STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555877	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Regional Transitional Care and Rehabili	1081 North China Lake Boulevard Ridgecrest, CA 93555

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 42744 Based on observation, interview, and record review, the facility failed to enusre call lights were withing reach for four of 36 sampled residents (Resident 47, Resident 61, Resident 16, Resident 15). This failure had the potential for residents' needs to go unmet and place residents' safety at risk. Findings: During an observation on 3/3/25 at 10:53 a.m. in Resident 47's room, Resident 47 was laying on her back toward her left side and was restless, moving both feet back and forth on the mattress. Resident 47's sensitive call light (a system to be used for limited mobility) was tied to the right upper side rail where she could activate or use call for assistance. During a concurrent observation and interview on 3/3/25 at 10:56 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 47's call light was observed tied to the right upper side rail. LVN 1 stated Resident 47 was able to use the round sensitive call light and it should be within her reach. During an observation on 3/3/25 at 1:19 p.m. in Resident 61's room, Resident 61's call light was hanging over the headboard out of reach of Resident 61. During a concurrent observation and interview on 3/3/25 at 1:23 p.m. with Certified Nursing Assistant (CNA) 1, Resident 61's call light was located hanging over her headboard out of reach. CNA 1 stated Resident 61 should be able to reach her call light. During a concurrent observation and interview on 3/3/25 at 1:26 p.m. with Resident 16 in Resident 16's room, Resident 16 was up in a wheelchair sitting next to her bed without a call light. Resident 16 stated she did not know where her call light was but probably mixed up in the bed linens. Resident 16 stated she would use the call light to call for help. Resident 16 stated, Where is it [call light]? During a concurrent observation and interview on 3/3/25 at 1:28 p.m. with CNA 4 in Resident 16's room, Resident 16 was up in a wheelchair sitting next to bed without a call light within reach. CNA 4 stated Resident 16 should have had a call light within reach. 50939 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555877	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/3/25 at 11:05 a.m. with CNA 7 in Resident 15's room, Resident 15's call light was on the floor. CNA 7 stated Resident 15's call light should be in Resident 15's hand or within her reach. During a review of the facility's Policy and Procedure P&P titled, Call System, Residents, undated, the P&P indicated, Policy Statement: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation: 6. Calls for assistance are answered as soon as possible and at a reasonable time. Urgent requests for assistance are addressed immediately.

