STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555872	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chaparral House	1309 Allston Way Berkeley, CA 94702

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50474 Based on observation, interview and record review, the facility failed to treat three of three sampled residents (Resident 21, 22, and 29) with dignity and respect when Residents 21, 22, and 29, who needed full assistance with meals, were not offered or fed their bread rolls during lunch. This failure had the potential to affect Residents 21, 22 and 29's psychosocial well-being and nutritional needs. Findings: During a dining observation on 9/23/24 at 12:53 p.m., in the dining room, Residents 21, 22, and 29 were being assisted by staff during lunch. Registered Nurse (RN) 3 asked Resident 29 if she wanted her bread roll to which Resident 29 replied, yes. RN 3 did not have gloves available to feed the bread roll and RN 3 offered water to Resident 29 instead. Residents 21, 22, and 29 did not receive their bread rolls from the staff who assisted them during feeding. During an interview on 9/25/24 at 3:07 p.m. with Director of Staff Development (DSD), DSD stated RN 3 should have accommodated and assisted Resident 29 when Resident 29 wanted to eat the bread roll. DSD further stated Residents 21, 22, and 29 were not able to feed themselves and needed a helper to pick up the food for them so they can eat. During a record review of the facility's policy and procedure (P&P) titled, Dignity, revised February 2021, the P&P indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .When assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience.

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 46487 Based on interview and record review, the facility failed to ensure Resident 8's Preadmission Screening and Resident Review (PASARR, a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care). PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting; and 3) receive the services they need in those settings.) completed when Resident 8 had diagnosis of brief psychotic disorder (mental disorder that can cause abnormal thinking and perception). This failure resulted in Resident 8 not being properly evaluated if he was receiving appropriate mental health services. (Cross Reference F758) Findings: During a review of Resident 8's Admission Record, dated 9/25/24, the record indicated Resident 8 had diagnosis of brief psychotic disorder. During a review of Resident 8's Physician's Orders, dated 8/22/23, the order indicated an order of Seroquel 12.5 milligrams (mg., a form of measurement), by mouth two times a day (Seroquel is an antipsychotic medication. Antipsychotic medications are medications that are used to treat symptoms of psychotic mental disorder such as delusions, hallucinations, paranoia, or confused thoughts). During a concurrent interview and record review on 9/26/24 at 10:36 a.m., with the Medical Record Director (MRD), MRD stated she was not able to find any PASARR evaluation in Resident 8's medical records. During an interview on 9/26/24 at 10:04 a.m., with the Administrator (Adm), the Adm acknowledged it was the facility's mistake for not having a PASARR evaluation for Resident 8. During a review of the facility's policy and procedure (P&P) titled, Admission Criteria, dated March 2019, the P&P indicated, . All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36593 Based on observation, interview, and record review, for two (Resident 10 and Resident 11) of thirteen sampled residents, the facility failed to implement its Care Plan, Comprehensive Person Centered policy and procedure when: 1. Facility did not develop care plan to address Resident 10's medical diagnoses of Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and Insomnia (persistent problems falling and staying asleep), and there was no care plan to address Resident 10's use of Amitriptyline and Trazadone (antidepressant medications, antidepressants are medications used to treat major depressive disorder, some anxiety disorders and chronic pain conditions), and 2. Facility did not identify and address Resident 11's hairy mole on chin with a care plan and appropriate interventions. (Hairy moles are skin lesions that have both hair and pigmentation. They are usually present at birth. Hairy moles can appear anywhere on the body, but are often found on the face, trunk, or limbs). These failures had the potential to result in Resident 10 and Resident 11 not receiving appropriate care and treatment. Findings: 1. During a review of Resident 10's Admission Minimum Data Set (MDS- an assessment and care screening tool used to guide care), dated 8/30/24. The MDS indicated Resident 10 had diagnoses of major depressive disorder and insomnia. During a review of Resident 10's physician orders, dated 8/23/24, the order indicated Resident 10 was prescribed: a. Amitriptyline HCL tablet 50 mg (milligram, unit of measurement) by mouth daily related to major depressive disorder, and b. Trazadone HCL oral tablet 100 mg by mouth at bedtime related to insomnia. During a concurrent interview and record review on 9/25/24 at 9:17 a.m., with the Director of Nursing (DON), Resident 10's MDS and care plans were reviewed. DON could not show Resident 10 had care plans that addressed the use of Amitriptyline and Trazadone for depression. DON could not provide documentation that Resident 10's diagnosis of major depression was care planned. DON stated care plan was not initiated for Resident 10 major depression and use of antidepressant. 