specializes in feet .]as needed) .

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NAME OF PROVIDER OR SUPPLIER Sierra Vista Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1715 South Cedar Fresno, CA 93702	

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure the facility medication error rate did not exceed five percent (11.54%) when: 1. Licensed Vocational Nurse (LVN) 3 administered glucophage (medication used to treat diabetes) medication and methenamine (medication used to treat urinary bladder infection suppression]) without food and did not follow instructions for medication administration with food. This failure had the potential for Resident 44 to develop gastrointestinal upset (GI-gastric upset like diarrhea) which could lead to serious health condition. 2. LVN 1 did not follow medication direction when he administered Polyethylene Glycol (medication used to treat constipation) to Resident 244. This failure had the potential for Resident 244 to develop constipation which could lead to serious health condition. Findings: 1. During a concurrent medication administration pass observation and interview on 9/25/24 at 8:40 a.m. at Station 1, LVN 3 was preparing Resident 44's medications. LVN 3 administered Resident 44's medications without food. LVN 3 stated Resident 44 ate breakfast at approximately 7:30 a.m. LVN 3 stated the medication direction were to administer metformin and methenamine with food. LVN 3 stated she did not give food to Resident 44 when she administered medications. LVN 3 stated medication given on an empty stomach could cause GI distress. During a review of Resident 44's Admission Record, dated 9/26/24, the admission record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar level in the blood), malignant neoplasm (cancerous tumor or abnormal growth of tissue that can spread to other parts of the body) and nausea with vomiting. During a review of Resident 44's Order Summary Report, (OSR) dated 9/26/24, the OSR indicated, . metformin HCl[brand name][hydrochloride] Oral 500MG [milligram-unit of measurement] Give one [1] tablet by mouth two times a day for Diabetes administer with food . Methenamine Mandalate Oral Tablet . administer with food . During an interview on 9/26/24 at 9:46 a.m. with the Assistant Director of Nursing (ADON), the ADON stated medication order with directions to give with food should be followed. The ADON stated licensed nurses should follow medication order directions. The ADON stated licensed nurses should have administered medication while the resident was eating to prevent GI distress. During an interview on 9/26/24 at 10:25 a.m. with the Director of Staff Development (DSD), the DSD stated LVN 3 should have followed the medication order direction when she administered Resident 44's medications. The DSD stated LVN 3 should have given Resident 44 a snack when she administered Resident 44's medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 7/25/24 at 8:58 a.m. in Station 1, LVN 1 was passing medication. LVN 1 prepared Resident 244's medications and administered six of seven medications scheduled for Resident 244. LVN 1 prepared Resident 244's Polyethylene Glycol and mixed in a four ounces cup with water. LVN 1 stated he mixed the polyethylene medication with four ounces of water and administered to Resident 244. During a review of Resident 244's Admission Record, dated 9/26/24, the admission record indicate Resident 244 was admitted to the facility on [DATE], with diagnoses which included orthopedic (bone) aftercare, polyneuropathy (malfunction of many nerves throughout the body) and muscle weakness. During a review of Resident 244's, Order Summary Report, dated 9/26/24, the Order Summary Report indicated, . Polyethylene Glycol 3350 Powder . mix with eight [8] ounces of water or juice . During a concurrent interview and record review 9/25/24 at 10:40 a.m. with LVN 1, he reviewed Resident 244's medication order and stated the medication direction indicated to mix the polyethylene powder with eight ounces of water. LVN 1 stated he used four ounces of water to mix the medication. LVN 1 stated he did not follow the medication direction which cause GI discomfort because the medication was too concentrated (thick) for Resident 244 to drink. During an interview on 9/26/24 at 10:28 a.m. with the Director of Staff Development (DSD), the DSD stated LVN 1 should have followed polyethylene glycol medication instruction to mix with eight ounces of water. The DSD stated not following the instruction to mix the medication with eight ounces of water resulted in more concentrated medication which could have led to gastrointestinal upset and or inefficient absorption. During an interview on 9/27/24 at 10:08 a.m. with LVN 1, LVN 1 stated it was important to follow ordered medication instructions when administering medications. LVN 1 stated not giving medication with foodas instructed could affect the GI system and irritate the stomach lining which could lead to more serious health condition. During an interview on 9/27/24 at 2:50 a.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses to follow medication directions to prevent adverse reaction which could lead to more serious health condition. During a review of facility's policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, dated 4/14, the P&P indicated, . medication error is defined as the preparation or administering of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional's providing services . Examples of medication errors include: .Failure to follow manufacturer instructions and/or accepted professional standards .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 40641 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with current accepted professional standards of practice when: 1. Two of four medication carts were found unlocked and unattended by Licensed nurses. This failure had the potential for residents, staff, and visitors to access the medication carts. 2. Polyethylene glycol 3350 was left on top of the medication cart 1 unattended in Station 1. This failure had the potential risk of other residents, staff and visitors walking by and gaining access to the medication and could lead to adverse effect when taken without a prescription. 