STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555922	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchards Skilled Nursing	1 Amistad Drive Ladera Ranch, CA 92694

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, clinical record review, and facility P&P review, the facility failed to ensure one of 13 final sampled residents (Resident 33) was accurately assessed as being capable to self-administer the medications. * Resident 33 had the nasal spray bottle left on his overbed table and self-administered the nasal spray. This failure had the potential for unsafe medication administration. Findings: Review of the facility's P&P titled Self-Administration of Medications dated 10/24/23, showed as part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medication is clinically appropriate for the resident. On 4/2/24 at 0900 hours, one opened bottle of 30 ml oxymetazoline hydrochloride (afrin) nasal spray was observed on Resident 33's overbed table. Resident 33 stated he had been using the medication one time every day to help relieve his stuffy nose. Medical Record Review for Resident 33 was initiated on 4/2/24. Resident 33 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 33 had BIMS score of 9 (moderately impaired). Review of Resident 33's physician's orders for April 2024 showed no order for nasal spray. Review of Resident 33's Assessments for Self-Administration of Medications dated 3/20/24, showed the question asking if the resident expressed an interest in the self-administration of medication with the answer no. On 4/2/24 at 0925 hours, an interview and concurrent medical record review was conducted LVN 4. LVN 4 stated he was unaware the nasal spray bottle was at the bedside. Resident 33 was not assessed for self-administration of the medication and no care plan was developed for the administration of the nasal spray. LVN 4 stated there was no physician's order for the nasal spray administration. LVN 4 verified the findings.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555922	A. Building B. Wing	04/04/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview, medical record review, and the facility P&P review, the facility failed to ensure the notification of change for one of one resident reviewed for weight loss (Resident 14). This failure resulted in a delay of Resident 14's significant weight loss being communicated to the resident's physician, responsible party, and RD, which had the potential to negatively impact the resident's well-being. Findings: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1. 18.11 dated October 2023 showed If a resident is losing a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status. Review the facility's P&P titled Nutrition Management Program revised 5/31/21, showed a weight change is significant per RAI manual definition with a weight loss of 5% and/or 5 lbs. in one month. The P&P also showed the following tasks at the time of identification of weight loss: - A referral is made to dietary. - The physician is notified of the weight loss. - Notification to the resident's family. Medical record review for Resident 14 was initiated on 4/2/24. Resident 14 was initially admitted to the facility on [DATE], discharged to the acute care hospital on 3/21/24, and readmitted to the facility on [DATE]. Review of Resident 14's Weight and Vitals Summary dated 4/4/24, showed the following weights: -On 2/23/24, a weight of 142.6 lbs. -On 2/28/24, a weight of 140 lbs. -On 3/7/24, a weight of 140.8 lbs. -On 3/15/24, a weight of 140 lbs. -On 3/26/24, a weight of 0.0 lbs. -On 3/29/24, a weight of 132.4 lbs. (a 5.4% and 7.6 lbs. weight loss from 2/28/24) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555922	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/3/24, a weight of 131.6 lbs. (a 6.5% and 9.2 lbs. weight loss from 3/7/24, and a 7.7% and 11 lbs. weight loss from 2/23/24) Review of Resident 14's medical record failed to show the resident's physician, responsible party, and RD were notified of the resident's weight loss. On 4/4/24 at 0929 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 reviewed Resident 14's weights and verified the resident's weight was triggered for a weight loss of more than 5% on 3/29/24. RN 1 verified Resident 14's medical record failed to show the resident's change of condition for weight loss was reported to the resident's physician, responsible party, and the RD. On 4/4/24 at 1128 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated for a significant weight change, the charge nurse or clinical nurse supervisor should notify the physician, RD and resident's responsible party once the weight change was identified. The DON reviewed Resident 14's medical record and verified the resident's weight loss on 3/29/24, was not reported to the resident's physician, responsible party, and RD once it was identified, and should have been.

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care reflected the residents' current care needs and interventions for one of 13 final sampled residents (Resident 12). This failure had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Comprehensive Care plan dated 11/17 showed the Interdisciplinary Team shall develop and implement a comprehensive person-centered care plan or each resident consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment within seven days after completion of the comprehensive assessments and after each MDS assessment, except the discharge assessment. Medical Record Review for Resident 12 was initiated on 4/2/24. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the History and Physical examination dated 6/15/23, showed Resident 12 had a diagnosis of dementia. On 4/3/24 at 1050 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 stated Resident 12 was alert and oriented to person, place, and time but forgetful. LVN 4 was asked to provide documentation for Resident 12's care plan problem to address the care specific for Resident 12 with dementia. LVN 4 was unable to provide it. LVN 4 verified the findings.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care for one of one sampled resident (Resident 639) was revised to address the resident's specific care needs and interventions. This failure posed the risk for the resident to not receive the care and services required to attain or maintain their highest level of physical and mental well-being. Findings: Review of the facility's P&P titled Comprehensive Care Plans dated 11/2017 showed the Interdisciplinary Team shall develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment within seven days after completion of the comprehensive assessments and after each MDS assessment, except the discharge assessment. Comprehensive care plan are reviewed and revised after each MDS assessment except the discharge assessments; and as the resident conditions changed. Medical record review for Resident 639 was initiated on 4/2/24. Resident 639 was admitted to the facility on [DATE]. Review of Resident 639's Order Summary Report dated 4/3/24, showed a physician's order dated 3/17/24, to provide non-pharmacological interventions: 1-Repositioning, 2-Dim light/Quiet environment, 3-Hot/Cold applications, 4- Relaxation, 5-Distraction, 6-Music, 7-Massage, 8-Aromatherapy, and 9-Other (progress note). Review of Resident 639's plan of care showed a care plan problem revised on 4/2/24, addressing the resident's presence of pain. However, the plan of care was not revised to reflect Resident 639's non-pharmacological interventions for pain. On 4/3/24 at 1406 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified Resident 639's plan of care did not include the non-pharmacological interventions for pain as ordered by the physician. LVN 1 stated she documented the non-pharmacological interventions provided on the MAR, under the resident's behavior. On 4/4/24 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding.