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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. 50939 Based on observation, interview, and record review, the facility failed to provide a home-like environment for one of six sampled residents (Resident 72) when the bathroom had an odor. This failure had the potential to cause a decrease in Resident 72 and visitors' comfort level and failed to protect Resident 72's right to a home-like environment. Findings: During a review of Resident 72's Admission Record (AR), dated 12/6/25, the AR indicated, Resident 72's admitted was 12/6/25. During a concurrent observation and interview on 3/5/25 at 8:08 a.m. with Resident 72's family member (FM) in Resident 72's room, there was a strong odor of urine in the bathroom. FM stated when the bathroom door is left open, there was a strong stale urine smell. FM stated she had visited Resident 72 every day since he was admitted three weeks ago. During an interview on 3/5/25 at 8:16 a.m. with Resident 72, Resident 72 stated, The bathroom stinks. During a review of Resident 72's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 2/13/24, the MDS indicated Resident 72 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13 (score of 13-15 means cognitively intact). During an interview on 3/5/25 at 8:16 a.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated the shared bathroom for Resident 72 had a strong urine smell especially in the mornings. During an interview on 3/5/25 at 2:20 p.m. with Housekeeping Aide (HKA), HKA stated she was assigned Resident 72's room. HKA stated the shared bathroom always smelled like urine. HKA stated she cleaned the bathroom daily but the smell of urine lingered. During an interview on 3/6/25 at 10:07 a.m. with Environmental Services Supervisor (EVSS), EVSS stated Resident 72's bathroom urine smell was still there. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 10/2018, the P&P indicated, Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50939 Based on observation, interview, and record review, the facility failed to ensure three of seven sampled residents (Resident 14, Resident 38, and Resident 56) were informed of the process to file a grievance (formal complaint) with the facility. This failure had the potential for residents' concerns to go unaddressed by the facility. Findings: During an interview on 3/4/25 at 10:04 a.m. with Resident 14, Resident 14 stated he did not know how to file a grievance. During a review of Resident 14's Minimum Data Set, (MDS- a federally mandated resident assessment tool) dated 1/17/25, the MDS indicated Resident 14 had a Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13 (score of 13-15 means cognitively intact). During an interview on 3/4/25 at 10:05 a.m. with Resident 38, Resident 38 stated she does not remember if the facility informed her on how to file a grievance. Resident 38 stated she just goes directly to the person she had a problem with to address her issues. During a review of Resident 38's MDS dated [DATE], the MDS indicated Resident 38 had a BIMS score of 12 (score of 8-12 means moderate cognitive impairment). During an interview on 3/4/25 at 10:07 a.m. with Resident 56, Resident 56 stated she did not know how to file a grievance. Resident 56 stated the facility did not let her know how to file a grievance and who to file it with. During a review of Resident 56's MDS dated [DATE], the MDS indicated Resident 56 had a BIMS score of 15. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 2/2021, the P&P indicated, residents have the right to.voice grievances to the facility. During a review of the facility's P&P titled, Grievances/Complaints-Staff Responsibility, dated 10/2017, the P&P indicated, 3. Staff members will inform the resident or the person acting on the resident's behalf as to where to obtain a Resident Grievance/Complaint Form and where to locate the procedures for filing a grievance or complaint.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42744 Based on interview and record review, the facility failed to follow its Policy and Procedure, Care Plans [CP], Comprehensive Person-Centered, when care plans were not developed and implemented for two of 38 sampled residents (Resident 32 and Resident 6) with infections. This failure had the potential to result in Resident 32 and Resident 6's individualized care needs to go unmet and negatively affect their health and recovery. Findings: During a concurrent observation and interview on 3/3/25 at 1:01 p.m. with Resident 32 in Resident 32's room, Resident 32 had an intravenous (IV- in the vein) catheter (small flexible tube used to administer medications) in his right wrist. Resident 32's room contained an IV bag labeled with an antibiotic (medication used to treat infections), with tubing attached and an IV infusion pump on a pole next to his bed. Resident 32 stated he had a urinary tract infection (UTI- microscopic organisms living in the urinary tract [bladder, ureters, urethra, or kidneys] causing pain while urinating, pain in the back or side, or needing to urinate often). During a concurrent interview and record review on 3/5/25 at 2:51 p.m. with Minimum Data Set Coordinator (MDSC) 1, Resident 32's electronic Medical Record (eMR) was reviewed. The eMR indicated Resident 32's first symptoms of a UTI begam on 2/26/25. Resident 32 was initially started on an oral antibiotics on 2/26/25. A urine culture (a lab test showing the type of microorganism growing and what antibiotics will kill it) results received on 2/28/25 indicated the antibiotics were not effective therefore IV antibiotics were started. MDSC 1 stated Resident 32 should have had a care plan developed and implemented that addressed his active UTI and she did not see one. 45654 During a review of Resident 6's Client Diagnosis Report (CDR), dated 3/5/25, the CDR indicated, Resident 6 had a diagnosis of Cellulitis of left lower limb. During a concurrent interview and record review on 3/5/25 at 3:12 p.m. with MDSC 2, Resident 6's Medical Recod was reviewed. MDSC 2 was unable to provide a CP for Resident 6's chronic wound cellulitis (bacterial infection of the skin) of the left lower limb. MDSC 2 stated a CP should have been developed and implemented by the nurses on the floor or the Infection Preventionist Nurse that addressed Resident 6's cellulitis of the left lower limb. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 27157 Based on interview, and record review, the facility failed to ensure one of one sampled residents (Resident 31) diet order was clarified per Resident 31's preference for lacto-vegetarian (which include dairy products but not egg products) diet, as orders are a plan of care and communication to the interdisciplinary team, including the physician responsible for the care of Resident 31. Facility failure to clarify the diet order with the physician responsible for prescribing diet orders had the potential for Resident 31's physician to be unaware Resident 31 excluded some foods that may lead to deficits in some nutrients, vitamins and minerals, in order for the doctor to evaluate if further tests or labs may be in order. Findings: During a review of Resident 31's Nutrition Risk Assessment (NRA), dated 7/16/24, the NRA indicated, Food/Cultural/Religious Preferences: Vegetarian diet -dairy ok. No eggs.Interventions; Recommend continue M/S [mechanical soft] diet as ordered.MVI [multivitamin] w/ [with] minerals requested. During a concurrent interview and record review on 03/05/25 at 11:50 a.m. with RD 1 and RD 2, Resident 31's Plan of Care NUT [nutrition](POCN), dated 7/16/24, was reviewed. The POCN indicated, Interventions. Provide diet as ordered - Mechanical soft, ground (vegetarian alternatives offered), Honor food/fluid preferences including religious, cultural & ethnic preferences and offer alternatives as needed. RD 2 stated vegetarian was a broad term and should be defined and resident specific. There was no documentation specifying what the preferences related to religious, cultural or ethnic would entail to pertain specifically to Resident 31, nor vegetarian alternatives was not specific to Resident 31's lacto-vegetarian preference for person centered care. RD 2 stated the RD's initiate, update and revise the IDT (interdisciplinary team) Nutrition Care Plan that was a communication tool to the IDT team caring for Resident 31. During a concurrent interview and record review on 03/05/25 at 11:53 a.m. with RD 1, Resident 31's Physician's Telephone Order; Mechanical [mech] Soft Ground Diet Oral information only, dated 7/16/24 was reviewed. RD 1 stated she was responsible for supervising the RD's. RD 1 stated it was standards of practice and her expectation for the RD who completed the nutrition assessment to get the diet order clarified with the physician to add lacto-vegetarian specifications to the mech soft ground diet order. During a review of the facility's policy and procedure (P&P) titled, Policy Statement, dated 2001, the P&P indicated, 1. The IDT including the dietitian will assess each resident's nutritional needs.2. A resident-centered diet and nutrition plan will be based on this assessment. During a review of the Academy of Nutrition and Dietetics Nutrition Care Manual (NCM), dated 2025, the NCM indicated, Diet names used in all areas should match: medical record documentation (electronic or paper), printed menus or tray tickets, diet manual, documents used by the kitchen staff (i.e. menu spreadsheets), diet guide sheets, and policies and procedures. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's diet manual for the diet titled Vegetarian & Vegan Diet (VVD), dated 2023, the VVD indicated, Diet orders need to clarify the correct category.There are four general categories.: Vegans., Lacto-ovo-vegetarians.Lacto-vegetarians., semi-vegetarians.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42744 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 32 and Resident 38) where not at risk for accident and injury when: 1. Resident 32's bathroom grab bar was slippery and grip tape (non-slip cover designed to maximize safety using hand hold surfaces) was not secured to grab bar. This failure had the potential to result in falls with injuries. 2. Resident 38 was left unsupervised while out on a patio and without means to call for assistance. This failure had the potential for Resident 38 to experience harm. Findings: 1. During a concurrent observation and interview on [DATE] at 1:01 p.m. with Resident 32 in Resident 32's room, a tube of silicone cream was on the resident 32's bed. In the bathroom, grab bars were on the left side of the toilet. No grip tape was on the grab bars. Resident 32 demonstrated how his hands slipped on the grab bars. Resident 32 stated his hands are slippery from silicone cream. Resident 32 stated the facility had put tape on the grab bars about a week ago, but it did not stick or stay on. During a concurrent observation and interview on [DATE] at 4:01 p.m. with Resident 32 in Resident 32's bathroom, blue tape was secured to the top surface of the grab bar and would not stay secured to the entire grab bar. Resident 32 stated he fell back onto the toilet seat about three weeks ago when he attempted to get up using the slippery grab bar. Resident 32 stated staff were aware of the fall. Resident 32 stated he was worried about breaking a hip if he fell . During a concurrent observation and interview on [DATE] at 11:40 a.m. with Resident 32 and Director of Nursing (DON) in Resident 32's bathroom, the grab bars on the left side of the toilet had blue tape on them. Some of the blue tape was wrapped around the bar and some was adhered to the top of the bar. Resident 32 demonstrated how slippery the top of the bar was when he gripped the grab bar with his hand. Resident 32 stated he did not feel safe. DON stated the grab bar was an accident hazard. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, dated , d+[DATE], the P&P indicated, Policy Statement Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being . 2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis. 3. In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as common areas in the facility. 45654 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on [DATE] at 10:06 a.m. with Resident 38, Resident 38 stated when she was outside, she was given a phone to call for assistance if needed but it did not work all the time. Resident 38 stated she was outside in the garden for 30 minutes and the phone did not work when she needed to go back into the facility. Resident 38 stated, I was mad, I had to yell out loud for someone to let me back in the facility. During an interview on [DATE] at 11:56 a.m. with Assistant Director of Nursing (ADON), ADON stated if a resident would like to go out to the patio a staff member should be there to frequently check on them. ADON stated staff can give a resident a phone to use and call when they are ready to come back inside. During a concurrent observation and interview on [DATE] at 12:03 p.m. with Director of Staff Development (DSD), at the nurses station, there was a portable electronic phone on a charging base. DSD stated the phone battery may have died on the phone if staff had not charged it. DSD stated if a resident was on the patio, staff are to round and check on them every 20 to 30 minutes. During an interview on [DATE] at 11:17 a.m. with Activities Director (AD), AD stated when we? are here, we check on residents outside on the patio every five minutes if they do not have capacity. AD stated residents were given a phone to call when they wanted to come in if they had capacity. During an interview on [DATE] at 8:42 a.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated Resident 38 goes out to the patio on Mondays, Tuesdays, and Thursdays. CNA 5 stated the process was to check on the resident every 20 minutes or there was a phone the resident could take with her. During a review of Resident 38's Plan of Care, (PC) dated [DATE], the PC indicated Resident 38's was dependent on staff for activities, cognitive stimulations, social interaction due to illness. During a review of Resident 38's Interdisciplinary Progress Note, (IPN) dated [DATE] through [DATE], the IPN indicated, Resident 38's activity was independent and Resident 38 enjoyed being outside. During a review of Resident 38's Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated [DATE], the BIMS score was 12 (score of ,d+[DATE] means moderate cognitive impairment). During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, dated ,d+[DATE], the P &P indicated, Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 37797 Based on interview and record review, the facility failed to monitor the effectiveness of pain medications for two of two sampled residents (Resident 35 and Resident 55). This failure had the potential for Resident 35 and Resident 55 to experience uncontrolled pain. Findings: During an interview on 3/3/25 at 10:50 a.m. with Resident 35, Resident 35 stated she had uncontrolled pain. During a review of Resident 35's Order History (a record of the resident's current medication orders), undated, the Order History indicated the following order: Dilaudid [a narcotic pain medication] 2 mg to be administered every 6 hours as needed for pain. During an interview on 3/3/25 at 11:32 a.m. with Resident 55, Resident 55 stated she had uncontrolled pain. During a review of Resident 55's Order History, undated, the Order History indicated the following order: Norco [a narcotic pain medication] 5/325 mg [milligrams] to be administered every 6 hours for pain. During a concurrent interview and record review on 3/6/25 at 7:53 a.m. with the DON, Resident 55's medication MAR, for the period 3/4/25 to 3/6/25, was reviewed. The MAR indicated, Resident 55 was administered Norco 5/325 mg on 3/4/25 at 1:51 a.m. for a reported pain level of 8 (on a zero to 10 scale), 3/4/25 at 11:46 a.m. for a reported pain level of 7 (on a zero to 10 scale), 3/5/25 at 1:47 a.m. for a reported pain level of 8 (on a zero to 10 scale), and 3/5/25 at 3:18 p.m. for a reported pain level of 8 (on a zero to 10 scale) with no documentation of pain management effectiveness of the Norco. The DON stated nurses should check the effectiveness of pain medications after each administration and document it on the MAR. During a concurrent interview and record review on 3/6/25, at 8:08 a.m. with the Director of Nursing (DON), Resident 35's Medication Administration Record (MAR) (where nurses document medication administration), for the period 3/4/25 to 3/6/25, was reviewed. The MAR indicated, Resident 35 was administered Dilaudid 2 mg on 3/4/25 at 6:22 a.m. for a reported pain level of 7 (on a zero to 10 scale), 3/4/25 at 1:47 p.m. for a reported pain level of 7 (on a zero to 10 scale), and on 3/5/25 at 00:17 a.m. for a reported pain level of 8 (on a zero to 10 scale) with no documentation of the effectiveness of Dilaudid. The DON stated nurses should check the effectiveness of pain medications after each administration and document on the MAR. During a review of facility policy and procedure (P&P) titled Pain Assessment and Management, dated October 2022, the P&P indicated: When opioids are used for pain management, the resident is monitored for medication effectiveness.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 45654 Based on interview and record review the facility failed follow their Policy and Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, for all residents (73) when direct care service hours per patient day for Certified Nursing Assistants (CNAs) fell below the minimum standard of 2.4. This failure had the potential for residents care needs not to be met by staff. Findings: During an interview on 3/4/25 at 2:39 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated when staff call off from work, they work short staffed. LVN 3 stated they would divide up the tasks that would have been completed by the staff who called off work. During an interview on 3/6/25 at 9:45 a.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated she has worked short staffed frequently. During a concurrent interview and record review on 3/6/25 at 11:12 p.m. with Director of Nursing (DON), Census and Direct Care Service Hours Per Patient Day (DHPPD), dated 3/1/25 and 3/2/25 were reviewed. DHPPD indicated on 3/1/25 actual CNA DHPPD was 2.31. A signature indicated the patient census and direct care service hours were reviewed and. acknowledge the information was true and correct. DHPPD indicated on 3/2/25 the actual CNA DHPPD was 2.24. DON stated some staff were unable to stay over to cover for the short staffed shifts. Facility DHPPD documents for the followed dates only: 2/6/25 2/25/25, 2/26/25, 2/27/25, and 2/28/25 3/3/2025. Requested 6 months DHPPD documetation, facility was unable to provide documentation all data. During a review of the facility's policy and procedure (P&P) titled Staffing, Sufficient and Competent Nursing, dated August 2022, the P &P indicated, Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determinization of sufficient and competent staffing.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37797 Based on observation, interview, and record review, the facility failed to ensure insulin (a medication to control blood sugar levels) vials were labeled with the resident's name for one of one sampled Resident (Resident 36). This failure had the potential for Residents 36 to receive another resident's insulin. Findings: During a concurrent observation and interview on 3/5/25 at 11:20 a.m. with Licensed Vocational Nurse (LVN) 1, during medication pass, LVN 1 was preparing to administer insulin to Resident 36. LVN 1 opened a drawer in the medication cart and removed a box labeled with Resident 36's name and Humulin (insulin used to treat high blood sugar) R]Regular] 100u/mL [unit/milliunits-units of measure] Solution - Inject before meals LVN 1 opened the box and pulled a vial labeled Humulin REGULAR (Insulin Human) Injection. The vial did not have resident 36's name or other resident identifying information. LVN 1 stated each resident receiving insulin had their own dedicated insulin vial, but the resident's name was placed only on the outside box and not on the vial. During an interview on 3/5/25 at 4:40 p.m. with the Director of Nursing (DON), the DON stated insulin vials were not labeled with resident names. The DON stated the medication label with the resident names was placed on the box that contained the insulin vial. The DON stated there was no place in the insulin vials to add the resident names without covering the medication name. During an interview on 3/6/25 at 11:05 a.m. with the facility's Consultant Pharmacist (CP), the CP stated the best practice was to label insulin vials and the insulin box with the resident's name to avoid a resident's insulin vial being mistakenly used to give insulin to another resident. During a review of the National Library of Medicine (NLM) document titled A Clinical Reminder About The Safe Use of Insulin Vials, dated 2015, the document indicated, Vials of insulin dispensed from the pharmacy should be labeled appropriately and include the patient's name. During a review of facility policy and procedure (P&P) titled, Medication Labeling and Storage, dated February 2023, the P&P indicated, Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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.