2. During a review of Resident 11's Admission record, dated 5/5/22, indicated Resident 11 was admitted to the facility with multiple diagnoses that included seborrhea (abnormally increased secretion and discharge of sebum) and rash and other nonspecific skin eruption. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 11's Minimum Data Set, dated dated [DATE], the MDS indicated Resident 11's Basic Interview of Mental Status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 12 and indicated moderate impaired mental status. The MDS indicated Resident 11 was able to recall the correct year, month, and day of the week. MDS indicated Resident 11 had clear speech, able to express her ideas and wants, and understood what others said to her. During a concurrent observation and interview on 9/23/24 at 10:00 a.m., Resident 11 laid in bed in her room, awake, alert and verbally responsive. Resident 11 was observed with hairy mole on her chin. Resident 11 stated she had hairy mole on chin for some time and would like the hair removed. Resident 11 stated nurses had not addressed the presence of hairy mole on her face. Resident 11 stated she would like to have facial hair removed. During a concurrent observation and interview on 9/23/24 at 10:21 a.m., with Certified Nursing Assistant/Restorative Nursing Assistant (CNA) 1 in Resident 11's room, Resident 11 had hairy mole on chin. CNA1 stated she was aware Resident 11 had a mole with facial hair on her chin. can 1 stated because of the presence of mole with facial hair and informed a licensed nurse. During a concurrent interview and record review on 9/26/24 at 8:49 a.m., with the DON, Resident 11's weekly summaries, care plans and MDS were reviewed. DON could not provide documentation that Resident 11 care plans identified and addressed hairy mole on Resident 11's chin. DON stated nursing staff did not identify or care plan Resident 11's hairy mole presence on the chin. During an interview on 9/26/24 at 1:31p.m., with the DON, the DON stated the expectation was for CNAs to observe residents' skin daily, during shower and notify licensed nurses who will notify physician with changes in skin condition and care plan. The DON stated there was no documentation that Resident 11's hairy mole on chin was identified or care planned. During a review of the facility's policy and procedure (P&P) titled, Care Plan, Comprehensive Person-Centered, revised March 2022, the P&P indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 36593 Based on observation, interview, and record review, the facility failed to ensure one sampled resident's (Resident 14) long toenails received podiatry (foot care) treatment services as ordered by the physician. This failure had the potential to place Resident 14 at risk for injury and infection. Findings: During an observation on 9/23/24 at 1:45 p.m., Resident 14 laid in bed in her room. Resident 14 had contracted (tightened and may cause deformity) feet with long toenails. During a review of Resident 14's Minimum Data Set (MDS, Resident Assessment tool used to guide care), dated 9/12/24, the MDS indicated Resident 14 had short- and long-term memory problem. The MDS indicated Resident 14 was dependent on staff and required two or more helpers for putting on and taking off socks and shoes or other footwear and personal hygiene. The MDS indicated Resident 14's diagnoses included Peripheral Artery Disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and Non-Alzheimer's Dementia (a loss of mental ability severe enough to interfere with normal activities of daily living). During a concurrent observation and interview on 9/24/24 at 11:00 a.m., with Licensed Vocational Nurse (LVN) 1 in Resident 14's room, LVN 1 stated Resident 14's long toenails needed podiatry care since Resident 14 had other comorbidity (presence of two or more diseases). During a concurrent interview and record review on 9/24/24 at 11:24 a.m., with Social Services Director (SSD), Resident 14's Progress Notes, dated 3/4/24 was reviewed. The progress notes by the podiatrist indicated Resident 14 had elongated toenail with plan to trim toenails every 2 to 3 months for foot care. SSD stated Resident 14's foot care was missed and was not seen by the podiatrist. SSD stated he coordinated with the podiatrist in making sure residents' schedule for podiatry care was kept. During a review of Resident 14's order summary report dated 8/19/2017, the order indicated the physician ordered Resident 14 to receive podiatry care as needed. During a review of the facility's policy and procedure (P&P) titled, Foot Care, revised October 2022, the P&P indicated, Residents with foot disorders or medical conditions associated with foot complication are referred to qualified professionals. Foot disorders that require treatment include corns, neuromas, calluses, hallux valgus, digit flexus, heel spurs and nail disorders.