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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. 50126 Based on observation, interview, and facility P&P review, the facility failed to ensure services provided met the professional standards of care for one when LVN 4 failed to properly take a blood pressure for one nonsampled resident (Resident 543). This failure posed the risk for not obtaining accurate blood pressure reading for this resident. Findings: Review of the facility's P&P titled Blood Pressure, Measuring dated 10/2010 showed the purpose of this procedure is to measure the pressure exerted by the circulating volume of blood on the walls of the arteries, veins, and chambers of the heart. The policy further showed to expose the resident's arm by rolling the sleeve up about five inches above the elbow. When locating the pulsation, place the diaphragm of the stethoscope firmly against the skin, and hold the diaphragm in place with hand. On 4/3/24 at 0813 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 took Resident 543's blood pressure prior to the administration of metoprolol (antihypertensive medication). LVN 4 wrapped the blood pressure cuff on the resident's left upper arm and placed the diaphragm of the stethoscope on the left brachial artery over Resident 543's sweater. On 4/3/24 at 0834 hours, an interview was conducted with LVN 4. LVN 4 verified the resident's sleeve should have been pulled up and the diaphragm of the stethoscope should have been placed on the skin. On 4/3/24 at 1424 hours, an interview was conducted with the DON. The DON verified the blood pressure cuff and diaphragm of the stethoscope were to be placed on the skin when taking a blood pressure.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the timely intervention for one of one resident reviewed for weight loss (Resident 14). This failure had the potential to result in continued nutritional decline and negative outcomes. Findings: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1. 18.11 dated October 2023 showed If a resident is losing a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status. Review the facility's P&P titled Nutrition Management Program revised 5/31/21, showed a weight change is significant per RAI manual definition with a weight loss of 5% and/or 5 lbs. in one month. The P&P also showed the following tasks at the time of identification of weight loss: - A referral is made to dietary. - The Nutritional Services Director and/or the Registered Dietician (RD) will complete an assessment Medical record review for Resident 14 was initiated on 4/2/24. Resident 14 was initially admitted to the facility on [DATE], discharged to the acute hospital on 3/21/24, and readmitted to the facility on [DATE]. Review of Resident 14's Weight and Vitals Summary dated 4/4/24, showed the following weights: - On 2/23/24, a weight of 142.6 lbs. - On 2/28/24, a weight of 140 lbs. - On 3/7/24, a weight of 140.8 lbs. - On 3/15/24, a weight of 140 lbs. - On 3/26/24, a weight of 0.0 lbs. - On 3/29/24, a weight of 132.4 lbs. (a 5.4% and 7.6 lbs. weight loss from 2/28/24) - On 4/3/24, a weight of 131.6 lbs. (a 6.5% and 9.2 lbs. weight loss from 3/7/24, and a 7.7% and 11 lbs. weight loss from 2/23/24) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 14's Nutritional Screen V3.1 - 101 evaluation dated 3/28/24, showed the resident was noted to have decreased PO (oral) intake since readmission; however it was improved on 3/28/24. The plan was to increase the resident's health shakes from twice a day to three times a day. Review of Resident 14's Nutritional Evaluation V6-103 dated 3/29/24, showed the resident's admission weight listed for the previous admission's weight was 140 lbs on 3/15/24. The most recent weight was listed as 0.0 lbs on 3/26/24. The evaluation showed Resident 14's ideal weight range was 139-169 lbs. The summary note showed the resident was now receiving health shakes three times a day to provide an additional 600 calories and 18 grams of protein a day. The note showed there were no recommendations at the time, and to monitor the resident's weights for significant changes. Review of Resident 14's Nutritional Services Note dated 3/29/24, showed the resident returned from a recent hospitalization and the resident's weight was 140 lbs. on 3/15/24. The document showed the resident was at a healthy weight with a target maintenance goal weight of 135-145 lbs. Resident 14's medical record failed to show the nutritional services or RD's intervention after the resident's weight loss was identified. Review of the facility's Report of Dietary Consultant Visit dated 4/3/24, showed a list of the residents that the RD saw and showed the RD calculated the monthly and weekly weight variances. The document failed to show Resident 14 was reviewed by the RD. On 4/4/24 at 0929 hours, an interview and concurrent record review was conducted with RN 1. RN 1 stated the RNA weighed the residents, entered the weight on a paper log, and gave the weight log to the desk nurse who would then enter the weights in the electronic health record. RN 1 stated herself and the RD had a weekly Nutritional At Risk (NAR) meeting every Wednesday and reviewed all the residents triggered with weight changes. RN 1 stated the last NAR was done on 3/27/24, and yesterday's review was rescheduled for today, since the RD was on vacation. RN 1 reviewed Resident 14's weights and verified the electronic health record (EHR) triggered the resident for weight loss. When asked if there was any documentation to show Resident 14's weight loss was reported and addressed, the RN stated no. RN 1 stated they would discuss it at today's NAR meeting. On 4/4/24 at 1128 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the process for the residents readmitted from the acute care hospital was to be weighed on readmission or the day after. The DON verified Resident 14 was readmitted on [DATE], and the first recorded weight was on 3/29/24. The DON stated there was nothing in the resident's record to show they refused their weight being checked. The DON stated significant weight changes should be addressed within that week since the RD made rounds weekly. The DON stated the RD covering for the regular RD's vacation saw the residents yesterday. The DON reviewed the RD's packet given to her by the RD and verified Resident 14 was not seen. The DON reviewed Resident 14's medical record and verified there was nothing to show the resident's weight loss was addressed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 1201 hours, an interview and concurrent medical record review was conducted with RD 1. RD 1 stated they usually were at the facility every Monday and Wednesday, but they were on vacation from 3/30/24-4/3/24, and another RD covered for them. RD 1 stated the covering RD came in on Wednesday, 4/3/24, and RD 1 was planning on coming in on Friday 4/5/24, to see the residents. RD 1 sated their usual process was to come in twice a week, run a weight report with the EHR system to identify residents with weight changes, with a 3 lbs weight change being the standard. RD 1 stated Resident 14's weight loss should have been on the weight report yesterday for the covering RD to know to review the resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of one final sampled resident (Resident 26) reviewed for oxygen use was provided with the appropriate respiratory care. The facility failed to ensure Resident 26's oxygen tubing was labeled and not touching the floor. These failures had the potential to affect the respiratory health and well-being of Resident 26. Findings: Review of the facility's P&P titled Oxygen Management revised 5/31/21, showed the oxygen is administered under orders of the attending physician, except in the case of an emergency. The general guidelines concerning oxygen safety during oxygen administration include nasal cannulas, masks and tubing should be changed every seven days, dated, time and initialed. On 4/2/24 at 1023 and 1548 hours, Resident 26 was observed wearing a nasal cannula attached to a portable oxygen tank with a setting of one liter per minute. Part of the oxygen tubing was observed touching the floor. Medical record review for Resident 26 was initiated on 4/2/24. Resident 26 was admitted to the facility on [DATE]. Review of Resident 26's Order Summary Report dated 4/3/24, showed a physician's order dated 3/27/24, to administer oxygen at one to three liters per minute via nasal cannula every shift to keep the oxygen saturation level greater than 92%. Another physician's order dated 2/20/24, showed to change the oxygen nasal cannula every Sunday night or as needed when in use. On 4/3/24 at 1010 hours, an observation and concurrent interview for Resident 26 with RN 1 was conducted. Resident 26 was observed in the activity room wearing a nasal cannula with the oxygen setting at two liters per minute. RN 1 verified Resident 26 was on oxygen therapy. RN 1 was asked when the oxygen tubing was last changed. RN 1 stated the facility had an order for the oxygen tubing to be changed every Sunday and as needed. RN 1 verified there was no label on the resident's oxygen tubing. Also, the part of the oxygen tubing was observed on the floor. RN 1 stated the oxygen tubing should have been labeled and not touched the floor. On 4/4/24 at 1104 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed of the above findings and was verified.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50126 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the resident's needs for one of 13 final sampled residents (Resident 13). * The facility failed to ensure Resident 13's oxycodone-acetaminophen (narcotic pain medication) was accurately reconciled. The oxycodone-acetaminophen tablets removed as shown on the Controlled Drug Record was not recorded as administered on the electronic MAR. This failure had the potential for drug diversion. Findings: Review of the facility's P&P titled Controlled Drugs revised 10/2018 showed each dose removed from the supply of controlled drugs shall be signed, dated, and timed out on the proof of count sheet on the line representing that particular dose prior to resident administration. Nurses must sign out, not just initial. Proof of count sheets shall be easily accessible by the medication nurse. Medical record review for Resident 13 was initiated on 4/2/24. Resident 13 was admitted to the facility on [DATE]. Review of the Internal Medicine H&P examination dated 3/1/24, showed Resident 13 had the capacity to understand and make decisions. Review of the Order Summary Report dated 4/3/24, showed a physician's order dated 3/14/24, to administer oxycodone-acetaminophen 10-325 mg one tablet by mouth every four hours as needed for moderate to severe pain. On 4/3/24 at 1119 hours, a controlled medication reconciliation for Resident 13 was conducted with LVN 3. Review of Resident 13's Controlled Drug Record showed oxycodone-acetaminophen was signed out on 3/30/24 at 1322 hours, and 4/1/24 at 1400 hours. Resident 13's medication bubble pack (a package used to dispense medication) for oxycodone-acetaminophen showed 15 tablets remaining, which matched with the number of oxycodone-acetaminophen tablets in the Controlled Drug Record. However, review of Resident 13's electronic MARs for March and April 2024 failed to show documented evidence the oxycodone-acetaminophen was administered to Resident 13 on 3/30/24 at 1322 hours, and 4/1/24 at 1400 hours, as shown in the Controlled Drug Record. LVN 3 verified the above finding. On 4/3/24 at 1411 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding. The DON stated the licensed nurses should sign both the Controlled Drug Record and MAR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50126 Based on observation, interview, and facility P&P review, the facility failed to ensure the proper disposal and storage of medications as evidenced by: * The facility failed to ensure the medications administered orally were stored separately from the externally used medications in one of two medication carts (Medication Cart A). * The facility failed to ensure the discontinued medications were properly disposed in one of one medication room (Medication Room A). In addition, the facility failed to ensure the medications administered orally were stored separately from the externally used medications in Medicaiton Room A. * The facility failed to ensure safe storage of one Theraworx Muscle Cramp (use to relieve muscle cramps and spasms) foam found at Resident 639's bedside cabinet. These failures had the potential to result in unsafe medication administration, cross-contamination of the medications, and unsafe handling and storage of the residents' medications. Findings: Review of the facility's P&P titled Storage of Medications revised 10/2018 showed external use drugs in liquid, tablet, capsule, or powder form shall be separated from drugs for internal use such as on a different shelf or separated by bins/partitions. Example: Separate oral tablets/capsules from oral liquids from internals (enema/suppositories) from ophthalmic drops from optic drops from injectable medications and from inhaled medications. In addition, the policy showed drugs shall be accessible only to personnel designated in writing by the licensee. 1. On 4/3/24 at 1153 hours, an observation and concurrent interview was conducted with LVN 4 in Medication Cart A. The following was observed: - two open boxes of Restasis (medication use to treat chronic dry eyes) eye drops were stored next to three boxes of levalbuterol (medication use to prevent or relieve wheezing, shortness of breath, coughing or chest tightness)inhalation solution. LVN 4 verified the findings. 2. On 4/3/24 at 1322 hours, an observation and concurrent interview was conducted with LVN 2 in Medication Room A. The following was observed: - One waste disposal bin with a blue top was observed with multiple whole tablets inside. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Orchards Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Amistad Drive Ladera Ranch, CA 92694	