27157

Based on observation, interview, and record review, the facility failed to ensure:

1. The planned menu for a therapeutic renal diet (for kidney disease) was followed for one of one sampled resident (Resident 43) when 2 oz. (ounces) of gravy was served instead of 1 oz. of gravy as planned. This failure had the potential for Resident 43 to not have her their individualized nutritional needs met.

2. A Registered Dietitian (RD) developed and prepared a lacto [dairy okay]-vegetarian menu to include an evaluation of nutritional adequacy for one of one sampled resident (Resident 31) with a lacto-vegetarian preference to meet Resident 31's choices and special dietary needs. A planned lacto-vegetarian menu was not prepared in advance to meet Resident 31's ordered textured diet of mechanical soft (M/S-foods that are soft and easy to chew and swallow) ground consistencies which resulted in whole blueberries with the skin on being served which was not allowed on a M/S diet. This failure resulted in Resident 31's special dietary needs to not be met and a variety of menu items to not be provided which failed to provide dignity and respect for Resident 31 who had dementia.

3. One of 38 sampled resident (Resident 19)'s food preference was honored when Resident 19 was served lasagna as observed on trayline, despite lasagna being listed as a food dislike on Resident 19's meal tray card (MTC-lists person-centered directions related to menu choices). This failure resulted in Resident 19's person-centered menu choices related to a food dislike to be not honored and placed the Resident 19 at risk of not meeting his individualized nutritional needs and could diminish quality of life.

Findings:

1. During a concurrent observation and interview on 03/04/25 at 12:20 p.m. with Food Service Assistant (FSA) 1 and [NAME] 1 in the kitchen, [NAME] 1 was using a 2 oz. ladle to serve gravy on top of a turkey patty for Resident 43's lunch meal plate. FSA 1 placed Resident 43's lunch meal tray onto the meal delivery cart for distribution to the resident. [NAME] 1 stated he used a 2 oz. ladle to serve gravy for Resident 43's renal diet order. [NAME] 1 was asked to check the planned therapeutic menu spreadsheet for a renal diet, and [NAME] 1 stated it said 1 oz. of gravy for renal diet. [NAME] 1 stated the renal diet menu was not followed for Resident 43.

During an interview on 03/04/25 at 03:37 p.m. with Dietary Manager (DM), DM stated [NAME] 1 had not followed the planned renal diet for Resident 43. [NAME] 1 stated FSA 1, who was checking trays for accuracy prior to placing the lunch meal tray onto the meal delivery cart, had not identified the error.

During a review of Resident 43's MTC, dated 03/04/25, the MTC indicated, Diet: Renal 80 g [grams] Protein (pro), CCHO (consistent carbohydrate diet for diabetes care) - ok to have 1 salt pkt [packet] w/ [with] meals.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the planned therapeutic menu spreadsheet for 80 gm [grams] pro/CCHO Low K+ [potassium] Low salt (renal), dated 03/04/25, the renal menu indicated, 3 oz. turkey patty 1 oz. gravy. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services, dated 2001, the P&P indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. 2. During a concurrent observation and interview on 03/04/25 at 12:26 p.m. with FSA 1 in the kitchen, FSA 1 placed Resident 31's lunch meal tray (LMT), that was plated by [NAME] 1, onto the meal delivery cart for distribution. FSA 1 was asked to remove Resident 31's LMT from the meal delivery cart and check it for accuracy. FSA 1 read Resident 31's meal tray card (MTC) located on his LMT. The MTC indicated, Diet: Regular [not a therapeutic diet]- Vegetarian (Cheese OK, no egg) Food in bowls; Consistency: M/S [mechanical soft] grd [ground]- Food in bowls. FSA 1 stated [Resident 31] was served cottage cheese, whole blueberries, garlic toast and green beans and there were no concerns with the foods served. During a concurrent observation and interview on 03/04/25 at 12:22 p.m. in the kitchen with RD, RD was asked to re-check Resident 31's LMT. RD 1 removed the blueberries and replaced with applesauce. RD 1 stated the consistency listed on the MTC instructed to provide M/S ground consistency and blueberries should not have been plated. RD 1 stated the M/S diet was not followed when whole blueberries with the skin were placed onto Resident 31's lunch meal plate. During a review of the facility's P&P titled, Food and Nutrition Services, dated 2001, the P&P indicated, Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. During an interview on 03/04/25 at 03:37 p.m. with Dietary Manager (DM) and RD 1, RD 1 was asked if the facility had vegetarian menus. DM stated they had some vegetarian recipes in a binder in the kitchen. RD 1 stated the facility did not have vegetarian, lacto-vegetarian or vegan pre-planned menus to direct [NAME] 1 on specific food items to serve to Resident 31 whose preference was a lacto-vegetarian diet on a M/S ground consistency textured diet. During a review of Resident 31's Speech/Language Pathology [evaluating and treating difficulty with chewing/swallowing] Certification (SLP), dated 7/16/24, the SLP indicated, Patient is basically edentulous, having only one decayed tooth on lower right jaw.No clinical s/s [signs/symptoms] of aspiration [food or drink enters the lungs instead of the stomach].Recommend continued mech soft ground consistencies. During a review of Resident 31's Nutrition Risk Assessment (NRA), dated 7/16/24, the NRA indicated, Food/Cultural/Religious Preferences: Vegetarian diet -dairy ok. No eggs.Comments: M/S diet r/t [related to] having only 1 tooth left in the front per ST [speech therapist]. Interventions; Recommend continue M/S [mechanical soft] diet as ordered. During a review of Resident 31's Physician's Telephone Order (TO), dated 7/16/24, the TO indicated, Mechanical [mech] Soft Ground Diet Oral information only. (continued on next page)