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 36593 Based on observation, interview, and record review, the facility failed to ensure one (Resident 9) of two sampled residents received treatment services to address limitation in range of motion to right upper extremity when Resident 9 had contracture (a condition of shortening and hardening of muscles often leading to deformity and rigidity of joints) of right upper extremity and a resting splint (a device that supports and protects a broken bone or injured tissue) was not applied to right hand as ordered by the physician. This failure had the potential to cause Resident 9's decline in range of motion and risk of decreased muscle strength. Findings: During an observation on 9/24/24 at 10:53 a.m., Resident 9 laid in bed in her room. Resident 9 had right hand contracture. Resident 9's right hand upper extremity had no splint. During a review of Minimum Data Set (MDS - an assessment screening tool used to guide care), dated 9/19/24. The MDS indicated, Resident 9 had short- and long-term memory problem. The MDS indicated Resident 9's had diagnosis of Non-Alzheimer's Dementia (a loss of mental ability severe enough to interfere with normal activities of daily living). During a review of Resident 9's care plan revised on 6/19/2017, the care plan indicated Resident 9 had an ADL (activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating.) self-care performance deficit related to limited mobility, interventions included nursing rehab/restorative splint/brace program. During a review of Resident 9's order summary report dated 9/3/21, the order indicated physician prescribed Resident 9 to receive RNA [restorative nurse assistant] program: RNA/can [certified nursing assistant] to do PROM [passive range of motion, the person performing the movement does not use any of their own muscles] to all joints to patient tolerance 3x/week flexible days. Goal: maintain res [resident] current joint ROM in all extremities and reduce risk of contracture development . During an interview on 9/25/24 at 8:55 a.m., with Certified Nursing Assistant/Restorative Nursing Assistant (CNA) 1, CNA 1 stated Resident 9 used to have splint applied to right upper hand contracture. CNA 1 stated Resident 9 was no longer on RNA program for a while and had not used a splint for some time. CNA 1 stated Resident 9 had contracture to right hand upper extremity. During a concurrent observation and interview on 9/25/24 at 11:03 a.m., with Licensed Vocational Nurse (LVN) 1 in Resident 9's room, Resident 9 sat up in wheelchair, right upper extremity had no resting splint. LVN 1 stated she was the charge nurse for Resident 9, cared for Resident 9 four days a week. LVN 1 stated she had not seen Resident 9 with splint application to right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 9/25/24 at 11:16 a.m., with CNA 2, CNA 2 stated she was Resident 9's caregiver. CNA 2 stated Resident 9 used to have a splint on the right hand but no longer for a while now. CNA 2 stated she did not know the reason for not having splint in place. CNA 2 stated that RNA was responsible for splint application. During an interview on 9/25/24 at 10:20 a.m., with Occupational Therapist (OT), OT stated facility will reevaluate Resident 9. OT stated there was no treatment record for Resident 9's right hand limitation in range of motion. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting revised March 2018, the P&P indicated Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46487 Based on interview and record review, the facility failed to have a written contract/agreement with Resident 189's outpatient dialysis provider (dialysis is the process of removing toxins from the kidneys and blood through a machine. The contract/agreement should include all aspects of how Resident 189's dialysis care and needs were to be managed by the dialysis provider outside of the facility). This failure had the potential to result in Resident 189's poor dialysis care management. Findings: During a review of Resident 189's Admission Record, dated 9/26/24, the record indicated Resident 189 had diagnosis of acute kidney failure (a condition where the kidneys stopped working properly). Review of Resident 189's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 9/20/24, the MDS indicated Resident 189's cognition was intact. During a review of Resident 189's Physician's Orders dated 9/14/24, the order indicated Resident 189 had outpatient hemodialysis (a medical procedure that filters a person's blood when their kidneys are not functioning properly) appointments on Mondays and Fridays from 10:00 a.m. to 1:00 p.m. During an interview on 9/23/24 at 2:41 p.m., with Resident 189, Resident 189 stated she just returned from having dialysis from the dialysis provider. During an interview on 9/25/24, at 10:21 a.m., with the Administrator (Adm), the Adm stated there was no contract in place between the facility and dialysis provider of Resident 189. The Adm further stated the facility also did not have a contract with the transportation company that transported Resident 189 to the dialysis provider. The Adm stated he knew it was a regulation to have a contract but acknowledged that he had not done it yet.