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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	- Three boxes of Refresh Tears (medication use for temporary relief from dry eyes) eye drops were stored next to three boxes of carbamide peroxide (medication use to treat earwax build up) ear drops, one bottle of loratadine (medication use to treat symptoms of allergies) and multiple bottles of Milk of Magnesia. LVN 2 verified the findings. LVN2 stated the facility did not use any liquid to dissolve the tablets, and the staff were trained to discard the tablets inside the disposal bin and lock the cabinet. On 4/3/24 at 1412 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding. The DON stated non-narcotic medications should be placed in the disposal bin and a dissolvent was used to dissolve the tablets. On 4/4/24 at 1053 hours, a follow-up interview was conducted with the DON. The DON stated the facility used the Drug Disposal System Rx Destroyer solution to dissolve the medications inside the disposal bins. The DON stated the facility disposed of the medications daily and weekly as necessary. 49644 3. During the initial tour of the facility on 4/2/24 at 0946 hours, an observation and concurrent interview was conducted with Resident 639. Resident 639 was observed with one bottle of Theraworx Muscle Cramps foam on top of the bedside cabinet. Resident 639 stated her family member brought in the Theraworx Muscle Cramps foam, but she had not used it at the facility. Medical record review for Resident 639 was initiated on 4/2/24. Resident 639 was admitted to the facility on [DATE]. Review of Resident 639's MDS dated [DATE], showed Resident 639 was cognitively intact. On 4/2/24 at 0953 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified the above finding and stated it was her first time to see the medication. On 4/4/24 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding.