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a concurrent interview and record review on 03/05/25 at 11:53 a.m. with RD, RD stated the facility had general guidance available to kitchen staff for those residents on vegetarian diets. The

facility's general guidance titled, Vegetarian Diets, dated 2023 was reviewed. The Vegetarian Diets indicated, Provide at meals: Breakfast = 1 oz [ounce] pro equivalent, Lunch= 2 to 3 oz

pro equivalent, Dinner= 2 oz pro equivalent, Each food item is listed according to the equivalent of 1 oz. of protein: cheese 1 oz, cottage cheese 1/4 cup, egg 1 [Resident 31 did not eat eggs], legumes 1/2 cup, peanut butter 2 tablespoons, peanuts 2 tablespoons, sunflower or sesame seeds 3-4 tablespoons, Tofu 1/4 cup, Walnuts 16 to 20 nuts, yogurt 8 oz.

During a review of Resident 31's Admission Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/02/24 (Date Registered Nurse signed assessment as complete), the MDS indicated Resident 31's Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) could not be completed due to Resident 31 had Severely impaired-never/rarely made decisions checked under the category C1000. Cognitive Skills for Daily Decision Making. Made decisions regarding tasks of daily life.

During a review of the facility's diet manual for the Regular Mechanical Soft Diet (M/S), dated 2023, the M/S diet indicated, Description: The mechanical soft diet is designed for residents who experience chewing or swallowing limitations. The regular diet is modified by mechanically altering, chopped, or ground. Food that may need to be modified include proteins, raw vegetables, raw fruit, and all other fibrous foods. Foods Avoid: Yogurt with nuts, raw fruit with skins, chopped nuts, anything with seeds.

During an interview on 03/05/25 at 11:57 a.m. with RD, RD stated it was an RDs responsibility to have planned lacto-vegetarian menus developed at least one week in advance for a three week menu cycle, which was the facility's process for any other type of diet order such as renal (for kidney disease) or CCHO (consistent carbohydrate for diabetes care). The planned lacto-vegetarian menu was to be evaluated for nutritional adequacy to meet the nutrition needs of Resident 31 who had been residing at the facility since 7/12/24. RD 1 stated an RD should have provided [NAME] 1 with a planned lacto-vegetarian diet menu/spreadsheet with specific foods and portions to have served to Resident 31 in accordance with the resident's assessed texture needs, developed within the expertise of an RD.

During an interview on 03/05/25 at 12:12 p.m. with [NAME] 1, [NAME] 1 stated he was not told what to serve to [name of Resident 31] M/S ground consistency lacto-vegetarian diet during lunch trayline yesterday, there was no menu given to him. [NAME] 1 stated, I just got one today.

During a review of the facility's P&P titled, Menus, dated 2001, the P&P indicated, Menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Policy Interpretation and Implementation: 1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences). 2. Menus for regular and therapeutic diets are written at least two (2) weeks in advance, and are dated and posted in the kitchen at least one (1) week in advance.The dietitian reviews and approves all menus. Input from the resident is considered in menu planning.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a concurrent observation and interview on 03/04/25 at 12:29 p.m. with FSA 1 in the kitchen, FSA 1 was placing Resident 19's lunch meal tray onto the meal delivery cart for distribution. FSA 1 was asked to remove Resident 19's lunch meal tray from the meal delivery cart and double check it for accuracy. FSA 1 reviewed Resident 19's MTC. The MTC indicated, Dislikes: Banana, Chunky Soups, Lasagna And Egg Noodles. Other Pasta Is Fine, Rice. FSA 1 stated lasagna should not have been served to Resident 19 because lasagna was listed as a food dislike on her MTC. During a review of the facility's P&P titled, Tray Card System (TCS), dated 2023, the P&P indicated, Policy: Each meal tray at breakfast, lunch, and dinner will have a tray card which designates the resident's name, diet, food dislikes, food requests, allergies, beverage preference, and portion size. During a review of the facility's P&P titled, Food Preferences (FP), dated 2023, the P&P indicated, Policy: Resident's food preferences will be adhered to within reason.Food preferences can be obtained from the resident, family, or staff members.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

50939

Based on observation, interview, and record review, the facility failed to ensure a sanitary environment within the foodservice operation and safe food handling when:

1. One of six sampled residents (Resident 34) had three unopened milk cartons left unrefrigerated in her room. This failure had the potential for Resident 34 to consume spoiled milk and develop foodborne illness.

2. Raw pasteurized shell eggs were stored under a pan of covered raw beef inside a walk-in refrigerator. This failure had the potential for cross-contamination and placed residents at an increased risk of foodborne illness.

3. There lacked adequate cleaning schedules, identifying, and reporting of unsanitary conditions in the kitchen by Dietary Manager (DM) and Registered Dietitian (RD) 1 when multiple drains were extensively covered with black, yellow and or white colored substances, an area of pooled water was on the floor near the steamer, accumulation of dust was on the ceiling vents, and there were cracked and/or chipped flooring and rims of the floor drains in various areas throughout the kitchen which impeded the ability to be effectively cleaned. These failures had the potential to cause foodborne illness.

4. A cracked cover to a light fixture, located in the dish machine room, was not identified and reported for repair. This failure posed a risk for an unrecognized fragment of foreign object to fall on or into a clean plate or serving pan and was a safety issue.

5. Three of three ice-machines were not sanitized in accordance with the manufacturer's guidelines. This failure placed the residents at an increased risk of foodborne illness.

Findings:

1. During a concurrent observation and interview on 3/3/25 at 12:47 p.m. with Resident 34 in Resident 34's room, there were three unopened cartons of milk on Resident 34's bed side table. Resident 34 stated two of the unopened milk cartons had been in her room since 8 a.m. this morning and the other unopened carton of milk was from last night.

During a review of Resident 34's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 2/8/25, the MDS indicated Resident 34 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (score of 13-15 means cognitively intact).