3. An expired bottle of Lactulose (a non-absorbable sugar used in the treatment of constipation), was observed in the medication cart. This failure had the potential for Resident to receive expired medication which could have undesired effects. Findings: 1. During a concurrent observation and interview on 9/25/24 at 8:50a.m. with Licensed Vocational Nurse (LVN) 1, the medication cart was observed unlocked and unattended in the hallway of station 1 outside of room [ROOM NUMBER], LVN 1 was inside a resident room and did not have direct sight of medication cart. LVN 1 stated the medication cart should always be locked when unattended. LVN 1 stated an unlocked medication cart was accessible to residents, staff and visitors walking by and they may grab medications from the medication cart and drink medication which could lead to adverse reactions. During a concurrent observation and interview on 9/25/24 at 3:35 p.m. with LVN 2 in Station 2 hallway outside of Resident 34's room. LVN 2 walked in resident 34's room and left her medication cart unlocked and unattended with residents, staff and visitors walking by. LVN 2 stated she should have made sure her medication cart was locked before she entered Resident 34's room. LVN 2 stated the unlocked medication cart was unattended and any residents, staff and visitors walking by could access the medications inside the medication cart and drink medication which could lead to adverse reaction. During a review of Resident 34's Admission Record, (AR-document containing resident personal information) dated 9/26/24, the AR indicated Resident 34 was admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar level in the blood), hemiplegia and hemiparesis (weakness to one side of the body) and muscle spasm. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/26/24 at 10:20 a.m. with the Director of Staff Development (DSD), the DSD stated the practice was to never leave a medication cart unlocked and unattended. The DSD stated an unlocked medication carts was easily accessible by residents, staff and visitors walking by. The DSD stated licensed nurses should never leave their medication carts unlocked and unattended. During an interview on 9/27/24 at 2:40 p.m. with the Director of Nursing (DON), the DON stated her expectation was to make sure medication carts were locked when not within the licensed nurses sight. The DON stated licensed nurses should always make sure to lock their medication carts when they walked inside resident room. 2. During a concurrent observation and interview on 9/25/24 at 8:59 a.m. with LVN 1 in station 1 hallway outside of Resident 244. LVN 1 walked inside Resident 244's room and left a bottle of medication on top of his medication cart. LVN 1 did not have sight of the medication on top of the medication cart. LVN 1 stated it was his fault he left the medication unattended on top of the medication cart. LVN 1 stated the practice was to make sure no medications were left on top of the medication cart because any residents, staff or visitors walking by could grab and drink medication which could lead to drug reaction or overdose of medication. During a review of Resident 244's Admission Record, dated 9/26/24, the AR indicated, Resident 244 was admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure), muscle spasm and muscle weakness. During an interview on 9/27/24 at 2:45 p.m. with the Director of Nursing (DON), the DON stated it was not acceptable to leave any medication on top of the medication cart unattended. DON stated, .Any medications left on top of the medication cart unattended is accessible to other residents, staff and visitors walking by . The DON stated any residents, staff and visitors could grab medication hide it and or distribute to other residents which could lead to serious health condition. During a review of facility's policy and procedure titled (P&P), Medication Administration-General Guidelines, dated 10/17, the P&P indicated, medications are administered as prescribed in accordance with good nursing principles and practices . During administration of medications, the medication cart is kept closed locked and secure. The medication cart needs to be secured and locked when unattended . 41608 3. During a concurrent interview and record review on 9/26/24 at 10:20 a.m. with Licensed Vocational Nurse (LVN) 5, in station two at medication cart (med cart) 2, a bottle of Lactulose was observed with the expiration date of 9/13/24. LVN 5 stated the medication carts should be checked every shift for expired medications. LVN 5 stated expired medications could no longer have the same effect or may have undesired side effects. During an interview on 9/26/24 at 11:07 a.m. with the Assistant Director of Nurses (ADON), in Medication Room two, the ADON stated, the lactulose should not have been in the med cart. Expired medication could not be as effective and could cause side effects that could be harmful to residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facilities policy and procedure (P&P) titled, Medication Storage in The Facility dated 1/2018, the P&P indicated, . E. The nurse will check the expiration date of each medication before administering it. F. No expired medication will be administered to a resident. G. All expired medication will be removed from the active supply and destroyed in the facility, regardless of amount remaining . I. Nursing staff should consult with dispensing pharmacist for any questions related to medication expiration dates . During a review of the facilities P&P titled, Specific Medication Administration Procedures (undated), indicated, To administer medications in a safe and effective manner . E. Check expiration date on package/container . During a review of the facilities P&P titled, HR Manual: Job Description . Licensed Vocational Nurse dated 10/19/2015, the P&P indicated, .Responsibilities/Accountabilities . 2. Care Planning: . 2.4. Evaluates effectiveness of interventions to achieve patient goals and minimize re-hospitalization s . 3. Provision of Direct Patient Care: 3.1. Administers medications and performs treatments per physician orders .