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F 0801

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39856

Based on observation, interview, facility personnel file, and facility document review, the facility failed to ensure the Food and Nutrition Services Director who was responsible to oversee the main kitchen which produced food for the skilled nursing facility was competent in managing the day-to-day functions of the food services department. The failure to employ staff with the skills and abilities to effectively implement departmental processes in accordance with standards of practice, may jeopardize the health and well-being of the 40 residents who received food prepared in the kitchen.

Findings:

Review of the facility's Resident Assessment Report (CMS-802) dated [DATE], showed 40 of 40 residents residing in the facility received food prepared in the kitchen.

Review of the facility's personnel file for the Food and Nutrition Services Director (FNSD) included the facility's document titled Food and Nutrition Services Director, Job Description signed and dated by the Food and Nutrition Services Director on [DATE], showed the Food and Nutrition Services Director was primarily responsible for providing effective food and nutrition services in the skilled nursing facility, staffing, training, QAPI (Quality Assurance Performance Improvement), budget preparation, and compliance and ongoing resident documentation. Principle duties included in part, educates, coaches' food and nutrition team members, organizes, directs, and supervises day-to-day department operations, assures efficiency of food serving; compliance with local, state and federal standards; sanitation, and hygiene and health standards of personnel. The FNSD personnel file did not include documentation of food service training such as a certification from the American National Standards Institute- Conference for Food Protection to show training in food service safety and sanitation guidelines.

Review of the facility's document titled Summary of Report of Meeting, Type of Meeting: Inservice dated , d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE], showed the Chef and kitchen staff were educated on hair restraints, cooling monitor log, and following recipes.

Review of the facility's document titled Competency Checklist-Cook dated ,d+[DATE] showed the Chef was competent on the cooling monitor log, dry, refrigerated and freezer storage chart, food handling, and hairnets/beard protectors.

Review of the facility's document titled Sanitation Review Audit dated [DATE] and [DATE], signed and completed by the Registered Dietitian (RD) showed food use-by-dates, food bins free of scoops, hair restraints and trash containers not covered were concerns in the kitchen.

(continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the annual recertification survey from [DATE] to [DATE], multiple issues were found in the main kitchen, including: lack of a thawing process for meats as per the facility's P&P, failure to discard expired food, lack of monitoring of cooling for TCS (time/temperature for safety foods), lack of adequate hair and facial hair covering, food preparation equipment was not in good condition, a food storage bin was not free of a scoop, a dry food storage container was not sealed, food preparation equipment was not air dried, food was not properly stored in the freezer, refuse was not stored appropriately in the kitchen, and puree recipes were not followed. Cross references to F803; F812, examples #1, #2, #3, #5, #6, #7, #8, #9, #10; and F814, example #1. On [DATE] at 1004 hours, an interview was conducted with the FNSD. The FNSD was asked about her food service training background. The FNSD stated she was trained as a clinical Registered Dietitian and had food service experience. When asked how she monitored the day-to-day kitchen activities, the FNSD stated she did kitchen walk through, in-serviced staff, and made observations. The FNSD was not able to provide written documentation of kitchen inspections. The FNSD stated the RD did monthly kitchen inspections. The FNSD was asked about the Chef's responsibilities. The FNSD stated the Chef was responsible to oversee the back of the house activities; supervise cooks and food preparation. The FNSD was asked how she assessed the Chef's competency. The FNSD stated employee competency was evaluated once a year. On [DATE] at 1032 hours, an interview was conducted with the Administrator. The Administrator was asked how she ensured the department heads were competent in their job functions. The Administrator stated she assessed the department head's competency by the department head's experience, knowledge of the policy and procedures, and outside oversight of the consultant Dietitian. The Administrator stated the FNSD should be monitoring and training the kitchen staff.