During an observation on 3/3/25 at 12:51 p.m. in Resident 34's room, three cartons of unopened milk were still on Resident 34's bedside table.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview with Registered Dietitian (RD) 1 in Resident 34's room, RD 1 took the temperature of the milk cartons with the facility's thermometer. The temperature readings were: Unopened milk carton one 73.6 Degrees Fahrenheit (F-temperature scale) Unopened milk carton two 73.8 F Unopened milk carton three 72.3 F RD stated, I'm sure the milk temperature are out of temperature by now. During a review of the facility's policy and procedure (P&P) titled, Food Preparation and Service, dated 11/2022, the P&P indicated, Policy Statement: Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: 1. Danger Zone means temperatures above 41 degrees Fahrenheit (F) .that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially Hazardous Foods (PHF) or Time/Temperature Control for Safety (TCS) Foods held in the danger zone for more than 4 hours .may cause foodborne illness outbreak if consumed. 2. Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) Food means food that requires time/temperature control for safety to limit the growth of pathogens (i.e. [for example], bacterial or viral organisms capable of causing disease or toxin formation). Examples of PHF/TCS foods include .milk. 27157 2. During a concurrent observation and interview on 03/04/25 at 8:53 a.m. with Dietary Manager (DM) in a walk-in refrigerator, a crate of raw pasteurized shell eggs located on a food storage tray on a rack was stored under a pan of covered, raw beef was placed on a food storage tray above the raw pasteurized shell eggs. DM stated he was not aware pasteurized shell eggs should be stored above raw meat. During a concurrent interview and record review on 03/04/25 at 9:40 a.m. with DM and Registered Dietitian (RD) inside the kitchen, a poster located on the door of the walk-in refrigerator titled Proper Refrigerator Storage; Policy #B006 (PRS), undated was reviewed. The PRS poster indicated the top shelf should store Raw Pasteurized Eggs and raw Whole Meat should be stored on the shelf below the raw pasteurized shell eggs. RD and DM stated the facility's policy on proper refrigerator storage was not followed. 3. During a concurrent observation and interview on 03/04/25 at 11:06 a.m. with DM in the kitchen, a floor sink drain located underneath the dish machine had extensive build-up of thick black and orange-colored substances on the sides, rims and floor of the floor sink drain. The floor sink drain's rim was chipped off one side. DM stated the floor sink drain was not maintained in a sanitary manner. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 03/04/25 at 11:31 a.m. with DM in the kitchen, an accumulation of dust was on vents located on the ceiling directly over trayline with exposed food. The vents on the ceiling located in the dish machine room also had an accumulation of dust. DM stated they were not currently on a cleaning schedule because he only used the vents when the kitchen's swamp cooler and/or air conditioner was on during the hot summer. During a concurrent observation and interview on 3/4/25 at 11:34 a.m. with DM in the kitchen, located in an alcove room, back behind, and adjacent to the janitorial closet, was an ice-machine and a large drying rack that held clean foodservice equipment. A wire mesh covered a large drain located underneath the ice-machine. The wire mesh had extensive white and yellow colored dried discoloration on the floor in multiple areas underneath the ice-machine. A black round/elongated shape was observed under the ice-machine which was not identifiable by DM. DM stated the bad smell was strongest around that area. During a concurrent observation and interview on 3/4/25 at 11:35 a.m. with DM in the kitchen, a small flat floor drain located in front of the ice-machine had cracked/chipped flooring around one part of the drain and build -up of black/brownish colored debris with a small amount of pooled water. DM stated he did not think the water was coming up out of the drain but thought it was due to melted ice that was accidentally dropped when dietary staff obtained ice. DM stated he had not reported the cracked/chipped flooring to the maintenance supervisor and it should have been reported. During an interview on 3/4/25 at 11:36 a.m. with Food Service Assistant (FSA) 1 in the kitchen, FSA 1 stated she sometimes smelled a bad odor in that area where the dish machine and janitorial closet were located. During a concurrent interview and record review on 03/04/25 at 11:37 a.m. with DM in the kitchen, the Cleaning Schedule for Cook, undated, Cleaning Schedule for Trayside, undated, and Cleaning Schedule for Dish Room, undated, were reviewed. DM stated the facility's maintenance supervisor (MS) was not responsible for cleaning of the floor sink drains. DM stated the floor sink drains located in the kitchen were not noted on any of the cleaning schedules and were not being cleaned. During a review of the Food and Drug Administration Food Code Annex (FDAFCA), dated 2022, the FDAFCA indicated, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. The objective of cleaning focuses on the need to remove organic matter from food contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. (FDA Food Code Annex: 4-601.11) During an observation on 3/4/25 at 11:39 a.m. with DM in the kitchen, the vents on the ceiling located in the dish machine room had an accumulation of dust. During a concurrent observation and interview on 03/4/25 at 11:50 a.m. with [NAME] 1 in the kitchen, an elongated grated floor drain with thick black colored debris, located in front of the steamer, had chipped flooring near it and water around the drain. [NAME] 1 stated the water was from the steamer and demonstrated by opening and then closing the steamer door in which a significant amount of water began to leak from the bottom of a green hose connected to the steamer. The water fell , and pooled, directly on the floor and had not reached a drain. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 03/4/25 at 11:55 a.m. with DM and RD 1 in the kitchen, a large floor drain, located under a small shelving rack, was covered with a grate that had extensive discoloration of a white and yellow colored substance. The shelving rack front right leg and back right leg were propped up on a white colored material with grooves that had build-up of white colored substance. RD and DM stated the area was not maintained in a sanitary manner. RD stated the legs were propped up because the floor was not even. During a concurrent observation and interview on 03/04/25 at 12:02 p.m. with DM and [NAME] 1 in the kitchen, a pipe was observed directly plumbed into the wall with the other end of the white colored plastic pipe coming out of the wall and connecting to a long thin pipe running underneath, and along the length of, a food preparation counter with the outlet of the pipe extending over a above-ground floor drain in which the water trap was filled with water. [NAME] 1 stated there was a work order for the backed up drain. In addition, the tile floor underneath the long food preparation counter was not clean as evidenced by extensive brownish color particularly along the rim of the floor and baseboard. During an interview on 03/04/25 at 12:05 p.m. with DM, DM stated once he entered the work order into the electronic software the facility used for work orders he could no longer see them or retrieve them. During a review of the FDAFCA, dated 2022, FDAFCA indicated, Liquid wastes need to be quickly carried away to prevent pooling which could attract pests such as insects and rodents. (FDA Food Code Annex; Chapter 6: Physical Facilities) During a review of the Food and Drug Administration Food Code [FDAFC], dated 2022, the FDAFC indicated, Floors.shall be designed, constructed, and installed so they are smooth and easily cleanable. During a review of the facility's policy and procedure (P&P) titled, Sanitization, dated November 2022, the P&P indicated, Policy Statement: The food service area is maintained in a clean and sanitary manner. 1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. 2. All.equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper. 4. During a concurrent observation and interview on 03/04/25 at 12:07 p.m. with DM in the kitchen, a light fixture located on the ceiling on the clean side of the dishmachine room, had a crack in the light cover. DM stated he had not identified the damaged light cover and thus had not reported the need for repair to maintenance. During a review of the facility's P&P titled, Walls, Ceilings, And Light Fixtures (WCL), dated 2023, the P&P indicated, Replace light fixtures as needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ridgecrest Regional Transitional Care and Rehabili		STREET ADDRESS, CITY, STATE, ZIP CODE: 1081 North China Lake Boulevard Ridgecrest, CA 93555	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. During a concurrent interview and record review on 03/06/25 at 10:08 a.m. with Maintenance Supervisor (MS), MS stated he was the one that cleaned the ice-machine located in the kitchen. MS showed a bottle labeled as Nu-Calgon Nickel-Safe Ice Machine Cleaner Food Grade.for removing scale deposits. MS stated he circulates the Nickel-Safe descaler which was both a cleaner and a sanitizer through the ice-making apparatus (top part of the ice machine) on a monthly basis. MS stated he used bleach only in the bin of the ice-machine to sanitize. MS was asked what product he circulated through the water distributor to sanitize and MS pointed to the bottle of Nickel-Safe Cleaner. MS stated that was all he had to use because it was both a cleaner and a sanitizer. During a concurrent interview and record review on 3/6/24 at 10:13 a.m. with MS, the manufacturer's label located on the bottle of Nu-Calgon Nickel-Safe Ice Machine Cleaner (IMC) was reviewed. The IMC label indicated, Rapid scale remover. The back of the IMC label indicated, 6. To clean evaporator and recirculating water system add Nickel-Safe Ice Machine Cleaner to the water in ice maker according to manufacturer's instructions. 