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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. 49949 Based on observation, interviews and record review, the facility failed to ensure Dietary [NAME] (DC) 1 was competent to carry out the functions of the food and nutrition services safely and effectively when DC 1 did not check the internal temperature of three pork loins prior to prepping to serve and was not able to be verbalize the cooking or process of reheating cooked food per the facility's policy. This failure had the potential to result in unsafe food being served, consumed, and could have cause food borne illness. Findings: During an observation on 9/24/24 at 10:18 a.m. in the kitchen, DC 1 was observed removing a baking tray containing three pork loins out of the oven without checking the internal temperature. DC 1 took the baking tray containing the three pork loins to the prep area for preparing to slice the pork loins for service. During an interview on 9/24/25 at 10:30 a.m. in the prep area, with DC 1, DC 1 stated he worked for the facility for three weeks. DC 1 stated he did not check the internal temperature of the pork loin. DC 1 stated he was not sure what the internal temperature of the pork loin was. DC 1 stated he should have checked the temperature of the pork loin when he first took it out of the oven. During an interview on 9/26/24 at 11:23 a.m. with the Dietary Service Manager (DSM), the DSM stated, DC 1 should have checked the temperature of the meat after taking it out of the oven to ensure the internal temperature was safe. The DSM stated the pork loin was precooked but DC 1 should have checked the temperature of the pork loin to ensure it was warmed properly. The DSM stated, residents could get sick if the food was not cooked according to the required temperature. The DSM stated, uncooked food could cause food borne illness. During an interview on 9/26/24 at 11:56 a.m. with the Dietitian, the Dietitian stated the DC 1 should have check the temperature of the pork loin after removing it from the oven. The Dietitian stated the pork loin should have been the temperature of what the recipe called for. The Dietitian stated the Dietary Service Manager was responsible to train DC 1. The Dietitian stated uncooked food had the potential to cause food borne illness. During a review of facility's policy and procedure titled, [Facility Name] #104-0004 .Preparation Instructions . convention oven: cover pain with foil and heat at 350-degree Fahrenheit for 15-17 minutes per pounds . During a review of the facility's job description titled, [NAME] dated 2003, the job description indicated, The primary purpose of your job position is to prepared food in accordance with current applicable federal, stated and local standards, guidelines and regulations with our established policy and procedures . Specific Requirements .must be knowledge of food procedures . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Food Preparation and Service dated revised 10/2017, the P&P indicated, Food Preparation, Cooking and Holding Temperatures and Times . previously cooked food must be heated to an internal temperature of 165- degree Fahrenheit for at least 15 seconds . During a profession reference review retrieved on 10/1/2024 from https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/kitchen-thermometers#:~:text=Why%20Use%20a%20Food%20Thermometer,may%20be%20in%20the%20food, .It is essential to use a food thermometer when cooking meat, poultry, and egg products to prevent undercooking, verify that food has reached a safe minimum internal temperature, and consequently, prevent food borne illness .Using a food thermometer is the only reliable way to ensure safety and to determine desired doneness of meat, poultry, and egg products. To be safe, these foods must be cooked to a safe minimum internal temperature to destroy any harmful microorganisms that may be in the food .A food thermometer should also be used to ensure that cooked food is held at safe temperatures until served. Cold foods should be held at 40 F or below. Hot food should be kept hot at 140 F or above .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 51271 Based on observation, interview and record review, the facility failed to determine and document resident meal preferences for one six sampled residents (Resident 11) when Resident 11 did not have his dislikes listed on his meal ticket (a document which indicates a resident's diet, allergies, preferences, and dislikes.) This failure resulted in resident 11 not eating his lunch on 9/23/24 and caused him to not receive the nutritional benefits of his meal. Findings: During a review of Resident 11's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 11 had no cognitive impairment. During an interview on 9/23/24 at 9:00 a.m. with Resident 11, Resident 11 stated he disliked Italian food and stated it was served frequently in the facility. During a concurrent observation and interview on 9/23/24 at 12:49 p.m. with Resident 11, Resident 11's lunch tray contained spaghetti, chopped zucchini, garlic bread, carton of milk, glass of water and chocolate ice cream. Resident 11 stated he did not like Italian food or zucchini, and he would not eat the provided meal. Resident 11 stated he did not want meal alternatives because the provided lunch ruined his appetite, and he did not want to ask staff for a meal alternative. During a concurrent interview and record review on 9/23/24 at 12:49 p.m. with Resident 11, Resident 11's Meal Ticket, dated 9/23/24, was reviewed. The Meal Ticket did not have any preferences or likes listed on it. Resident 11 stated he did not like Italian food and no one had documented his dislike of Italian food on his Meal Ticket. During an interview on 9/24/24 at 11:00 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated it was the nurse's responsibility to check meal trays for accuracy. If the resident received a meal they did not like, CNAs could go to the kitchen directly and get the resident an alternate meal or snack. If CNAs and nurses noticed Resident 11's meal tray was mostly untouched, it was their responsibility to ask the resident if they liked the provided meal. CNA 1 stated it was important to give residents their preferred meals because residents would have an easier time eating food they liked. During an interview on 9/24/24 at 11:15a.m. with Registered Nurse (RN) 1, RN 1 stated it was the nurse's responsibility to check each meal tray and ticket for accuracy. Such checks included verifying correct resident name, allergies listed, diet type, consistency, restrictions, and preferences. RN 1 stated CNA's can help check the meal as well, but the responsibility for tray accuracy relied on the nurses. RN 1 stated residents had the right to receive meals they actually preferred. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/25 at 11:00 a.m. with the Assistant Dietary Services Manager (ADSM), the ADSM stated it was the responsibility of the dietary department to document residents' food preferences. This task should have been done shortly after residents' admission to the facility. The ADSM stated it was important for residents to receive their preferred meals because it ensured residents were getting their full nutrition. During an interview on 9/25/25 at 11:15 a.m. with the Dietary Services Manager (DSM), the DSM stated one of her responsibilities was to ensure meal tickets were completed and accurate for each resident. If a resident needed changes to be done to their meal preferences, it was the expectation for nursing staff and kitchen staff to have open communication to ensure meal preferences were current and accurate. The DSM stated it was important for residents to receive meals in accordance with their preferences because it helped ensure residents actually received the meals they liked. During an interview on 9/25/25 at 2:00 p.m. with the Registered Dietitian (RD), the RD stated the facility policy was for staff to get residents an alternate meal if they requested one or if it appeared most of the meal was untouched. The process involved the CNA or RN going to the kitchen and bringing updated preferences to kitchen staff's attention. The RD stated it was her expectation nursing staff would have escalated such issues to kitchen staff if the resident had changes in meal preferences which may not have been previously discussed. During a concurrent interview on 9/27/24 at 11:22 a.m. with the Director of Nursing (DON) and the Administrator (ADM), the DON stated nurses were responsible for checking the accuracy of meal trays during meal delivery. The ADM stated if nurses or CNAs noticed a resident did not eat the food, they should have asked the resident why in order to figure out what the problem was. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services, dated 2017, indicated .Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident . During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, dated 2017, indicated . if the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with .when possible, staff will interview the resident directly to determine current food preferences .