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46487 Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic drugs (medications that can affect the mind, emotions, and behavior) for three of 38 sampled residents (Residents 8,7 and 10) when: 1. Resident 8 did not have the appropriate indications for the use of Seroquel (Seroquel is an antipsychotic medication; Antipsychotic medications are medications that are used to treat symptoms of psychotic mental disorder such as delusions, hallucinations, paranoia, or confused thoughts), 2. Resident 7 had no rationale for continued use of PRN Ativan beyond 14 days (PRN is short for pro re nata [a Latin phrase], meaning as needed, or as necessary; Ativan is a psychotropic medication used to treat anxiety; psychotropic medications are used to treat mental health disorders), and 3. Resident 10 was administered Trazadone (an antidepressant medication to treat major depressive disorder, some anxiety disorders and chronic pain conditions) for insomnia (difficulty falling and staying asleep) and facility did not monitor hours of sleep for Resident 10. These failures had the potential to not promote or maintain Residents 8, 7 and 10's highest practicable mental, physical, and psychosocial well-being. (Cross Reference F645) Findings: 1. During a review of Resident 8's Admission Record, dated 9/25/24, the record indicated Resident 8 had diagnosis of brief psychotic disorder (mental disorder that can cause abnormal thinking and perception). During a review of Resident 8's Physician's Orders(PO), dated 8/22/23, the PO indicated an order of Seroquel 12.5 milligrams (mg., a form of measurement), by mouth two times a day. The PO indicated the symptoms to be managed by Seroquel were, agitation/restlessness/anxiety, manifested by repetitive questioning of things, events. Easily gets frustrated despite reassurance and with aggressive response. Review of Resident 8's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 7/20/24, the MDS indicated Resident 8's cognition was severely impaired. The MDS indicated Resident 8 had no verbal and physical behavioral symptoms directed toward others (verbal- threatening others, screaming at others, cursing at others; physical - hitting, kicking, pushing, scratching .). During an interview on 9/27/24 at 9:28 a.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 8 did not get agitated whenever she took care of him. CNA 4 stated Resident 8 would get confused at times but would calm down when CNA 4 reoriented Resident 8. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/24 at 2:18 p.m., with Registered Nurse (RN) 2, RN 2 stated Resident 8 was not physically aggressive. RN 2 further stated Resident 8 was not a danger to himself and to others. During a concurrent interview and record review on 9/26/24 at 1:50 p.m. with the Director of Nursing (DON), Resident 8's Electronic Health Record (EHR) for physician orders dated 9/25/24 was reviewed. The DON stated the use of Seroquel for Resident 8 was not appropriate because the resident was not aggressive and was not a danger to himself, other residents, and the staff. 2. During a review of Resident 7's clinical record indicated a diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities) and anxiety (a type of mental health condition). During a review of Resident 7's physician order dated 9/25/24, the order indicated the physician prescribed Ativan 0.5 mg by mouth every 6 hours PRN for anxiety with a start date of 3/28/24. The order did not indicate a stop date for the PRN Ativan. During a concurrent interview and record review on 9/25/24 at 12:45 p.m., with the Director of Nursing (DON), Resident 7's Physician's Order, dated September 2024 was reviewed. The DON stated Resident 7's PRN Ativan did not have a stop date and should have a duration of 14 days per the facility policy. DON also acknowledged there was no physician documentation found which indicated Ativan PRN should be extended. During an interview on 9/26/24 at 12:39 p.m. with the Medical Doctor (MD), the MD stated Resident 7's PRN Ativan should have had a stop date of 14 days. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated July 2022, the P&P indicated, . PRN orders for psychotropic medications are limited to 14 days . If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale (reason) for extending the use and include the duration for the PRN order . During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, dated July 2022, the P&P indicated, . Diagnoses alone do not warrant the use of antipsychotic medication . antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others AND: (1.) The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity) . 36593 3. During a review of Resident 10's Admission Minimum Data Set, dated dated [DATE], the MDS indicated Resident 10 had daily mood symptom of feeling down, depressed or hopeless. The MDS indicated Resident 10's diagnoses included Major Depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and insomnia (persistent problems falling and staying asleep). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10's physician Orders, dated 8/23/24, the physician order indicated Resident 10 was prescribed Trazadone HCL oral tablet 100 mg by mouth at bedtime related to insomnia. During a review of the Medication Administration Record (MAR), dated 9/1/24 to 9/30/24, the MAR indicated Resident 10 was administered Trazadone 100 mg tablet by mouth at bedtime. The MAR indicated Resident 10's hours of sleep was not monitored from 9/7/24 to 9/23/24. During a concurrent interview and record review on 9/25/24 at 9:17 a.m., with the (DON), Resident 10's physician orders and MARs were reviewed. The DON stated there was no hour of sleep monitored for use of trazadone. The DON stated monitoring sleep provides information on the effectiveness of medication. The DON stated if Resident 10 did not sleep, the physician will be notified to reevaluate the use of Trazadone. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated July 2022, the P&P indicated, Psychotropic medication management includes: a. indication for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences.

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Chaparral House	1309 Allston Way Berkeley, CA 94702

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50474 Based on observation, interview, and record review, the facility failed to follow the menu for the soft and bite-sized (foods that are soft, moist, and easy to swallow) and easy to chew diet (soft, tender foods that are easy to chew) for 12 out of 12 residents (Residents 13, 23, 8, 6, 190, 29, 7, 12, 34, 18, 15 and 22) when Residents 13, 23, 8, 6, 190, 29, 7, 12, 34, 18, 15 and 22 did not receive two ounces of gravy for lunch with their chicken on 9/23/24. This failure had the potential for Residents 13, 23, 8, 6, 190, 29, 7, 12, 34, 18, 15 and 22 to have problems chewing and swallowing the food when the established menu was not followed accordingly and had the potential for poor nutrition and to further compromise the medical status of the residents. Findings: During the tray line (an assembly line preparation of meal trays in the kitchen to be delivered to residents) observation on 9/23/24, at 12:17 p.m., in the kitchen, the Dietary Services Supervisor (DSS) did not serve gravy to residents who were on the soft and bite-sized and easy to chew diet. During a record review of a facility document titled Therapeutic Spreadsheet Menu Week 1, dated 9/23/24, the document indicated both the soft and bite-sized diet and easy to chew diet's baked chicken were to be served with two ounces of gravy. During an interview on 9/25/24 at 1:21 p.m., with DSS, the DSS stated she had prepared the gravy but forgot to serve it to the residents. The DSS further stated the weekly menu should have been followed, and the gravy should have been served to residents who were on soft and bite-sized and easy to chew diet. During a record review of the facility's policy and procedure (P&P), titled, Menus, dated 2018, the P&P indicated Menus are planned to meet guidelines as established by the most current federal/state regulations . All menus will provide adequate nutrients to meet the special needs of the residents, including dietary modifications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50474 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices when: 1. Can opener had red discoloration on the blade that pierced the can, 2. Under the stove and steam tray line, the floors had a build-up of food crumbs, trash, dust, and grime, 3. The oven had build-up of black grime inside, 4. Dry storage floors had build-up of food crumbs, trash, and dead ants, and 5. Diet Aide 1 (DA 1) did not wear a bear net during meal preparation and service. These failures had the potential to expose 38 medically compromised residents who received food from the kitchen to foodborne illness due to cross-contaminations (the transfer for harmful substances or disease-causing microorganisms to food). Findings: 1. During an initial tour observation of the kitchen and interview on 9/23/24 at 9:32 a.m. with Dietary Service Supervisor (DSS), the can opener had red discoloration on the blade. DSS stated the can opener should have been cleaned. During a phone interview on 9/25/24 at 1:10 p.m. with the Registered Dietician 1 (RD 1), RD stated the can opener should have been kept clean and should have been washed after each use. 2. During an observation and interview on 9/23/24 at 9:46 a.m. with DSS, the kitchen floors under the two stoves and steam table tray line counter had build-up of food crumbs, dust, trash, and black grime. DSS stated they have not done a deep cleaning in the kitchen recently because the person who was assigned to do the task had retired. 