7. Allow cleaning solution to circulate for up to 10 minutes.9. Recommend: Sanitize the machine with IMS-III Sanitizing concentrate. During a concurrent interview and record review on 03/06/25 at 10:46 a.m. with MS, the ice-machine manufacturer's guidelines (IMMGs) titled, Sanitizing and Water System Cleaning, undated, were reviewed. The IMMGs indicated, The water system is cleaned by pumping a mixture of water and nickel safe type ice machine cleaner through the water distributor, over the evaporator and back to the reservoir.Note: The ice making portion of the water system should be sanitized after cleaning by repeating steps 7-9, except substitute an approved sanitizing solution. MS stated IMMGs were for the ice-machine located in the kitchen. MS stated the ice machine's manufacturer's guidelines were not followed as MS missed the sanitizing step. During an interview on 03/06/25 at 10:50 a.m. with MS, MS stated he did the same cleaning process for the ice-machine located near 200 hall nursing station and for the ice-machine located near 300 hall nursing station. MS stated he thought the Nickel Safe Cleaner was also a sanitizer. During a review of the facility's P&P titled, Sanitization, dated November 2022, the P&P indicated, Ice machines and ice storage containers are drained, cleaned and sanitized per manufacturer's instructions.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37797 Based on observation, interview, and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify, develop, and implement infection prevention and control action plans to correct infection control deficient practices identified by the survey team (Reference tags F-880, F-882 and F-945). This failure placed all 73 facility residents at risk for infectious diseases. Findings: During a concurrent interview and record review on 3/6/25 at 11:50 a.m. with the Administrator, the minutes of the facility's Quality Assurance and Performance Improvement (QAPI) (a committee that identifies quality deficits and implements corrective plans) meeting dated 1/23/25 (the most recent QAPI meeting) were reviewed. The Administrator indicated the 1/23/25 QAPI meeting covered the period of October, November, and December 2024. The facility's QAPI meeting minutes dated 1/23/25 were reviewed. The QAPI meeting minutes indicated a one page infection prevention control report titled Quarterly Report Infection Prevention 2024. The Quarterly Report Infection Prevention 2024 report indicated the rate of Urinary Tract Infections (UTIs) (infection of the urinary system), respiratory infections, and skin infections at the facility. No other infection and prevention control concerns or issues were documented in the 1/23/25 meeting minutes. The surveyor reviewed the survey team's infection prevention and control deficient practices identified during the current survey with the Administrator. The facility's deficient practices reviewed included failure to clean and disinfection glucometers (devices use to measure blood sugar levels) between resident use, infection prevention and control education not provided to staff, enhanced barrier precautions (an infection control strategy) not implemented in the facility, and failure to ensure the Infection Preventionist conducted surveillance activities (collecting, analyzing, and tracking and trending of infection control practices and data) (Reference tags F-880, F-882 and F-945). The Administrator stated the above infection control deficient practices had not been identified by the facility and were not covered during the most recent (1/23/25) QAPI meeting. During a review of the facility policy and procedure (P&P) titled QAPI [Facility Name], dated 1/18/24, the P&P indicated: Our QAPI activities will cross service areas and departments and we will work together to assure we address all concerns and strive to continuously improve the provided services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50939 Based on observation, interview, and record review, the facility failed to implement infection prevention and control practices when: 1. One of six sampled residents (Resident 6) had three opened gallons of distilled water on top of a commode. This failure had the potential for contamination of the distilled water. 2. Treatment Nurse (TN) dropped an item from the treatment cart, picked it up off the floor, and placed it back in the treatment cart. This failure had the potential for contamination of clean items in the treatment cart. 3. Infection Preventionist (IP) did not follow the facility's policy and procedure (P&P) titled, Monitoring Compliance with Infection Control for surveillance (monitoring) activities, collecting, analyzing, and tracking and trending of data. This failure had the potential for facility to be unaware of outbreaks and transmission of infectious diseases. 4. Enhanced Barrier Precaution (EBP-a set of infection control measures that use gowns and gloves to reduce the spread of multi-drug-resistant organisms [MDROs-bacteria resistant to antibiotics]) was not implemented for three of three sampled residents (Resident 6, Resident 31, and Resident 11). This failure had the potential to spread infections to residents, staff, and visitors. 5. The facility failed to clean and disinfect glucometers (medical devices that measure blood sugar levels) between resident use according to manufacturer's instructions for two of two sampled residents (Resident 30 and Resident 61). This failure placed Resident 30 and Resident 61 at risk for bloodborne (diseases that spread via the blood) infectious diseases. Findings: 1. During a concurrent observation and interview on 3/3/25 at 10:32 a.m. with Resident 6 in Resident 6's room, there were three opened gallons of distilled water on top of Resident 6's commode. Resident 6 stated the gallons of water were used for her continuous positive airway pressure machine (CPAP-a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in). Resident 6 stated she used the commode occasionally. During a review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/28/25, the MDS indicated Resident 6 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (score of 13-15 means cognitively intact). During a review of Resident 6's Client Diagnosis Report (CDR), dated 3/5/25, the CDR indicated Resident 6 had a diagnosis of Obstructive Sleep Apnea (airflow blockage during sleep). During a review of Resident 6's Physician's Telephone Order'' (PTO), dated 2/19/25, the PTO indicated, CPAP MACHINE WITH PRE-SET SETTINGS AT NIGHT WHILE SLEEPING EVERY BEDTIME. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/3/25 at 11:23 a.m. with IP, IP stated there were three gallons of used distilled water on top of Resident 6's commode. IP stated the distilled water was used for Resident 6's CPAP machine. IP stated the distilled gallons of water should not be stored on top of the Resident 6's commode. IP stated the water storage on top of the commode was unsanitary. 2. During an observation on 3/3/25 1:03 p.m. in the hallway, TN opened a drawer of the treatment cart, a packaged (medical device) kit fell out of the treatment cart, TN picked up the item from the floor, and placed item back into a drawer in the treatment cart. During a concurrent observation and interview on 3/3/25 at 1:04 p.m. with TN in the hallway, TN opened the drawer of the treatment cart and the packaged (medical device) kit that fell out of the cart was in the treatment cart next to an opened package of gauze. TN stated she should not have put the packaged item that fell on the floor back into the treatment cart. 3. During an interview on 3/5/25 at 8:53 a.m. with IP stated he only monitored hand hygiene which included hand washing and hand rub, and donning on and doffing (removing) of Personal Protective Equipment (PPE-clothing and equipment that is worn for protection against hazardous substances and/or environments). IP stated, I try to go out to the floor every other day and on every shift. IP stated glucometer use and cleaning was not part of his infection control surveillance. During a review of the facility's Hand Hygiene Monitoring Tool (HHMT), dated January 2025, February 2025, and March 2025, the HHMT did not indicate an adherence rate for staff hand hygiene compliance or actions taken to correct non-compliance with infection control practices. IP stated he did on-the-spot education with staff who are non compliant with hand hygiene but he did not document it. IP did not provide tracking and trending of the staff noncompliance of hand hygiene practices analysis of the surveillance, or actions taken to correct non-compliance. During a review of the facility's P&P titled, Monitoring Compliance with Infection Control, dated 8/2019, the P&P indicated, Policy Statement: Routine monitoring and surveillance of the workplace are conducted to determine compliance with infection prevention and control policies and practices. 6. The infection preventionist and/or the IPC committee provides reports to the QAPI [Quality Assurance and Performance Improvement] committee that reflect: all infection surveillance data. 4 a. During a concurrent observation and interview on 3/3/25 at 10:32 a.m. in Resident 6's room, Resident 6 had a dressing to the right leg. Resident 6 state she had an ulcer (open sore) on the right side of her heel. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had a BIMS score of 15. During a review of Resident 6's AOR dated 3/6/25, the AOR indicated, Cellulitis (bacterial infection of the skin) of right lower limb, Cellulitis of left lower limb. During an observation on 3/3/25 at 10:55 a.m. outside Resident 6's room, there was no EBP signage posted and there were no PPE supplies in Resident 6's room or outside the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's Active Orders Report (AOR), dated 3/5/25, the AOR indicated, Venous wound to the Right/Left heel Cleanse venous wounds on the Right and Left heel with wound spray, pat dry, apply Xeroform [treats wounds], then apply non-adherent pad, wrap with Kerlix [gauze] The AOR also indicated, Right Lower Extremity Open Wound Cleanse with wound spray, pat dry, apply adaptic, apply non-adhesive pad, wrap with kerlix .Non-pressure chronic ulcer [an open sore] of right calf with fat layer exposed. b. During a concurrent observation and interview on 3/3/25 at 10:39 a.m. in Resident 34's room, Resident 34 had swelling to bilateral legs with a dressing to her right leg. Resident 34 stated she had cellulitis (a skin infection that causes swelling and redness) to both of her legs. During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 had a BIMS score of 15. During an observation on 3/3/25 at 10:55 a.m. outside Resident 34's room, no EBP signage was observed and no PPE supplies were in Resident 34's room or outside the room. c. During an observation on 3/3/25 at 2:21 p.m. in Resident 11's room, Resident 11 was sitting in her wheelchair with a Foley catheter (a hollow tube inserted into the bladder to drain or collect urine) bag in a privacy bag behind wheelchair. No EBP signage was