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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. 39856 Based on observation, interview, and facility document review, the facility failed to ensure the resident menu was followed when the puree procedure for meat and vegetables was not followed. This failure posed the risk for an inconsistent product and to not meet the nutritional needs of the five residents who received puree diets. Findings: Review of the facility's recipe: Pureed Vegetables (undated) showed Number of Servings: five. Ingredients: Seasoned Vegetables two and 1/2 cup, Cooked and Drained (Reserve liquid). Food Thickener: one and 1/2 (half) teaspoon. The Directions were as follows: 1. Remove portions required from regular prepared recipe; drain and reserve cooking liquid. Place in food processor or blender and process until smooth. 2. If necessary, add a small amount of reserved cooking liquid or hot water. 3. If needed, gradually add thickener and process until smooth in consistency. Note: volume of liquid required may vary slightly, depending on the texture of the product. Note: Amount of thickener will vary slightly. Start with one and 1/2 teaspoon and add more gradually until desired texture is achieved. 4. Scrape down the side with a rubber spatula and reprocess for 30 seconds. 5. Ensure mixture achieves smooth, lump free and extremely thick consistency. 6. Serve using appropriate scoop size. Review of the facility's recipe: Pureed Fish/Meat/Poultry - three ounces (undated) showed Number of Servings: five. Ingredients: Meat Product, Cooked 3/4 lb. (pound), three ounces, Reserved Cooking Liquid or Broth, Hot one cup. Food Thickener one and 1/2 Teaspoon. The Directions were as follows: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Remove required portion amounts from regular prepared recipe; place in food process or blender. If necessary, debone meat prior to blending. Note: remember to weight meat only; do not include cooking juices or gravy. 2. Process until meat is smooth in consistency. Gradually add broth or gravy and thickener to meat while processing. (All liquid may not be required, depending on the texture of the meat). Note: volume of the liquid required may need to be adjusted, depending on the texture and moisture of the product. Note: Amount of thickener will vary slightly. Start with one and 1/2 teaspoon and add more gradually until desired texture is achieved. 3. Scrape down sides with rubber spatula; reprocess for 30 seconds. 4. Ensure mixture achieves smooth, lump free and extremely thick consistency. Note: For dry meat and fish. Dry meat such as roast pork or baked chicken may be pureed with one ounce of gravy per serving in addition to the cooking liquid or broth. On 4/3/24 at 1031 hours, an observation of the lunch meal puree food preparation and concurrent interview was conducted with Cook 3. Cook 3 stated he was preparing five portions of the puree green beans. Cook 3 added four #8 scoops (two cups) of the green beans, one cup of the chicken broth and 1/2 Tablespoon (equivalent to one and 1/2 teaspoon) to the blender. The green bean mixture was blended. Cook 3 stated the puree vegetables should be ice cream consistency. Cook 3 stated the vegetable mixture was too runny and added another 1/2 Tablespoon of thickener and blended the product. The puree green beans were then put in the hot holding box at 165 degrees Fahrenheit (F). Cook 3 proceeded with the puree food preparation and stated he was preparing five portions of the puree pork. Cook 3 stated each serving of the pork was three ounces. Cook 3 used a # six scoop (equivalent to 5.5 ounces) to measure five serving of pork into the blender. Cook 3 added one cup of the broth and 1/2 tablespoon (equivalent to one and 1/2 teaspoon) to the blender. The pork mixture was blended. Cook 3 stated since the pork was dry, he needed to add more of the chicken broth. Cook 3 added 1/2 cup of the chicken broth to the pork mixture and blended it. After blending the pork mixture, Cook 3 stated the pork mixture was too runny and he needed to add more thickener. Cook 3 added another 1/2 tablespoon of the thickener and blended the pork mixture. On 4/4/24 at 1500 hours, the puree food preparation procedure was discussed with the Administrator, FNSD, RD, and Chef. The FNSD, RD and Chef acknowledged the puree procedure was not followed correctly.

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	555922	A. Building B. Wing	04/04/2024

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, and facility P&P review, the facility failed to honor the food preference for one of two sampled residents (Resident 17) reviewed. This failure had the potential for inadequate nutrition. Findings: Review of the facility's P&P titled Initial Resident Visitation/Nutritional Screening dated 9/2/21, showed obtain food preferences, allergies or intolerance and note on Dietary interview/pre-screen (FORM 101) or other designated form and tray card. The interview form is filed in the medical record, preferably. Medical record review for Resident 17 was initiated on 4/2/24. Resident 17 was admitted to the facility on [DATE], and readmitted on [DATE]. On 4/2/24 at 0845 hours, a concurrent observation and interview was conducted with Resident 17. Resident 17 almost finished her breakfast and had one glass of cranberry juice on her breakfast tray. Resident 17 stated she did not like the cranberry juice and had mentioned this to the staff, but she still was provided with cranberry juice. On 4/2/24 at 0900 hours, LVN 4 was summoned to the room. Resident 17 told LVN 4 that she had been served the cranberry juice for breakfast. LVN 4 stated he would update her preference and wrote down no cranberry juice on her diet card. Review of Resident 3's diet order for breakfast dated 4/3/24, showed Resident 17's beverage was cranberry juice. On 4/3/24 at 0845 hours, a concurrent observation and interview was conducted with Resident 17. Resident 17 was observed finished her breakfast and stated they still served cranberry juice. On 4/3/24 at 0915 hours, an interview was conducted with LVN 4. LVN 4 stated this morning they still served cranberry juice and he took it out because Resident 17 stated she did not like it. LVN 4 was asked about Resident 17's diet card showed the resident's beverages was cranberry juices. LVN 4 did not know why it was not updated. LVN 4 verified the findings. On 4/4/24 at 1500 hours, an interview was conducted with the FNSD. The FNSD stated the nurse could give a slip with any staff or could verbally talk to any kitchen staff to update the residents' food preferences.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, and facility P&P review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the meat thawing process was followed. * The facility failed to ensure the expired food was discarded. * Time/Temperature Control for Safety (TCS) foods (food that required time and temperature controls to limit the growth of illness causing bacteria) were not monitored to ensure the proper cool down process was followed. * Two of two ice machines were not clean. * The facility failed to ensure hair and beard restraints were worn by dietary personnel inside the main kitchen. * The facility failed to ensure the food preparation equipment were in good condition. * The facility failed to ensure a storage container was free of a scoop. * The facility failed to ensure a dry food storage container was properly sealed. * The facility failed to ensure the food preparation equipment were properly air dried prior to storage. * The facility failed to ensure proper labeling and dating of the opened food in the freezer. * The facility failed to ensure the drying rack was clean. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared from the kitchen. Findings: Review of the facility's Resident Assessment Report (CMS-802) dated [DATE], showed 40 of 40 residents residing in the facility received food prepared in the kitchen. 1. According to USDA Food Code 2022, Section ,d+[DATE].13, Thawing, showed freezing prevents microbial growth in foods, but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/ or produce toxins. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's P&P titled Meat Cookery and Storage revised [DATE], showed the meat which needs defrosting should be pulled three days prior to service and defrosted in a dry, cool area at 41 degrees Fahrenheit (F) or less. Date meat when pulled for defrosting. Review of facility's P&P titled Food Storage revised [DATE], showed all products should be inspected for safety and quality and be dated upon receipt, when opened, and when prepared. Any expired or outdated food products should be discarded. Date meat when taken out of freezer. Follow meat pull schedule when available in menu program. On [DATE] at 0830 hours, during the initial tour of the kitchen, an observation of the walk-in refrigerator and concurrent interview was conducted with the FNSD. The following items were observed: - 51 lbs of chicken breasts with no use by date or freezer pull date; - 40 lbs of chicken thighs with a received date of [DATE], but with no use by date or freezer pull date; - 12 lbs. of turkey breasts with a received date of [DATE], but with no use by date or freezer pull date; - two 12 lbs. of sealed packs of beef tenderloin with a received date of [DATE], but with no use by date or freezer pull date; and - two boxes of 10 lbs of cod fish with no use by date or freezer pull date. All food items were completely thawed. The FNSD stated the food from the freezer in the process of thawing should be labeled with the received date, use by date, and freezer pull date. The FNSD verified the above findings. 2. According to U.S. Food and Drug Administration, the fresh poultry (chicken and turkey whole and parts) should be kept in the refrigeration for one to two days. These short but safe time limits will help keep refrigerated food to 40 degrees F from spoiling or becoming dangerous. Review of the facility's P&P titled Food Storage revised [DATE], showed all products should be inspected for safety and quality and be dated upon receipt, when opened, and when prepared. Any expired or outdated food products should be discarded. Review of the facility's P&P titled Meat Cookery and Storage revised [DATE], showed the meat which needs defrosting should be pulled three days prior to service and defrosted in a dry, cool area at 41 degrees F or less. Date meat when pulled for defrosting. On [DATE] at 0830 hours, during the initial tour of the kitchen, an observation of the walk-in refrigerator was conducted. 51 lbs of completely thawed chicken breasts with no received date, no use by date, and no freezer pull date was observed. 40 lbs of completely thawed chicken thighs with the received date of [DATE], had no use by date and no freezer pull date observed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 1015 hours, an observation of the walk-in refrigerator was conducted with the Chef. The 40 lbs of chicken thighs with the received date of [DATE], and with no use by date and no freezer pull date observed on [DATE], were still stored in the walk-in refrigerator. The Chef stated the chicken thighs were never stored in the freezer but put directly in the walk-in refrigerator when received. The Chef further stated normally, the chicken breasts were stored upon receipt in the freezer, then transferred to the refrigerator and thawed. When asked what happened to the undated chicken breasts observed on [DATE], the Chef stated the chicken breasts had been transferred to the cook's preparation refrigerator for dinner service on [DATE]. When asked, the Chef stated he was not sure what the shelf life of the raw chicken was. The Chef checked the posted facility guidelines titled Refrigerated Storage Chart revised [DATE], for the fresh meat, fish, and poultry. The Refrigerated Storage Chart showed unopened fresh chicken was good for two days in the refrigerator. On [DATE] at 1020 hours, the undated chicken breasts observed on [DATE], were observed in the cook's preparation refrigerator, unpacked in a tray, and covered with a plastic wrap. The chicken breasts were labeled with a preparation date of [DATE], and a use by date of [DATE] for dinner. On [DATE] at 1027 hours, an interview was conducted with the FNSD. The FNSD stated she thought the 51 lbs. of thawed chicken breasts and 40 lbs. of thawed chicken thighs had been discarded on [DATE]. The FNSD discarded the chicken breasts prepared in a tray and the 40 lbs. of chicken thighs. 3. According to the USDA Food Code 2022, Section ,d+[DATE].14 Cooling, (A) Cooked time/temperature control for safety food shall be cooled: (1) within two hours from 135 degrees Fahrenheit (F) to 70 degrees F; and (2) within a total of six hours from 135 degrees F to 41 degrees F or less. On [DATE] at 1003 hours, an interview was conducted with Cook 3 and the Chef. Cook 3 stated the chicken would be cooked to use for the chicken salad as a meal alternative. Cook 3 stated they did not have a cool down log to monitor the cool down process. The Chef stated they cooked the chicken in the oven, put the cooked chicken and other salad ingredients in the robot coupe (a device to mince or puree meat) to blend, then stored the chicken salad in the refrigerator. The Chef further stated they did not monitor the temperature of the chicken salad. A clip board with more than 20 blank forms titled Cooling Monitoring Forms were observed posted in the kitchen. 4. According to the USDA Food Code 2022, Section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, Food-Contact surfaces and utensils shall be clean to sight and touch. Review of the facility's P&P titled Ice Machine Service revised [DATE], showed the unit is to be cleaned and sanitized per manufactory guidelines as posted on machine on a quarterly basis to ensure that the unit is free of scale and lime buildup. If needed, unit can be cleaned on a more frequent basis. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 0945 hours, an observation of Ice Machine 1 located in the main kitchen and concurrent interview was conducted with the Plants Operation Manager and the Maintenance Technician. Ice Machine 1 was observed with a slimy yellow residue on the ice machine deflector (a device that directs ice from the machine into the ice storage bin) and on the groove in front of deflector when wiped with white paper towel. A yellow-white crusty residue was also observed surrounding the ice chute (area where ice is dispensed into the ice storage bin). The Plants Operation Manager stated the ice machine was cleaned every six months. The Plants Operation Manager stated they would work on cleaning the ice machine. On [DATE] at 1005 hours, an observation of Ice Machine 2 located in the nourishment station and concurrent interview was conducted with the Maintenance Technician. The interior frame of the ice machine door had a clear plastic-like residue. The clear plastic-like residue came off when wiped with a white paper towel. The Maintenance Technician stated the clear plastic-like residue was a silicon sealant. The Maintenance Technician further stated he would close Ice Machine 2 and remove the plastic residue. 5. According to the USDA Food Code 2022, Section ,d+[DATE].11 Hair Restraints, Effectiveness, showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens. Review of the facility's P&P titled Personal Hygiene/ Safety/Food Handling/ Infection Control revised [DATE], under the Head Covering Worn section, showed the following: - Wear a clean hat or other hair restraint. Hair must be appropriately restrained or completely covered. - Head covering must be clean. - Beards, mustaches, or any body hair that maybe exposed must be covered. On [DATE] at 0820 hours, during the initial tour of the kitchen, Cook 1 was observed to wear a baseball cap with exposed hair at the back of his head and uncovered facial hair. On [DATE] at 0955 hours, Cooks 2 and 3 were observed to wear a baseball cap with exposed hair at the back of his head and uncovered facial hair while pureeing resident's food. On [DATE] at 1150 hours, during the lunch meal tray line service, the Chef, Cooks 1, 2, and 3 were observed with uncovered facial hair. The Chef, Cooks 1, 2, and 3 were observed to wear a baseball cap with exposed hair at the back of their head. On [DATE] at 1003 hours, during an interview in the kitchen, Cook 3 was observed to wear a baseball cap with exposed hair at the back of his head and uncovered facial hair. On [DATE] at 1015 hours, an interview was conducted with the Chef. The Chef was noted to wear a baseball cap with exposed hair at the back of his head and uncovered facial hair. The Chef stated he was not aware a hair restraint was required if a baseball cap was worn. The Chef further stated he ordered beard restraints in the past but no longer ordered beard restraints. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Orchards Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Amistad Drive Ladera Ranch, CA 92694	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. According to the USDA Food Code 2022, Section ,d+[DATE].12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. According to the USDA Food Code 2022, Section ,d+[DATE].11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, Section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, Food-Contact surfaces and utensils shall be clean to sight and touch. On [DATE] at 0845 hours, during the initial tour of the kitchen and concurrent interview with the FNSD, the following items were observed: - two large and one small frying pans with thick black residue buildup on the cooking surface; - four muffin pans with a crusty thick black residue buildup on interior surface; and - three cutting boards were heavily marred with knife marks. The FNSD verified the above findings and stated they would throw the food equipment. 7. Review of the facility's P&P titled Food Storage under Dry Storage section revised [DATE] showed to remove food stored in bins from their original packaging, label and date all storage containers or bins and keep free of scoops. On [DATE] at 1031 hours, during the pureed meal preparation observation, Cook 2 left the spoon used for scooping the thickener in the container after touching it with gloved hands and touching multiple unclean surfaces. On [DATE] at 1040 hours, an interview was conducted with the Chef. The Chef stated the spoon used for scooping should never be left in the food container. He acknowledged the above findings. 8. Review of the facility's P&P titled Food Storage under Dry Storage section revised [DATE] showed any opened products should be placed in seamless plastic or glass containers with tight-fitting lids and labeled and dated. On [DATE] at 0840 hours, during the initial tour of the kitchen, an observation of the dry storage area was conducted with the FNSD. A chicken base plastic container was observed with the cover not sealed. The FNSD stated the product was open and she tried to close the cover, but it did not seal. The FNSD stated it was not good and she would discard the chicken base. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. According to the USDA Food Code 2022, Section ,d+[DATE].11, Equipment and Utensils, Air- Drying Required, showed items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganism can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms. Review of the facility's P&P titled Dry Storage-Dishes and Utensils revised [DATE], showed the dishes must be stored to promote air drying that is to use dish racks or trays with plastic mesh that allow air to circulate, and air dry the dishes. On [DATE] at 0845 hours, during the initial tour of the kitchen with the FNSD, the robot coupe and blender were observed to be stored with the top on, and the inside of each equipment was still wet. The FNSD verified the findings and stated the equipment were not air dried properly. 