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure adaptive equipment was provided for one of three sampled residents (Resident 68) when Resident 68 was not provided built-up utensils on her meal tray. This failure had the potential to limit Resident 68's ability to feed herself independently and safely. Findings: During an observation on 9/23/24 at 12:45 p.m. in the dining room, Resident 68's meal tray had a regular spoon and fork. During a review of Resident 68's Admission Record, dated 9/26/24, the Admission Record indicated Resident 68 was admitted to the facility on [DATE] with diagnoses which included psychosis (set of symptoms that can cause someone to lose touch of reality and have difficulty distinguishing what is real and what is not), and muscle weakness. During a review of Resident 68's Order Summary Report (OSR), dated 9/26/24, the OSR indicated, . Resident to have a divided plate and built-up utensils for use during meals, and a 2-handled mug with lid for liquids . During a review of Resident 68's Meal Ticket (MT), MT indicated, Adaptive Equip [equipment]: Built-Up Utensils. During an interview on 9/24/24 at 12:50 p.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated Resident 68's meal ticket indicated she should have built-up utensils on her meal tray and not regular utensils. CNA 4 stated built-up utensils have a big plastic foam handle in order for Resident 68 to hold the utensils and feed herself better. During an interview on 9/24/24 at 12:55 p.m. with Assistant Dietary Service Manager (ADSM), the ADSM stated dietary aides are responsible for making sure the correct utensils are placed on the meal trays for residents. ADSM stated Resident 68 should have gotten built-up utensils. During an interview on 9/24/24 at 12:58 p.m. with Dietary Aide (DA)1, DA 1 stated dietary aides are responsible for making sure the right utensils are placed on residents' meal trays. DA 1 stated the dietary aides should have made sure to inspect and done a final check before the tray cart was sent out, but they did not. During an interview on 9/26/24 at 8:59 a.m. with Dietary Service Manager (DSM), the DSM stated kitchen staff should have made sure Resident 68 was given the built-up utensils on her meal trays. The DSM stated dietary aides are responsible for making sure special utensils are placed on Resident 68's meal tray. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Vista Healthcare	1715 South Cedar Fresno, CA 93702

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/27/24 at 10:45 a.m. with Registered Dietitian (RD), the RD stated dietary aides are responsible for placing special utensils on meal trays. RD stated nursing staff is responsible to checked Resident 68's meal tray for accuracy and the nursing assistant served the tray to Resident 68. RD stated she was not sure how three pairs of eyes missed the built-up utensils not being on Resident 68's meal tray. During a review of facility's policy and procedure (P&P) titled, SELF-FEEDING DEVICES, dated 2023, the P&P indicated, . Devices commonly used . such as divider plates and feeding cups, will be kept in stock. A physician's order is recommended . The Food and Nutrition Services Department will store self-feeding devices. Residents needing devices will receive them with each meal or snack, on their meal trays. Tray cards and diet profile will record which device is needed .

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49949 Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food preparation and storage practices were followed for 87 of 91 residents when: 1. A serving cart was observed with a white powdered substance spilled and scattered throughout the top surface. 2. A storage room in the kitchen was observed with dirt and debris on the floor and the base boards were peeling and missing from one side of the wall. These failures placed residents at risk for foodborne illnesses (illness caused by consuming contaminated food) and had the potential to attract pest and rodents. Findings: 1. During a concurrent observation and interview on 9/23/24 at 7:35 a.m. with the Dietary Manager Supervisor (DMS) in the kitchen, a white powdered substance was spilled and scattered on the top of the serving cart. On the serving cart was two serving tray, a box of gloves, a box of aprons, a roll of clear garbage bags and a plastic holder container for utensil. The DMS stated, The serving cart should not be like that. The DMS stated the dirty serving cart can cause contamination and should be cleaned daily to prevent infection. The DMS stated the dirty serving cart was not acceptable and it was the responsibility of the dietary aid to clean the dirty serving cart. 2. During a concurrent observation and interview on 9/23/24 at 7:37 a.m. with the DMS in the storage room in the kitchen, a base board was missing from one wall of the room. A rack containing cleaning supplies, had dirt, debris and a green plastic cap on the floor under the rack. The DMS, the DMS stated the maintenance was responsible for fixing the floors, baseboards and painting the rooms. The DMS stated, the area was not clean, and was an eye sore. The DMS stated, the floor should be cleaned, and the baseboard should be replaced. During an interview on 9/26/24 at 11:57 a.m. with the Registered Dietitian (RD), the RD stated the serving cart should be cleaned daily. The RD stated it was important to clean the cart to prevent cross-contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another). The RD stated, the storage room should not have anything on the floor. The RD stated, the kitchen storage room wall should have a baseboard. The RD stated it was important to keep the area clean to prevent pest attraction. The RD stated the room was not properly cleaned and it should have been. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/24 at 2:33 p.m. with the Administrator (ADM), the ADM stated he has been the administrator for 1.5 yrs. The ADM stated, the serving care should be cleaned daily and as needed when it was dirty. The ADM stated the cart should have cleaned before the staff placed any items on the cart. The ADM stated it was important to keep the serving cart clean to prevent cross- contamination and infections. The ADM stated he saw the missing baseboard in the room, and it was not a priority on the janitor's list and was the last thing to do. The ADM stated, the room should have been cleaned and the missing baseboard should have been replaced because keeping the room clean is important. During a review of the facility's policy and procedure (P&P) titled, Kitchen Sanitation: Definition of Terms dated 2023, the P&P indicated, .Standard of cleanliness need to be defined in order to clearly understand the type and scope of procedure to be used in the Food & Nutrition Service Department Cleaning .removal of soil, particles and debris and microorganisms adherent to surface . During a review of the professional reference titled, USFDA Food Code, dated 2017, the USFDA Food Code indicated, . Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils (A): Equipment food-contact surfaces and utensils shall be clean to sight and touch . During a review of the professional reference titled, USFDA Food Code, dated 2017, the USFDA Food Code indicated, . 4-602.13 Non FOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues . During a review of the professional reference titled, USFDA Food Code, dated 2017, the USFDA Food Code indicated, . 501.113 Storing Maintenance Tools . Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be: (A)Stored so they do not contaminate FOOD, EQUIPMENT,UTENSILS, LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES; and (B) Stored in an orderly manner that facilitates cleaning the area used for storing the maintenance tools .