3. During an observation and interview on 9/23/24 at 9:47 a.m., the oven had a build-up of black grime under the racks. DSS stated the black grime was from food residue. During a phone interview on 9/25/24 at 1:10 p.m. with RD 1, RD 1 stated the oven should have been wiped down after each use and should have been cleaned based on the cleaning schedule. 4. During an observation on 9/23/24 at 9:52 a.m., inside the dry storage, the floors had build-up of dead ants, food crumbs, and trash under the shelves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 9/25/24 at 1:10 p.m. with RD 1, RD 1 stated the kitchen should have been kept cleaned and floors should have been free from food crumbs, dust, trash, and grime. RD 1 stated the dead ants should have been cleaned right away in the dry storage area. 5. During a tray line (an assembly line preparation of meal trays in the kitchen to be delivered to residents) observation on 9/23/24 at 12:24 p.m., DA 1 with facial hair did not have a beard net on while assisting DSS in plating the residents' foods. During an interview on 9/25/24 at 1:15 p.m. with DSS, DSS stated DA 1 should have worn a beard net or shaved his facial hair when directly in contact with food. During a record review of the facility's policy and procedure (P&P), titled, Sanitation and Infection Control (Cleaning Schedule), dated 2018, the P&P indicated The Dining Services Director will develop comprehensive cleaning schedules that staff will follow in order to maintain a sanitary department, prevent cross-contamination, and meet state/federal requirements. During a review of the facility's P&P, titled, Sanitation and Infection Control (Personal Hygiene), dated 2018, the P&P indicated, The Director of food and Nutrition services will instruct Department of Food and Nutrition Services employees regarding the relationship between personal hygiene and food safety, including the association of hand contact personal habits and behaviors and food employees' health to food borne illness . Beards and/or mustaches should be covered during meal preparation and service. During a record review of the Food and Drug Administration (FDA) Federal Food Code 2022, .Non-food contact surfaces of equipment shall be kept free of accumulation of dust, dirt, food residue, and other debris. The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents and other pests.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 46487 Based on observation, interview and record review, the facility failed to ensure two (Residents 15 and 21) of 38 sampled residents' call lights were within easy reach. This failure had the potential for the Resident 15 and Resident 21 to not to be able to use the call light when needing assistance. Findings: During an initial tour of the facility on 9/23/24 at 10:43 a.m., in Resident 15's room, Resident 15 was observed lying in bed, alert and was able to answer questions. The call button wire was observed to be hanging in right middle side of Resident 15's bed and the call button was almost touching the floor. Resident 15 attempted to reach for the call button but had a difficult time and failed. Resident 15 stated she could not reach her call button and further stated she needed the call light to call for help. During a concurrent observation and interview on 9/25/24 at 12:09 p.m., with Certified Nursing Assistant (CNA) 3 in Resident 15's room, CNA 3 confirmed that Resident 15 was not able to reach her call light. CNA 3 stated the call light should be within the resident's reach at all times. CNA 3 acknowledged that the risk for the resident in not being able to reach the call light was that the resident could not call for her needs. During an initial tour of the facility on 9/23/24 10:49 a.m., in Resident 21's room, Resident 21 was observed lying in bed, alert and was able to answer questions. The call light was observed to be on the floor in the upper right side of Resident 21. Licensed Vocational Nurse (LVN) 3 confirmed Resident 21's call light should not be on the floor. LVN 3 stated the call light should be always within the resident's reach so that the resident could call for her needs. During an interview with the Director of Nursing (DON) on 9/25/24 at 12:09 p.m., the DON stated the residents should be able to reach the call lights all the time, especially when they were in bed. The DON further stated, the risk for the residents on not being able to reach their call lights were unmet needs. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated September 2022, the P&P indicated, .Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor .