STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555920	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Care Center	5265 East Huntington Avenue Fresno, CA 93727

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure residents were provided with dignity and respect for two of eight sampled residents (Resident 146 and Resident 243) when: 1. Licensed Vocational Nurse (LVN) 3 checked vital signs (V/S-measurements of blood pressure, pulse rate and temperature) and administered medication to Resident 146 in hallway B and did not provide privacy. 2. LVN 3 checked V/S and administered medication to Resident 243 in Residents' room and did not provide privacy. These failures resulted in Resident 146 and Resident 243 not being treated with respect and dignity while their vital signs were taken and while taking their medications. Findings: 1. During a concurrent observation and interview on 5/15/24 at 8:51 a.m. in B hallway, Resident 146 was sitting up in his wheelchair. LVN 3 checked Resident 146's V/S and prepared Resident 146's medications. LVN 3 administered Resident 146's medications in the hallway with other residents and staff walking by. During a review of Resident 146's clinical record titled, Admission Record (AR-document with resident demographic and medical diagnosis information), dated 5/16/24, AR indicated Resident 146 was admitted to the facility on [DATE], with diagnosis which included cerebral infarction (damage of issues in the brain due to a loss of oxygen), hemiplegia (paralysis- unable to move or control the muscles in the affected body part) and hemiparesis (weakness or the inability to move on one side of the body) and muscle weakness. During a review of Resident 146's Minimum Data Set (MDS - an assessment tool used to identify resident cognitive [pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 146's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 14 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 146 had no cognitive deficit. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/24 at 3:45 p.m. with LVN 3, LVN 3 stated she should not have checked Resident 146's V/S and administered his medications in the hallway. LVN 3 stated the practice was to not administer medications or check V/S in the hallway because of privacy issue. LVN 3 stated she should have asked Resident 146 to go in his room and check his V/S and administered his medications. During an interview on 5/17/24 at 10:30 a.m. with the Director of Nursing (DON), the DON stated LVN 3 should have asked Resident 146 to go in his room then checked his V/S and administered Resident 146's medications. The DON stated it was a resident rights to privacy, there were other residents, staff and visitors walking by and could see what was going on. The DON stated resident's privacy was very important. 2. During a concurrent observation and interview on 5/15/24 at 9:10 a.m. in Resident 243's room, Resident 243 was laying in bed with head of bed elevated, Resident 243's upper body and legs were exposed and privacy curtain was not drawn to provide privacy. LVN 3 checked Resident 243's V/S without providing privacy. LVN 3 prepared Resident 243's medications and administered his medications while Resident 243 was laying in bed and did not provide privacy with other residents and staff walking by. During a review of Resident 243's clinical record titled, Admission Record (AR), dated 5/16/24, AR indicated Resident 243 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, epilepsy (seizures-a sudden, uncontrolled burst of electrical activity in the brain) depression (a low mood or loss of pleasure or interest in activities for long periods of time) and muscle weakness. During a review of Resident 243's MDS assessment dated [DATE], indicated Resident 243's BIMS assessment score was 15 out of 15 indicating Resident 243 had no cognitive deficit. During an interview on 5/15/24 at 3:45 p.m. with LVN 3, LVN 3 stated she did not provide privacy to Resident 243 when she checked V/S and administered his medications. LVN 3 stated privacy curtain was open and Resident 243 was exposed to other residents, staff and visitors walking by the hallway. LVN stated she should have closed the privacy curtain providing privacy to Resident 243 while his V/S were taken and when taking his medications. LVN 3 stated the practice was to provide privacy when administering medications and when checking V/S. During an interview on 5/17/24 at 10:35 a.m. with the DON, the DON stated LVN 3 should have provided privacy to Resident 243 by closing the privacy curtain when she checked the V/S and administered resident's medications. The DON sated there were other residents, staff and visitors walking by in the hallway and could see residents taking their medications. The DON stated residents' privacy was very important, it was one of their rights as a resident in the facility. During a review of facility's Policy and Procedure (P&P) titled, Resident Rights/Resident Exercise Right, dated 10/2022, the P&P indicated, . Be treated with respect and dignity . right to personal privacy and confidentiality . During a review of facility's policy and procedure (P&P) titled, Medication Administration General Guidelines, dated 1/21, the P&P indicated, . Provide for privacy as appropriate .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40641 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for one of five sampled residents (Resident 142) when Resident 142 was administered heparin (anticoagulant-blood thinner) medication as prophylaxis (prevention) for venous thromboembolism (condition that occurs when a blood clot forms in a vein) and the facility did not initiate a care plan. This failure had the potential for Resident 142 to experience a thromboembolism. Findings: During a concurrent observation, and interview on 5/13/24, at 7:40 a.m. in Resident 142's room, Resident 142 was lying down in his bed. Resident 147 stated she had been in the facility for a month. Resident 147 stated she had a hip surgery due to a fall at home and sustained a hip fracture (broken bone). Resident 147 stated she was working with therapy to walk again and go home. During a review of Resident 142's Admission Record (AR-document with resident demographic and medical diagnosis information), dated 5/16/24, AR indicated Resident 142 was admitted in the facility on 4/17/24 with diagnoses which included fracture of right femur (long bone), end stage renal disease (kidney failure-kidney no longer work to meet body's needs) and muscle weakness. During a review of Resident 142's clinical record titled Order Summary Report (OSR) undated, indicated, . Order date 4/25/24 . Heparin Sodium (Porcine) Solution 5000 UNIT/ML [milliliter-unit of measurement] Inject 5000 unit subcutaneously (under the skin) every 12 hours for Prophylaxis of venous thromboembolism. for three (3) weeks . During a concurrent interview and record review on 5/16/24 at 3:25 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 142's OSR was reviewed. LVN 2 stated Resident 142's heparin was prescribed on 4/25/24. LVN 2 stated she did not find a care plan for Resident 142's heparin use. LVN 2 stated there should have been a care plan developed and it was the Minimum Data Set Nurse (MDSN) responsibility to initiate a care plan. LVN 2 stated care plan was very important because it directed the nursing staff how the care was provided to residents. During a concurrent interview and record review on 5/16/24, at 3:50 p.m. with the Minimum Data Set Nurse (MDSN), Resident 142's care plan was reviewed. The MDSN stated she did not find a care plan for Resident 142's use of anticoagulant medication. The MDSN stated she was responsible in making sure there was a care plan in place. The MDSN stated there should have been a care plan to monitor for side effects of the anticoagulant medication. The MDSN stated there should have been a care plan in place but there was not. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/17/24 at 10:16 a.m. with the Director of Nursing (DON), the DON stated Resident 142 had an order for anticoagulant medication to be given for three weeks. The DON stated she could not find a care plan for the use of anticoagulant medication. The DON stated there should have been a care plan initiated to monitor Resident 142 for any side effects of the medication. The DON stated, . Care plan is the driving force of the care of residents . During a review of facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 3/22, the P&P indicated, . The comprehensive, person-centered care plan is developed within seven (7) days . and no more than 21 days after admission . includes measurable objectives and timeframe; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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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. 48430 Based on observation, interview, and record review, the facility failed to provide quality of care and treatment in accordance with professional standards of practice for one of four sampled residents (Resident 18) when fasting blood sugar levels (FBS- A test to determine how much sugar is in blood after an overnight fast) was not performed per physician's orders. This failure resulted in Resident 18's blood sugar level not being monitored which could lead to hypoglycemia (a condition where there isn't enough sugar in the blood) or hyperglycemia (a condition where there is too much sugar in the blood). Findings: During a concurrent observation and interview on 5/13/24 at 2:59 p.m. with Resident 18 in his room, Resident was sitting upright in bed eating. Resident 18's both legs were amputated (cut off). Resident 18 stated, his legs were amputated two years ago due to diabetes mellitus (DM-a condition in which the sugar is high in the blood). Resident 18 stated his blood sugar levels were not checked. During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) Section C, dated 3/7/24 was reviewed. The MDS Section C indicated Resident 18 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 18 was cognitively intact. During a concurrent interview and record review on 5/15/24 at 3:41 p.m. with the Director of Nursing (DON), Resident 18's Admissions Record (AR-document with resident demographic and medical diagnosis information), the AR was reviewed. The DON validated, Resident 18's AR indicated, Resident 18 had DM. During a review of Resident 18's AR, dated 5/16/24, the AR indicated, Resident 18 had a diagnosis of Type 2 Diabetes Mellitus .(DM) During a record review of Resident 18's Order Summary Report (OSR) dated 3/6/24, the OSR indicated, . FBS (Fasting Blood Sugar) one time a day related to TYPE 2 DIABETES MELLITUS . Start Date: 3/7/24 0600 End Date: Indefinite . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/15/24 at 4:04 p.m. with the Director of Nursing (DON), Resident 18's Medication Administration Record (MAR) dated March 2024 was reviewed. The DON stated, the MAR indicated there was an order from the MD (Medical Doctor) to check blood sugar levels everyday at 6:00 a.m. The DON stated, there were no records of Resident 18's blood sugar levels being checked since the order was placed on 3/6/24. The DON stated, It's a mistake [nurses should have been checking blood sugars as ordered]. The DON stated, Nurses should have been following orders. The DON stated, not knowing the accurate levels of blood sugars had the potential to result in hypoglycemia or hyperglycemia. The DON stated, it was important to follow the orders to check blood sugar levels daily at 6 a.m. to have accurate measurements of resident's blood sugar levels. The DON stated, having accurate measurements were important so the MD would be aware of any potential hypoglycemic (low blood sugar levels) or hyperglycemic (high blood sugar levels) conditions and to receive appropriate treatments. During a phone interview on 5/16/24 at 8:08 a.m. with Licensed Vocational (LVN) 4, LVN 4 stated, she was the night shift LVN for Resident 18. LVN 4 stated, I never knew that Resident 18 had DM or have an order to check Resident 18's blood sugars. LVN 4 stated, today [5/16/24] was the first time she had checked the blood sugar levels for Resident 18, it was never checked in the past. LVN 4 stated, it was important to know the resident's diagnosis and orders so quality of care could be provided. LVN 4 stated, the resident had wounds on his back and with his diagnosis of DM could potentially extend the healing time of those wounds if Resident 18's blood sugar was not controlled properly [expected healing time]. LVN 4 stated, by following the orders that were in place to check the blood sugar levels, would provide an accurate measurement of blood sugar levels. During a concurrent interview and record review on 5/16/24 at 8:41 a.m. with the Minimum Data Set Nurse (MDSN), Resident 18's OSR dated March 2024 was reviewed. The MDSN stated, the Orders indicated blood sugar levels to be checked daily at 6 a.m. The MDSN stated, I didn't know it [blood sugar checks prompts] wasn't popping up in the MAR. The MDSN stated, because the blood sugar was not being checked, there was potential for hypoglycemia and hyperglycemia to occur. During an interview on 5/16/24 at 9:17 a.m. with the Medical Records Staff (MR), the MR stated, she and the DON review orders monthly. The MR stated, the orders should have been reviewed more carefully. During an interview on 5/16/24 at 9:20 a.m. with the DON, the DON stated, nurses should review the MD orders daily to know what type of care residents need. The DON stated, failing to check MD orders could lead to potential mistakes and harm. During a review of the facility's policy and procedure (P&P) titled, Diabetes-Clinical Protocol dated 2001, the P&P indicted, .The physician will order .monitoring and reporting information related blood sugar management . During a review of Nursing 2024 The Peer-Reviewed Journal of Clinical Excellence (N2024), Who has the authority to give RNs an order?, dated 10/17/2018, the N2024 indicated, .you [nurses] have a legal duty to carry out a physician's .orders.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40641 Based on observation, interview and record review, the facility failed to provide pharmaceutical services which ensured the administration of medication to meet the need for one of eight sampled residents (Resident 20) when Resident 20's Lactulose (brand name-laxative medication taken to treat constipation) was not available for administration for one day (5/15/24). This failure had the potential for Resident 20 to develop constipation which could lead to more serious health condition like stool impaction (the result of severe constipation, unable to regularly pass stool or feces and it backs up inside the large intestine (colon). Findings: During a concurrent medication pass observation and interview on 5/15/24 at 8:22 a.m. at A- hallway, Licensed Vocational Nurse (LVN) 3, was preparing Resident 20's medications. LVN 3 did not administer Resident 20's lactulose medication. LVN 3 stated the medication was not available to give to Resident 20. During a review of Resident 20's Admission Record (AR-document with resident demographic and medical diagnosis information), dated 5/16/24, the AR indicated, Resident 20 was admitted in the facility on 1/28/19 with diagnoses which included constipation and muscle weakness. During a review of Resident 20's Order Summary Report (OSR) dated 5/16/24, the OSR indicated, . Lactulose Oral Solution 20GM[gram-unit of measurement]/30ML[milliliter-unit of measurement] (Lactulose) 30 ml by mouth one time a day for constipation . Order Date 01/19/2024 . During an interview on 5/15/24 at 3:31 p.m. with LVN 3, LVN 3 stated Resident 20's lactulose was routine medication and should have been available to administer to Resident 20. LVN 3 stated the outgoing nurse did not mention Resident 20's lactulose medication was not available and if pharmacy was notified of medication not being available. LVN 3 stated she notified the Director of Nursing (DON) and the DON called the Medical Doctor (MD) to inform of medication not available to administer to Resident 20. LVN 3 stated DON called pharmacy to deliver medication. During an interview on 5/17/24 at 10:30 a.m. with the DON, DON stated licensed nurses were responsible in making sure they were ordering residents' medications from the pharmacy and available for administration. The DON stated the licensed nurse who administered the last dose should have followed up with the pharmacy. The DON stated Resident 20's missed medication was for her constipation and if not given as ordered it could lead to more serious health conditions. During a review of facility's policy and procedure (P&P) titled, Medication Ordering and Receiving From Pharmacy Provider Ordering and Receiving Non-Controlled Medications, dated 01/22, the P&P indicated, . All medications shall be reordered in advanced by writing the medication name and prescription number . Timely delivery . is required so that medication administration is not delayed .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure the appropriate food texture was provided for one of six sampled residents (Resident 11) when Resident 11 did not received large portions finger foods as ordered. This failure placed Resident 11 at risk for weight loss due to not being able to utilize utensils. Findings: During a concurrent observation, interview and record review on 5/13/24 at 12:13 p.m. with Certified Nursing Assistant (CNA) 1 in the dining room, Resident 11 was observed eating lunch. In Resident 11's plate, there were two whole pieces of chicken breast, steamed rice, cut up broccoli and fruit cobbler in a dessert bowl. Review of meal tray ticket indicated, .Large Portions FINGER FOODS . CNA 1 stated she served the tray to Resident 11 and did not know Resident 11's diet was regular finger foods. CNA 1 stated she did not check the food in the tray when she served the food to Resident 11 because the licensed nurse already checked the tray and did not find any mistake. CNA 1 stated CNAs were supposed to check foods, comparing the food with the meal tray ticket prior to serving to residents. CNA 1 stated she should have checked the food when she served it to Resident 11 but she did not. Resident 11 did not answer questions but instead just looked at surveyor. During a record review of Resident 11's Admission Record (AR-document with resident demographic and medical diagnosis information), dated 5/16/24, the AR indicated, Resident 11 was readmitted to the facility on [DATE] with diagnoses which included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), hemiplegia (paralysis) and hemiparesis (one-sided weakness), dysphagia (difficulty swallowing). During a review of Resident 11's Order Summary Report (OSR) dated 5/16/24, the OSR indicated, . Regular diet Finger Food Texture .Order Date 3/22/24 . During an interview on 5/13/24 at 12:30 p.m. with Rehabilitative Nurse Assistant (RNA) in the dining room, RNA stated licensed nurses were supposed to check the food consistency making sure it was correct and CNAs picks up the tray and served to residents. RNA stated finger foods were foods that can be picked up using the fingers and not using any utensils. RNA stated she did not think Resident 11's food was considered finger foods. During a concurrent interview and record review on 5/13/24, at 12:37 p.m. with the Minimum Data Set Nurse (MDSN), the MDSN reviewed the meal ticket of Resident 11 and observed the foods placed in front of Resident 11 and she stated the foods was not finger foods. MDSN stated finger foods were foods that can be picked up without using utensils. MDSN stated Resident 11's diet was changed to finger food on 3/22/24 because he did not have a good grip on the utensils to bring the food to his mouth. MDSN stated Resident 11 could lose more weight when not served the correct diet consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/24, at 10:43 a.m. with Registered Dietitian (RD), RD stated she went in the facility once a week and available on phone as needed. RD stated Resident 11 was switched to finger food because he did not like the chopped up food and did not want staff cutting up his food. RD stated not following Resident 11's diet consistency could lead to weight loss because of his inability to feed self so he was eating less food. During an interview on 5/17/24, at 10:15 a.m. with the Director of Nursing (DON), DON stated dietary and nursing staff should be making sure residents were receiving the correct diet ordered. DON stated there was no reasons for Resident 11's diet not to be corrected before it reached resident. DON stated the checking started in the kitchen then the licensed nurse checked and compared the meal tray ticket and the CNAs when they bring the food in front of Resident 11. During an interview on 5/17/24 at 11:29 a.m. with the Dietary Services Manager (DSM), the DSM stated all residents' diet should be followed. The DSM stated the practice was; cook read the diet slip and put food in the plate, the licensed nurse checked and compared the diet consistency with the diet tray slip and the CNAs checked the food consistency when they placed the food in front of residents. The DSM stated Resident 11's diet order was large portion finger foods. The DSM stated Resident 11 did not received the correct diet consistency for lunch on 5/13/24. Review of facility's policy and procedure (P&P) titled, Food and Nutrition Services, dated 10/17, the P&P indicated, . The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs . A resident-centered diet and nutritional plan will be based on this assessment . Food and nutrition services staff will inspect food trays to ensure the correct meal is provided to each resident .

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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. 48739 Based on observation, interview and record review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety when: 1. One of three kitchen personnel, [NAME] (CK) 2 did not use a surface sanitizer with the correct concentration when wiping the food preparation table. 2. One of three kitchen personnel, CK 1 did not take the temperature reading of food items after the items were heated in the microwave before serving it to one of 47 residents. 3. Plates, Plate holders, lids, and cooking pans were not air dried and were stacked and stored wet in the kitchen. These failures had the potential to expose 46 of 47 residents who received food from the kitchen to pathogenic microorganism (an organism that is so small that it cannot be seen by the naked eye and is capable of causing disease) growth that could inadvertently (accidentally) be transferred to food and cause foodborne illness (illness caused by ingestion of contaminated food or beverages) to residents who ate the food. Findings: 1. During a concurrent observation and interview on 5/14/24 at 8:52 a.m. in the kitchen, the Cook/Dietary Aide (CK) 2 was observed wiping the food preparation table that had been inadvertently sprayed with water from the dishwasher with a cloth that was in a red sanitizer bucket. CK 2 was requested to test the sanitizer solution to verify it had the appropriate sanitizer concentration. CK 2 dipped a test strip in the sanitizer solution, and it was observed to register zero parts-per-million (ppm- describes the concentration of sanitizer in water) of sanitizer concentration. CK 2 changed the sanitizer solution and retested the solution with a new test strip. The test strip was observed to register between 100-200 ppm. CK 2 stated the range for the sanitizer solution should be between 50ppm and 100ppm. During an interview on 5/15/24 at 11:20 a.m. with the Registered Dietician (RD), the RD stated her expectation was for the sanitizer solution to be at the correct concentration. The RD stated a solution reading of zero ppm was not acceptable. The RD stated there was a possibility that bacteria could grow and get residents sick. During an interview on 5/17/24 at 10:56 a.m. with CK 1, CK 1 stated if the sanitizer solution was not within adequate ppm range, then food would be prepped on dirty surfaces and germs would go to the items or food placed on it. CK 1 stated it was the cooks' job to be sure the food prep area was sanitized, and food was prepped correctly. During an interview on 5/17/24 at 11:16 a.m. with the Dietary Services Manager (DSM), the DSM stated the sanitation solution should be changed every two hours and have the correct concentration of ppm. The DSM stated residents could get sick if food was prepped on dirty surfaces. (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 review of the facility document titled, Job Description (JD) . Dietary Aide , dated 2023, the JD indicated, .Ensures that food procedures are followed in accordance with established policies . cleaning of the kitchen per established protocols . assists in daily cleaning duties as assigned to include worktables . in accordance to established policies and procedures . During a review of the facility document titled, Job Description-Dietary Cook, dated 2023, the JD indicated, . Ensures that food procedures are followed in accordance with established policies . assists/directs daily cleaning duties in accordance to established policies and procedures . ensures the department, necessary equipment and supplies are clean and maintained in a safe manner . During a review of the facility document titled, Job Description-Dietary Manager(JD), dated 2023, the JD indicated, .Maintains a clean and sanitary environment . During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2001, the P&P indicated, . All equipment, food contact surfaces and utensils shall be . sanitized using hot water and/or chemical sanitizing solutions . sanitizing of environmental surfaces must be performed with one of the following solutions . 50-100 ppm chlorine solution . 150-200 ppm quaternary ammonium compound (QAC) . During a review of professional reference (PR) titled, FDA Food Code, section 4-602.11 Equipment Food-Contact Surfaces and Utensils, dated 2022, the PR indicated, . Equipment food-contact surfaces and utensils shall be cleaned . at any time during the operation when contamination may have occurred . 2. During an observation on 5/14/24 at 12:07 p.m. in the kitchen, CK 1 was observed putting frozen breaded vegetable patties in the microwave to heat. CK 1 was then observed plating the microwave heated patties and sending it out with the meal trays without taking the temperature of the patties. During a concurrent interview and record review on 5/17/24 at 10:56 a.m. with CK 1, the Service Line Checklist (Checklist), dated 5/14/24 was reviewed. The Checklist indicated, . item names and temperatures for all hot and cold foods should be taken prior to service and recorded in the boxes below . CK 1 stated the alternate frozen food item was a vegetarian patty. CK 1 stated the vegetarian patties were not temped or entered in the log on 5/14/24. CK 1 stated the vegetarian patties should have been heated to 165 degrees Fahrenheit. During an interview on 5/17/24 at 11:16 a.m. with the DSM, the DSM stated staff should be temping alternate food items. The DSM stated it was a safety and a quality issue for the resident. The DSM stated residents could get sick. During a review of the facility's P&P titled, Record of Food Temperatures, dated 2024, indicated, .It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled . food temperatures will be checked on all items prepared in the dietary department . (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 review of professional reference titled, FDA Food Code, section 3-403.11 Reheating for Hot Holding, dated 2022, indicated, . (C) READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that has been commercially processed and PACKAGED in a FOOD PROCESSING PLANT that is inspected by the REGULATORY AUTHORITY that has jurisdiction over the plant, shall be heated to a temperature of at least 57oC (135oF) when being reheated for hot holding . 3. During a concurrent observation and interview on 5/14/24 at 8:52 a.m. with CK 1 in the kitchen, CK 1 was observed placing wet plate holders and lids inverted on top of each other on the counter and wet plates stacked on top of each other on the plate warmer. CK 1 stated the plates were air dried for one minute and were still a little wet when placed on the warmer. CK 1 stated it was okay to stack plates on the warmer when not completely dry. The plate holders, and lids were observed stacked and left wet on the warmer. During a concurrent observation and interview on 5/14/24 at 9:14 a.m. with the DSM, heating pans were observed stacked and stored under the food preparation table with drops of water inside them. The DMS stated pots and pans should not be stacked wet. The DMS stated plates were air dried for a bit then placed on the warmer to continue drying. The DMS stated the lids and plate holders were air dried for a bit then stacked on top of each other upside down to continue drying. The DMS stated this practice was okay since the plate holders and lids were upside down and the water would drip down off the plate holders and lids until dry. During an interview on 5/15/24 at 11:20 a.m. with the RD, the RD stated, the policy for storing dishware was that dishware was to be completely dry before storing. The RD stated if dishware was stored wet, there was the possibility that bacteria could grow and residents could get sick. The RD stated her expectation was that the dishware was dry before being stored. During an interview on 5/17/24 at 11:16 a.m. with the DSM, the DSM stated, water from the inverted plate holders and lids dripped down onto the counter. The DMS stated there was no other dry area the plate holders and lids could moved to. The DMS stated the plate holders and lids were stored in a wet area. During a review of professional reference titled, FDA Federal Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, dated 2022, indicated, . Cleaned EQUIPMENT and UTENSILS . shall be stored . in a clean, dry location .where they are not exposed to splash, dust, or other contamination . During a review of professional reference retrieved from, https://www.anfponline.org/docs/default-source/legacy-docs/docs/ce-articles/fpc032019.pdf titled, Sanitation Pitfalls in the healthcare Kitchen, dated March-April 2019, the professional reference indicated, .wet-nesting occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow. FDA guidelines mandate that all wares should be air dried .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview, and record review, the facility failed to ensure dialysis (procedure to remove wastes and excess fluids from the body) communication forms were completed for two of four sampled residents (Resident 142 and Resident 25) when Residents 25 and 142 did not have documentation of completed post-dialysis assessments of access sites (site used for dialysis) on multiple dates. These failures placed Resident 142 and 25 at risk for delayed detection, reporting, and/or management of complications from the hemodialysis (dialysis done through blood vessels)access sites. Findings: During a concurrent observation and interview on 5/13/24 at 7:40 a.m. in Resident 142's room, Resident 142 was observed sitting up in bed, eating breakfast. Resident stated she had hip surgery due to a fracture (break in bone) sustained from a fall at home. Resident stated she had been in the facility for a month and working with therapy to get stronger so she can go back home. During a record review of Resident 142's, Admission Record (AR-document with resident demographic and medical diagnosis information), dated 5/16/24, the AR indicated, Resident 142 was admitted on [DATE], with a diagnosis that include End-Stage kidney disease (final permanent stage of kidney disease when kidneys no longer function, needing dialysis) and fracture of right femur (long bone). During an interview on 5/15/24 at 1:30 p.m. with certified nursing assistant (CNA) 3, CNA stated Resident 142 was alert and oriented. CNA 3 stated Resident 142 went to dialysis three times a week, every Tuesday, Thursday and Saturday. CNA 3 stated she made sure Resident 142 ate breakfast before she was picked up for dialysis. During a record review of Resident 25's, AR dated 5/17/24, the AR indicated, Resident 25 was admitted on [DATE], with diagnosis which included End-Stage Renal Disease. During a record review on 5/16/24, at 10:28 a.m. with Licensed Vocational Nurse (LVN)1, LVN 1 stated the charged nurse was responsible in making sure dialysis communication forms were filled up and given to residents when they leave for dialysis. LVN 1 stated when resident returns from dialysis the charged nurse checked the dialysis communication form to make sure dialysis nurse filled up their part and assessed resident and fill the post treatment box of the dialysis communication form. LVN 1 stated dialysis communication forms were important to ensure the facility were not missing any new orders and updates of resident status while in dialysis center. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/16/24 at 2:02 p.m. with LVN 2, Resident 25's dialysis communication form was reviewed. LVN 2 stated Resident 25 went to dialysis every Tuesday, Thursday and Saturday. LVN 2 stated there was only one dialysis communication form dated 5/14/24 in the binder for the month of May 2024. LVN 2 stated there should have been a dialysis communication forms for the following dates: 5/2/24, 5/4/24, 5/7/24, 5/9/24 and 5/11/24. LVN 2 stated all dialysis communication form should be completed as soon as resident returned from dialysis and filed in the dialysis binder. LVN 2 stated medical records audits the binders and followed up with dialysis centers for incomplete dialysis communication forms. During a concurrent interview and record review on 5/16/24 at 2:30 p.m. with Medical Records staff (MR), she stated she was responsible in auditing the dialysis forms. MR stated she checked the resident dialysis binder to make sure the dialysis communication forms were completed for all the dialysis residents. MR reviewed Resident 124's dialysis communication form and stated Resident 14's dialysis communication forms dated 5/11/24 and 5/14/24 are incomplete and should have been completed. MR reviewed Resident 25's dialysis communication forms and stated there was only one dialysis communication form dated 5/14/24 for the month of May 2024. During an interview on 5/17/24 at 10:40 a.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurse and medical records to make sure dialysis communications forms were completed and filed in the dialysis binder. DON stated licensed nurses are responsible in making sure to complete dialysis communication form for each resident who goes to dialysis and follow up with the dialysis center for incomplete dialysis communication forms assessment. DON stated the MR should have been auditing the dialysis binder on a regular basis to make sure all dialysis communication forms were completed and filed in the dialysis binder. During a review of the facility's policy and procedure (P&P) titled, Hemodialysis dated 10/2022, the P&P indicated, .The facility will assure that each resident receives care and services for the provision of hemodialysis . The licensed nurse will communicate to the dialysis facility . such as dialysis communication form . Timely medication administration . Physician/treatment orders . weights . intake and output measurements . Dialysis treatment provided and resident's response . recommendations for follow up observations and monitoring .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48430 Based on observation, interview and record review, the facility failed to provide a safe and sanitary environment for one of five sampled residents (Resident 34) when brown-colored, fecal stains and remnants (remaining, small amount) was found on the toilet and toilet seat in Resident 34's bathroom. This failure had the potential of cross-contamination from one resident to another. Findings: During an interview on 5/13/24 at 7:52 a.m. with Resident 34 in his room, Resident 34 stated his bathroom was dirty with feces and urine. Resident 34 stated, when other residents use the bathrooms; there were remnants of feces and urine. Resident 34 stated, he did not feel comfortable in using the bathroom due to the issues with cleanliness. During an observation on 5/13/24 at 8:07 a.m. in Resident 34's room, fecal matter was observed smeared on the toilet seat and toilet bowl in Resident 34's bathroom. During a review of Resident 34's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) Section C, dated 02/25/24 was reviewed. The MDS Section C indicated Resident 34 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 34 was cognitively intact. During a concurrent observation and interview on 5/13/24 at 8:10 a.m. with the Director of Nursing (DON) in Resident 34's bathroom, the DON stated, the stains and remnants on the toilet seat and bowl were fecal matter and toilet needed to be cleaned. The DON stated the dirty toilet was an infection control issue. During a concurrent observation and interview on 5/13/24 at 8:14 a.m. with the Infection Preventionist (IP-are professionals who make sure healthcare workers and patients are doing all the things they should to prevent infections) Nurse in Resident 34's bathroom, the IP validated the brown stain on the toilet and toilet seat were fecal stains and should be cleaned. The IP stated the unclean toilet was an infection control issue. The IP stated, diseases such as CDIFF (clostridium difficile- a bacteria that causes an infection of the colon), Hepatitis C (a virus that causes inflammation of the liver), and other pathogens (disease causing microorganisms [microscopic animals]) could be transmitted to other residents from the fecal matter. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program dated 2024, the P&P indicated, .This facility has established and maintains infection prevention and control . designed to provide a .sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Safe and Homelike Environment, dated 2023, the P&P indicated, . the facility will provide a safe, clean, and comfortable .environment .Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the resident's .bathrooms .Sanitary includes .preventing the spread of disease causing organisms by keeping resident equipment clean . includes, but not limited to, equipment used in the completion of the activities of daily living . During a review of the facility's P&P titled, Routine Cleaning and Disinfection, dated 2023, the P&P indicated, .it is the policy of this facility to ensure .routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections .Cleaning refers to the removal of visible soil from objects and surfaces .Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces .to include .toilet seats .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 48430 Based on observation and interview during the survey period of 5/13/24 to 5/17/24, the facility failed to provide and maintain minimum square footage for each resident in 12 of 19 rooms (Rooms 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 19). Findings: During an observation of the facility on 5/13/24 to 5/17/24, the following rooms did not provide the minimum square footage as required by the regulation: Rooms 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 19. The residents had reasonable amount of privacy. Closets and storage spaces were adequate. Bedside stands were available. There was sufficient room for nursing care and for residents to ambulate. Wheelchairs and toilet facilities were accessible. The waiver will not adversely affect the health and safety of residents. Room # Square Feet # Residents 7 203.7 3 8 210.2 3 9 213.3 3 10 209.1 3 11 203.2 3 12 209.5 3 13 154.0 2 14 152.4 2 15 159.2 2 16 158.2 2 17 154.9 2 19 154.7 2 Recommend waiver continue in effect. _____ (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Health Facility Evaluator Nurse / Date Request continuance of waiver. _____ Administrator Signature / Date