observed. No PPE supplies were in the resident's room or outside the room. During a review of Resident 11's Physician's Telephone Order, (PTO) dated 3/5/25, the PTO indicated, FOLEY CATHETER .Retention of urine. During an interview on 3/5/25 at 10:05 a.m. with IP, IP stated EBPs were not really implemented in the facility, and he did not know what the criteria was for EBP. IP stated he did not know what type of PPE was required for EBP. During an interview on 3/5/25 at 10:41 a.m. with Licensed Vocational Nurse (LVN) 13, LVN 13 stated this was the first time she heard about EBP. During an interview on 3/5/25 at 10:47 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated she was unaware of EBP. During an interview on 3/5/25 at 10:52 a.m. with Assistant Director of Nursing (ADON). ADON stated she did not know much about EBP. During an interview on 3/5/25 at 11:54 a.m. with Director of Staff Development (DSD), DSD stated she had not heard much about EBP. During an interview on 3/5/25 at 12:35 p.m. with Director of Nursing (DON), DON stated she went to an infection prevention conference, but was not sure when the AFL (All Facilities Letter) indicated EBPs were required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the California Department of Health's AFL (CDPHAFL), dated 6/13/24, the CDPHAFL indicated, On March 20, 2024, CMS [Centers for Medicare & Medicaid Services] distributed CMS QSO-24-089 NH (PDF), which updated its infection prevention and control guidance for long-term care facilities to include the CDC [Centers for Disease Control and Prevention] guidance for EBP. During a review of the facility's P&P titled, Enhance Barrier Precaution, dated 12/2024, the P&P indicated, 2. Enhanced barrier precautions apply when: a. A resident is infected or colonized with a CDC-targeted MDRO . b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices .5. Indwelling medical devices include .urinary catheters, feeding tubes .7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities. 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering, c. providing hygiene or grooming; d. changing briefs or assisting with toileting; e. transferring; f. providing bed mobility; g. changing linens; h. prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin .10. Residents on EBPs may come out of their rooms and participate in group activities and dining with other residents .16. Staff are trained prior to caring for residents on EBPs. 17. Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE required. 18. Personal protective equipment .are readily accessible to staff. 37797 5. During a concurrent observation and interview on 3/5/25 at 11:20 a.m. with LVN 1, LVN 1 checked the blood sugar level of Resident 36 using an ACCU-CHEK Inform II (brand name) Glucometer and placed the glucometer on top of the medication cart without cleaning or disinfecting the device. After administering insulin (a medication to control high blood sugar levels) to Resident 36, LVN 1 took the same glucometer used for Resident 36 from the top of the medication cart, inserted a test strip, went into Resident 61's room, poked Resident 61's finger with a lancet (a small, sharp needle), brought the glucometer with the strip's tip towards Resident 61's finger when LVN 1 was stopped by the surveyor and questioned if she had cleaned and disinfected the glucometer after using it to check Resident 36's blood sugar. LVN 1 stated she had not cleaned the glucometer. During a concurrent observation and interview on 3/5/25 at 11:40 a.m. with LVN 2, LVN 2 checked the blood sugar level of Resident 10 using an ACCU-CHEK Inform II Glucometer and placed the glucometer on top of the medication cart without cleaning or disinfecting it. After administering insulin to Resident 10, LVN 2 took the same glucometer used for Resident 10 from the top of the medication cart, inserted a test strip, went into Resident 30's room, poked Resident 30's finger with a lancet, brought the glucometer with the strip's tip towards Resident 30's finger when LVN 2 was stopped by the surveyor and questioned if she had cleaned and disinfected the glucometer after using it to check Resident 10's blood sugar. LN 2 stated she had not cleaned the glucometer. During an interview on 3/6/25, at 10:45 a.m. with the facility's IP, IP stated nurses should clean and disinfect glucometers after each resident using purple wipes (Sani-Cloth Sanitizing Wipes - a type of healthcare disinfectant that kills bloodborne pathogens) observing a two-minute contact time (the amount of time the glucometer surfaces must be wet with the disinfectant solution to kill the pathogens). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the ACCU-CHEK Inform II Glucometer Operator Manual (OM), undated, the OM indicated: The meter should be cleaned and disinfected between each patient use. During a review of the facility's policy and procedure (P&P) titled, Blood Sampling - Capillary (Finger Stick), dated September 2014, the P&P indicated, The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees . Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses . Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50939 Based on observation, interview, and record review, the Infection Preventionist (IP) failed to demonstrate competency to carry out the functions of the Infection Prevention and Control Program for the facility when: 1. The IP did not follow the facility's policy and procedure (P&P) titled, Monitoring Compliance with Infection Control for surveillance (monitoring) activities, collecting, analyzing, tracking and trending of data. This failure had the potential for facility to be unaware of outbreaks and transmission of infectious diseases. [reference F880] 2. Enhanced Barrier Precaution were not implemented in the facility. This failure had the potential to spread infections to residents, staff, and visitors. [reference F880] Findings: 1. During a concurrent interview and record review on 3/5/25 at 8:53 a.m. with IP, the facility's surveillance activities for infection control were reviewed. IP stated he only monitored hand hygiene which included hand washing and hand rub, and donning on and doffing of Personal Protective Equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments). IP stated I try to go out to the floor every other day and on every shift. IP stated he observed Certified Nursing Assistants, Licensed Vocational Nurses, Registered Nurses, Administrator, Physical Therapists, Transportation, and Environmental Services. IP stated the glucometer use and cleaning was not part of his surveillance. During a review of the facility's Hand Hygiene Monitoring Tool (HHMT), dated January 2025, February 2025, and March 2025, the HHMT did not indicate an adherence rate or the actions taken to correct non-compliance. IP stated he did on-the-spot education but did not document it. IP stated he only collected data. IP did not provide tracking and trending reports, analysis of surveillance, or actions taken to correct non-compliance. During a review of the facility's P&P titled, Monitoring Compliance with Infection Control, dated 8/2019, the P&P indicated, Policy Statement: Routine monitoring and surveillance of the workplace are conducted to determine compliance with infection prevention and control policies and practices. 6. The infection preventionist and/or the IPC committee provides reports to the QAPI [Quality Assurance and Performance Improvement] committee that reflect: all infection surveillance data. 2. During a concurrent observation and interview on 3/3/25 at 10:32 a.m. in Resident 6's room, Resident 6 had a dressing to right leg. Resident 6 state she had an ulcer (open sore) to right side of her heel. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had a BIMS score of 15. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/3/25 at 10:55 a.m. outside Resident 6's room, no EBP signage or PPE supplies were observed in Resident 6's room or outside the room. During a review of Resident 6's Active Orders Report (AOR), dated 3/5/25, the AOR indicated: 1.Venous wound to the Right/Left heel Cleanse venous wounds on the Right and Left heel with wound spray, pat dry, apply Xeroform [treats wounds], then apply non-adherent pad, wrap with Kerlix [gauze] . 2.Right Lower Extremity Open Wound Cleanse with wound spray, pat dry, apply adaptic, apply non-adhesive pad, wrap with kerlix .Non-pressure chronic ulcer [an open sore] of right calf with fat layer exposed. During a concurrent observation and interview on 3/3/25 at 10:39 a.m. in Resident 34's room, Resident 34 had swelling to bilateral legs with a dressing to her right leg. Resident 34 stated she had cellulitis (a skin infection that causes swelling and redness) to both of her legs. During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 had a BIMS score of 15. During an observation on 3/3/25 at 10:55 a.m. outside Resident 34's room, no EBP signage or PPE supplies were observed in Resident 34's room or outside the room. During a review of Resident 6's AOR dated 3/6/25, the AOR indicated, Cellulitis (bacterial infection of the skin) of right lower limb, Cellulitis of left lower limb. During an observation on 3/3/25 at 2:21 p.m. in Resident 11's room, Resident 11 was sitting in her wheelchair with Foley catheter (a hollow tube inserted into the bladder to drain or collect urine) bag in a private bag behind wheelchair. No EBP signage or PPE supplies were observed in Resident 11's room or outside the room. During a review of Resident 11's Physician's Telephone Order, (PTO) dated 3/5/25, the PTO indicated, FOLEY CATHETER .Retention of urine. During an interview on 3/5/25 at 10:05 a.m. with IP, IP stated EBP ws not really implemented in the facility, and he did not know what the criteria was to place residents on EBP. IP stated he did not know what type of PPE was used for EBP. During an interview on 3/5/25 at 10:41 a.m. with Licensed Vocational Nurse (LVN) 13, LVN 13 stated this was the first time hearing about EBP. During an interview on 3/5/25 at 10:47 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated she did not know what EBP was. During an interview on 3/5/25 at 10:52 a.m. with Assistant Director of Nursing (ADON) , ADON stated she did not know much about EBP. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/25 at 11:54 a.m. with Director of Staff Development (DSD), DSD stated, I haven't heard much about Evidence Based Precaution. During an interview on 3/5/25 at 12:35 p.m. with Director of Nursing (DON), DON stated she went to an infection prevention conference, but was not sure when EBP or the AFL (All Facilities Letter) was rolled out. During a review of the California Department of Health's AFL, (CDPHAFL) dated 6/13/24, the CDPHAFL indicated, On March 20, 2024, CMS [Centers for Medicare & Medicaid Services] distributed CMS QSO-24-089 NH (PDF), which updated its infection prevention and control guidance for long-term care facilities to include the CDC [Centers for Disease Control and Prevention] guidance for EBP. During a review of the facility's P&P titled, Enhance Barrier Precaution, dated 12/2024, the P&P indicated, 2. Enhance barrier precautions apply when: a. A resident is infected or colonized with a CDC-targeted MDRO . b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices .5. Indwelling medical devices include .urinary catheters, feeding tubes .7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities. 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering, c. providing hygiene or grooming; d. changing briefs or assisting with toileting; e. transferring; f. providing bed mobility; g. changing linens; h. prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin .10. Residents on EBPs may come out of their rooms and participate in group activities and dining with other residents .16. Staff are trained prior to caring for residents on EBPs. 17. Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE required. 18. Personal protective equipment .are readily accessible to staff. During a review of the facility's CRITERIA-BASED JOB DESCRIPTION INFECTION PREVENTIONIST, (CBJDIP) dated 10/8/20, the CBJDIP indicated, This individual is accountable for decreasing the incidence and transmission of infectious diseases between patients, staff, visitors and the community. Through strategic planning, leadership and consultation, the individual will be the lead in the identification and implementation of infection prevention goals and objectives throughout the facility. During a review of the facility's P&P titled, Infection Prevention and Control Program, dated 10/2018, the P&P indicated, 3. The infection prevention and control programs a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. 4. The elements of the infection program is coordination/oversight .surveillance, data analysis .5a. The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist). 7b .monitoring adherence to infection prevention and control practices. 9a. Data gathered during surveillance is used to oversee infections and spot trends. 11a. (3) educating staff and ensuring that they adhere to proper techniques and procedures .(8) following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 27157 Based on observation, interview, and record review, the facility failed to ensure essential equipment was maintained in safe operating condition when: 1. A food preparation sink located in the kitchen had an air gap and floor sink drain in accordance with the Food and Drug Administration Food Code (FDAFC), dated 2022. Facility failure to ensure proper plumbing installation may result in potential health hazards such as cross connections, back siphonage or backflow. These conditions may result in the contamination of food, utensils, equipment, or other food-contact surfaces. (FDAFC, 5-402.11, 2022) 2. Two of two ice-machines located near two different nursing stations had an air gap per the ice-machine's manufacturer's guidelines (MG) and FDAFC, dated 2022. In addition, the ice-machine located near 300 hall nursing station was not stored in a manner that eliminates harborage of pests when there was opened holes/crevices between the baseboard and wall, peeling paint coming off the wall, and the floor was not clean with cracked tiles. Findings: 1. During an observation on 03/04/25 at 12:02 p.m. in the kitchen, a pipe was observed directly plumbed into the wall with the other end of the white colored plastic pipe coming out of the wall and connecting to a long thin pipe running underneath, and along the length of, a food preparation counter with the outlet of the pipe extending over a above-ground floor drain in which the water trap was filled with water. During an interview on 03/06/25 at 09:46 a.m. with Maintenance Supervisor (MS), MS stated the outlet for the hose connected to the coffee maker was draining into the above-floor drain which caused coffee grounds to accumulate in the drain which was why the drain had standing water. MS stated the pipe under the food prep sink was plumbed into the wall into the water system and the white colored pipe under the food prep sink was a P trap and that was why there was no outlet with an air gap nor a floor sink drain for the food prep sink. MS stated he was unaware of the requirement for a food prep sink to have an air gap per the FDA Food Code 2022. During a review of an e-mail communication on 03/07/25 at 6:29 a.m. with Compliance Officer (CO) from Department of Health Care Access and Information Office of Statewide Hospital Planning and Development (HCAI), after CO observed a picture of the plumbing structure located underneath the food preparation sink in the kitchen, the CO's e-mail indicated, The [food] prep sink is a problem, this sink is required to be discharged to a floor sink with copper DWV (Drain, Waste, and Vent) piping per the local health department requirements. During a review of California Health and Safety Code (HSC) Section 114193, dated 2024, the HSC indicated, All steam tables, ice machines and bins, food preparation sinks, warewashing sinks, display cases, walk-in refrigeration units, and other similar equipment that discharge liquid waste shall be drained by means of indirect waste pipes, and all wastes drained by them shall discharge through an airgap into a floor sink or other approved type of receptor. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the FDAFC, dated 2022, the FDAFC indicated, An air gap between the water supply inlet and the flood level rim of the plumbing fixture [such as a food preparation sink], equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm [millimeters] (1 inch). (FDAFC; 5-202.13 Backflow Prevention, Air Gap). During a review of the FDAFC, dated 2022, the FDAFC indicated, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. During a review of an e-mail communication on 03/07/25 at 6:29 a.m. with Compliance Officer (CO) from HCAI, the e-mail indicated, The work at the prep sink will require a HCAI project record. The deficiencies.are beyond normal maintenance. 2. During a concurrent observation and interview on 03/06/25 at 10:46 a.m. with MS, an ice-machine near 200 hall nursing station was observed. MS stated the ice machine did not have a visible air gap nor a drain. During a concurrent interview and record review on 03/06/25 at 10:55 a.m. with MS, MS provided ice-machine manufacturer's guidelines and stated the MGs were for the ice-machine located near 200 hall nursing station. The MGs indicated, Maintain the air gap required by local code between the end of the drain tubes and the building drain receptacle. During a concurrent observation and interview on 03/06/25 at 11:33 a.m. with MS, an ice-machine near 300 hall nursing station was observed to have a pipe inserted into a white plastic pipe which did not allow for a 1 inch air gap of space that separates a water line from an ice machine drain. During a review of an e-mail communication on 03/07/25 at 6:29 a.m. with Compliance Officer (CO) from HCAI, after CO observed a picture of the plumbing structure for the ice machine located near 300 hall nursing station, the e-mail indicated, The ice machine fixed air gap is installed wrong. The pipe should terminate as high as possible in the air gap. The pipe is inserted into the air gap where any blockage would contaminate the pipe. The drain piping should be copper with DWV fittings. During an observation on 03/06/25 at 11:35 a.m. near 300 hall nursing station where the ice machine was located, the wall surrounding the ice machine above the baseboard had cracks and crevices due to the baseboard separating from the wall with extensive peeling paint coming off the wall. The floor was dirty with cracked tiles. During a review of the FDAFC, dated 2022, the FDAFC indicated, Floors that are smooth.are required to ensure effective cleaning is possible. During a review of the FDAFC, dated 2022, the FDAFC indicated, The presence of .dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food [ice is food]. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the FDAFC, dated 2022, the FDAFC indicated, shall be protected against the entry of insects and rodents by: (1) Filling or closing holes and other gaps along floors, walls, and ceilings. During a review of the facility's policy and procedure (P&P) titled, Walls, Ceilings, And Light Fixtures (WCL), dated 2023, the P&P indicated, 1.Walls and ceilings must be free of chipped and/or peeling paint. 2. It is important to repair peeling paint areas as soon as they appear.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 45654 Based on interview, and record review, the facility failed to follow its Policy and Procedure titled, Employee Training on Infection Control, for 11 of 25 sampled Licensed Vocational Nurses (LVN) (LVN 1, LVN 2, LVN 3, LVN 4, LVN 5, LVN 6, LVN 7, LVN 8, LVN 10, LVN 11, and LVN 12) and four of six sampled Registered Nurses (RN) (RN 1, RN 2, RN 4, and RN 5). This failure resulted in licensed nursing staff being unaware of standard infection prevention precautions, increasing the potential for the spread of infectious diseases to residents, staff, and visitors. Findings: During a concurrent interview and record review on 3/5/25 at 2:39 p.m. with Infection Preventionist (IP) the facility's education titled,Infection Prevention (IP), dated 6/18/24, 6/19/24, 1/24/24, and 1/25/24 was reviewed. The IP education indicated some of the topics that should have been covered during the training included: the six elements of Standard Precautions, the importance of hand hygiene, contact wet time of disinfectants, proper use of personal protective equipment, the difference between cleaning and disinfecting, and maintaining separation between clean and soiled devices to prevent the spread of infection. IP stated he did not remember what he trained staff on and did not provide training documents. During an interview on 3/6/25 at 10:27 a.m.with Licensed Vocational Nurse, (LVN)3, LVN 3 stated he could not remember the last Infection Control training he attended. During a review of the facility's policy and procedure (P&P) titled, Employee Training on Infection Control, dated January 2012, the P&P indicated all staff and personnel would complete orientation and training on preventing the transmission of healthcare associated infections.