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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** 48424 Based on observation, interview, and record review the facility failed to ensure an infection prevention and control program was maintained for 91 of 91 sampled residents when: 1. A room containing five full sharps containers (a bin used to store needles which have been used on residents) was unlocked and accessible to 91 of 91 residents. The sharps containers were stacked on top of each other. One of those containers was full and did not have a lid covering it. This failure had the potential to cause residents to enter the room and hurt themselves if they touched the exposed sharps. 2. Resident 58's oxygen concentrator (a medical device which provides oxygen to a resident) filter was covered in dirt, dust, and lint like materials. This failure had the potential to introduce contaminants (materials which can make something dirty) into the oxygen supply and cause Resident 59 to breathe in dirty air. 3. Resident 61 and Resident 3's oxygen concentrator filters were covered with grayish white material. This failure could result in Resident 61 and Resident 3 to develop serious respiratory health problems. 4. Resident 345's oxygen tubing was not labeled with the date it was changed. This failure had the potential to put Resident 345 at risk for possible respiratory infection. Findings: 1. During a concurrent observation and interview on 9/26/24 at 11:52 a.m. with Licensed Vocational Nurse (LVN) 1 near nurses' station 1, a room containing five full sharps containers was accessible to residents. The sharps containers were stacked on top of each other. One of those containers was full and did not have a lid covering it. LVN 1 stated the room was used by the lab collection company contracted by the facility. The lab company's employees were using the room to store their equipment and sharps. LVN 1 stated the sharps containers should not have been stacked on top of each other and the open sharps container should have had a lid to prevent injuries. (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 concurrent interview on 9/26/24 at 12:23 p.m. with the Director of Nursing (DON) and the Infection Preventionist (IP), the DON stated the room which contained the sharps containers was utilized by the outside contracted company who store their supplies. The DON stated the facility needed to incorporate the room in their infection control program since it was in their facility. The DON stated staff should have also reported to her if they noticed the sharps containers were in an unacceptable condition, like sharps containers being full and having no lid. The IP stated her expectation was for staff to have brought up the condition of the room to her because there was potential for residents to walk into the room and puncture themselves with supplies in the sharp's containers. The IP stated it was important for staff to monitor the room and keep it in an acceptable condition because it could have led to cross contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another) across the facility. During an interview on 9/26/24 at 2:31 p.m. with the Phlebotomist (PHL), the PHL stated the room containing all the sharps containers was used by the lab company to store all of their equipment. The PHL stated none of the sharp's containers should have been stacked on top of each other, the lab company's staff should have been disposing of the sharps containers as they got full. The PHL stated she was surprised by how the sharps containers were being stored in the room. The PHL stated it looked like the room had accumulated over a week's worth of sharps containers. The PHL stated there should not have been any containers without covers because they had the potential to fall and spill all of their contents on the floor. During an interview on 9/27/24 at 10:17 a.m. with the IP, the IP stated even though a separate company was storing sharps containers in the facility, it was still the responsibility of the facility staff to ensure their storage practices followed infection control standards. During a concurrent interview on 9/27/24 at 10:52 a.m. with the DON and the Administrator (ADM), the ADM stated it was not acceptable to have the sharps containers stacked on top of each other or with missing lids. The ADM stated even if the storage was left by an outside company, it was still the responsibility of the facility and the staff to ensure everything was stored appropriately. The DON stated it was the responsibility of staff to notify their supervisor if they identified any issue with the room. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 2018, the P&P indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . important facets of infection prevention include: . Educating staff and ensuring that they adhere to proper techniques and procedures .instituting measures to avoid complications or dissemination (spread) . During a review of the facility's P&P titled, Sharps Disposal, dated 1/12, indicated, . contaminated sharps will be discarded into containers that are a. closeable . 3. During use, containers for contaminated sharps will be handled as follows .b. Nursing staff will ensure that the containers are maintained in an upright position throughout use; and c. Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks .7. Whoever observes incorrect disposal or handling of contaminated sharps should report the information to the Infection Preventionist . 51271 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a review of Resident 58's Admission Record (AR-a document that s) provides resident contact details, a brief medical history, level of functioning, preferences and wishes) dated 9/25/24, the AR indicated Resident 58 had a history of asthma (a chronic lung disease that makes breathing difficult by causing inflammation and narrowing of the airways) and dependence of supplemental oxygen (person requires continuous use of oxygen therapy to maintain adequate oxygen levels). During a concurrent observation and interview on 9/23/24 at 9:17 a.m. in Resident 58's room, Resident 58's oxygen concentrator filter was covered in dirt, dust and lint. Resident 58 stated she received continuous oxygen via nasal cannula (a thin, flexible tube that goes around the ears and into the nose). During a concurrent interview and record review on 9/26/24 at 3:11 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she was not permitted to handle Resident 58's oxygen concentrator or cannula. It was the responsibility of the nurse to maintain resident oxygen devices and equipment at the facility. CNA 2 stated if there were any potential issues she noted, she would report them to the nurse. During a concurrent interview and record review on 9/26/24 at 3:30 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 58's Physician Orders, dated 9/26/24, were reviewed. The Physician Orders indicated Resident 58 was ordered oxygen at 2 liters per minute (flow rate) from a nasal cannula, albuterol sulfate (medication used to prevent and treat difficulty breathing caused by lung disease) via nebulizer (machine which changes liquid medicine into droplets which are inhaled through a mouthpiece or mask) as needed, and budesonide (medication which treats a variety of conditions by reducing swelling in the body) via nebulizer every six hours. LVN 2 sated Resident 58 was receiving oxygen for her asthma. LVN2 stated Resident 58 had always received oxygen through her nasal cannula. LVN 2 stated she was not aware of where the oxygen concentrator filters were located on the oxygen concentrator or how to clean them. During an interview on 9/27/24 at 11:30 a.m. with Director of Staff Development (DSD), DSD stated it was the expectation of the facility for CNAs to escalate potential issues or concerns regarding the oxygen concentrator to a nurse. During an interview on 9/27/24 at 12:00 p.m. with the IP, the IP stated the expectation was for all oxygen concentrator filters to be changed every Friday. The IP stated this expectation was communicated to staff when they got hired. The IP stated the filters on the oxygen concentrator suck in air from the outside. The IP stated it was important to change out the oxygen concentrator filters because it ensured Resident 58 could breathe in clean air. During an interview on 9/27/24 at 11:04 a.m. with the DON, the DON stated the expectation was for the nurses to wash and clean the oxygen concentrator filters, they should have cleaned them every seven days or as needed. The DON stated if the filters were not clean, dust and lint could have been breathed in by Resident 58. (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 review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 2018, the P&P indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . important facets of infection prevention include: . Educating staff and ensuring that they adhere to proper techniques and procedures .instituting measures to avoid complications or dissemination (spread) . During a review of facility's P&P titled, Respiratory Therapy - Prevention of Infection, dated 11/15/23, the P&P indicated, . Infection Control Considerations Related to Oxygen Administration . Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry . 40641 3. During observation on 9/23/24 at 7:45 a.m. in Resident 61's room during initial tour, Resident 61 was lying in bed, eyes closed and appeared comfortable. Resident 68 was noted with a oxygen cannula connected to the oxygen concentrator. Resident 68 did not answer questions when asked. Resident 68's oxygen concentrator filter was observed covered with grayish white materials. During a concurrent observation and interview on 9/23/24 at 8:30 a.m. during initial tour in Resident 3's room, Resident 3 was observed lying in bed watching Television. Resident 3 was observed using oxygen via nasal cannula connected to a oxygen concentrator. Resident 3's oxygen concentrator filter was found covered with grayish white lint like material. Resident 3 stated she did not have any concerns. During a concurrent observation and interview on 9/23/24 at 8:35 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the Resident's 3 and 61's oxygen concentrator filters were not clean, the filters were covered with white lint like material. LVN 3 stated the oxygen filters needed to be cleaned. LVN 3 stated dirty oxygen filters placed residents using oxygen at risk for respiratory illness and they are already compromised. LVN 3 stated she was not sure who was responsible in cleaning and replacing the oxygen filters. During an interview on 9/23/24 at 8:50 a.m. with Assistant Director of Nursing, the ADN stated housekeeping are responsible in changing and cleaning oxygen concentrator filters. During a concurrent observation and interview on 9/23/24 at 9:04 a.m. with Housekeeping Supervisor (HKS), HKS verified Residents' 61 and 3's oxygen concentrator filters are covered with lint like materials and stated, . the oxygen concentrator filters are dirty and should have been cleaned . The HKS stated housekeeping role was to clean oxygen concentrators after resident discharged . The HKS stated it was not housekeeping's job to clean or replace oxygen concentrator filters while a resident is in the facility. The HKS stated she did not know who was responsible in cleaning oxygen concentrator filters for current residents. (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 concurrent observation and interview on 9/23/24 at 9:25 a.m. with Infection Preventionist (IP), Residents' 61 and 3's oxygen concentrator filters are observed and IP stated, . It does not look like they were cleaned at all . The IP stated licensed nurses are responsible in making sure to clean oxygen concentrator filters. The IP stated licensed nurses replaced nasal cannulas every week and should have been cleaning and/or replacing oxygen concentrator filters at the same time. The IP stated not cleaning oxygen concentrator filters could exacerbate respiratory condition which could result in more serious respiratory health problems. During an interview on 9/27/24 at 2:30 p.m. with the Director of Nursing (DON), the DON stated oxygen concentrator filters are cleaned and replaced every seven days and as needed. The DON stated there was a miscommunication about who was responsible in cleaning and replacing the oxygen concentrator filters. The DON stated licensed nurses will be cleaning and replacing oxygen concentrator filters every seven days when nasal cannulas are replaced. The DON stated dirty filters could further worsen respiratory problems of residents' using oxygen. During a review of facility's policy and procedure (P&P) titled, Respiratory Therapy - Prevention of Infection, dated 11/15/23, the P&P indicated, . Infection Control Considerations Related to Oxygen Administration . Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry . 49949 4. During a review of Resident 345's Admission Record (document containing resident demographic information and medical diagnosis) dated 9/26/24, the admission record indicated, Resident 345 was admitted to the facility on [DATE]. Resident 345's diagnosis included Covid 19 (infectious disease caused by the SARS-CoV-2 virus) chronic Obstructive Pulmonary Disease (COPD- a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe), Acute Respiratory Failure (occurs when the lungs and blood have impaired gas exchange, resulting in low oxygen levels in the body's tissues) and Depression. During a review of Resident 345's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 9/26/24, the MDS, indicated Resident 345 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 345 was moderately cognitively intact. During an observation on 9/23/24 at 11:15 a.m. in Resident 345's room, Resident 345 had a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) connected to an oxygen concentrator (medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen). The nasal cannula tube did not have the date written on it. During an interview on 9/23/24 at 11:15 a.m.in Resident 345's room, Resident 345 stated she was admitted to the facility for one week for covid-19. Resident 345 stated she was not sure when the nasal cannula tube was changed. (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 on 9/23/24 at 11:25 a.m. with Registered Nurse (RN) 2, RN 2 stated, the nasal cannula tube should have had the date on it. RN 2 stated the nasal cannula tube should had been replaced every week. RN 2 stated the nurses and central supply person was responsible to change the nasal cannula tube weekly. RN 2 stated, the nasal cannula tube needed to be changed weekly to prevent clogging. RN 2 stated, the nasal cannula needed to have a date to make sure it was changed weekly. RN 2 stated, Resident 345 was at risk for respiratory failure with a clogged nasal cannula tube. During an interview on 9/26/24 at 12:23 p.m. with the Infection Preventionist (IP), the IP stated, the nasal cannula tube should have had a date on it. The IP stated, the nasal cannula tube should had been changed every seven days and as needed when the nasal cannula tube was clogged or dirty. The IP stated, it was important to date the nasal cannula tube, so staff knew when to changed it. The IP stated, When we date the [nasal cannula] tubing it is to make sure the residents had a clean tubing. The IP stated, the tubing had to be changed to prevent a respiratory infection. The IP stated, the nasal cannula tube had to be dated to changed timely. During an interview on 9/26/24 at 12:30 p.m. with the Director of Nursing (DON) the DON stated, My expectation is to make sure they [nasal cannula tube] are label and if they [nurses] see it on the floor, whatever the situation would be to make sure it is replaced and labeled. The DON stated the nasal cannula tube needed to be changed every seven days. The DON stated, the nasal cannula tube needed to have a written date on it every time it was removed from the package and used on Residents. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 2018, the P&P indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . important facets of infection prevention include: . Educating staff and ensuring that they adhere to proper techniques and procedures .instituting measures to avoid complications or dissemination (spread) . During a review of professional reference retrieved from https://www.ucsfhealth.org/education/your-oxygen-equipment, titled, Patient Education Your Oxygen Equipment, dated 2022-2024 indicated, . the nasal cannula should be changed every week . if you are using a humidifier, empty it at least once a day .