10. Review of the facility's P&P titled Food Storage, under the Meat/Poultry and Foods section, revised [DATE], showed the food should be stored in their original containers if designed for freezing. Food to be frozen should be stored in airtight containers or wrapped in heavily-duty aluminum foil or special laminated papers. The P&P also showed to label and date all food items. On [DATE] at 0820 hours, during the initial tour of the kitchen, an observation of the walk-in freezer and concurrent interview was conducted with Cook 1. One box of cookies gourmet sugar was observed with an opened interior plastic bag. The cookies appeared freezer burned (a condition caused by air reaching the surface of the food). The box was not labeled with an open date. Cook 1 stated the cookies were no longer good. 11. According to the USDA Food Code 2022, Section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, Food-Contact surfaces and utensils shall be clean to sight and touch. According to the USDA Food Code 2017, Section ,d+[DATE].13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On [DATE] at 0845 hours, during the initial tour of the kitchen, the drying rack was observed with yellow and black debris. The FNSD verified the findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 49258 Based on observation, interview, and facility P&P review, the facility failed to ensure the P&P for the resident's food brought by the visitors was followed. * The facility failed to ensure the safe food handling guidelines were communicated to the resident's family/visitors who brought the resident food from the outside. This failure had the potential to cause foodborne illness to the residents who received food brought by the visitors. Findings: Review of the facility's P&P titled Food from Outside Sources dated 2020 showed if the food is brought in by the visitors, friends, family members or other guests, the community should help them understand safe food handling practices as summarized in Safe Food Handling Guide for Visitors and Staff (DOC 403). On 4/2/24 at 1506 hours, an interview was conducted with LVN 1. LVN 1 stated she normally educated the resident's family members/visitors regarding the resident's diet only and not on safe food handling. LVN 3 further stated she did not know any document they ave for the family members/visitors regarding for safe food handling. On 4/3/24 at 1447 hours, an interview was conducted with the DON. The DON stated the RNs, LVNs, and CNAs received an in-service training regarding the outside food and safe food handling; however, the facility had not provided the residents' family members/visitors with the Safe Food Handling Guide for Visitors and Staff (DOC 403). The DON further stated it was overwhelming for the family members/visitors to read the DOC 403.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 49258 Based on observation, interview, and facility P&P review, the facility failed to store trash in a sanitary manner as evidenced by: * The facility failed to ensure the green organic trash container and one of three dumpsters were properly covered. This failure had the potential to harbor pests. Findings: According to the US Food Code 2022, Section 5-501.113, Covering Receptacles, showed receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids. Review of the facility's P&P titled Garbage and Trashcans revised 5/20/20 showed: - All food waste must be placed in covered garbage and trashcans; and - The dumpster area must be free of debris on the ground and the lid must be closed. On 4/2/24 at 0845 hours, during the initial tour of the kitchen and concurrent interview with the FNSD, a green organic trash container with raw vegetables inside had no cover. The FNSD stated the cover was broken. On 4/2/24 at 1417 hours, an observation of the trash disposal and concurrent interview with the EVS Manager. The lid of one of three dumpsters was observed fully open. The EVS Manager stated the staff forgot to close the dumpster cover. The EVS Manager further stated the dumpster cover should always be closed. The EVS Manager further stated he had a problem with the employees not closing the dumpster cover.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39683 Based on interview and record review, the facility failed to ensure the complete and accurate medical records for three of six residents reviewed for advanced directives (Residents 14, 26, and 35). * Residents 14, 26, and 35's POLST were incomplete. This failure had the potential for the resident's advanced directive status not being communicated to the health care staff in the event of an emergency for these residents. Findings: 1. Medical record review for Resident 14 was initiated on 4/2/24. Resident 14 was readmitted to the facility on [DATE]. Review of Resident 14's Internal Medicine History and Physical examination dated 3/27/24, showed Resident 14 did not have capacity (to understand and make decisions). Review of Resident 14's POLST form dated 3/25/24, showed the POLST was a legally valid physician's order, and to send the form with the resident whenever they are transferred or discharged . Resident 14's POLST also showed Section D - Information and Signatures was incomplete when asked to select if the resident had an advance directive, and if the advance directive was available and reviewed. The POLST was signed by the physician on 3/25/24. Review of Resident 14's Social Services Evaluation - V6 dated 3/28/24, showed Resident 14's POLST form was completed and on file, the resident did not have an advanced directive, the resident's capacity fluctuates, and a blank advanced directive form was provided to the resident's family. On 4/3/24 at 1336 hours, an interview and concurrent medical record review were conducted with the SSD. The SSD verified they left Resident 14's POLST - Section D incomplete because they were hoping the resident would eventually have capacity, and if the SSD left the section blank, it just meant there was not an advanced directive. The SSD stated if they selected the check box that showed there was no advanced directive, and the resident was later able to formulate an advance directive, they would have to complete a new POLST to update the changes. 2. Medical record review for Resident 35 was initiated on 4/2/24, Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's Internal Medicine History and Physical examination dated 3/1/24, showed Resident 35 had capacity (to understand and make decisions). Review of Resident 35's POLST form dated 3/1/24, showed the POLST was a legally valid physician's order, and to send the form with the resident whenever they were transferred or discharged . Resident 35's POLST also showed Section D - Information and Signatures was incomplete when asked to select if the resident had an advance directive, and if the advance directive was available and reviewed. The POLST was signed by the physician on 3/1/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 35's Social Services Evaluation - V6 dated 3/1/24, showed Resident 35's POLST form was completed and on file, the resident did not have an advanced directive, and a blank advanced directive form was provided to the resident. On 4/3/24 at 1336 hours, an interview and concurrent medical record review were conducted with the SSD. The SSD verified they left Resident 35's POLST - Section D incomplete, and if the SSD left the section blank, it just means there was not an advanced directive. The SSD stated if they selected the check box that showed there was no advanced directive, and the resident later could formulate an advance directive, they would have to complete a new POLST to update the changes. 39670 3. Medical record review for Resident 26 was initiated on 4/2/24. Resident 26 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 26 had severe cognitive impairment. Review of Resident 26's POLST dated 2/20/24, showed the POLST was signed by the physician and the treatment of the resident was selected in the event Resident 26's health conditions worsen. However, Section D of the POLST showed the advance directive was incomplete. Review of Resident 26's Social Services Evaluation - V6 dated 2/23/24, showed the POLST form was completed, and Resident 26 had an advance directive. On 4/3/24 at 1343 hours, an interview and concurrent medical record review for Resident 26 was conducted with the SSD. The SSD stated the POLST form was to be completed upon admission of the resident to the facility. The SSD verified Resident 26's POLST was incomplete and stated she was waiting for the resident's family to submit the advance directive and it was pending. On 4/4/24 at 1104 hours, an interview and concurrent medical record review for Resident 26 was conducted with the DON. The DON was informed and verified the above findings. The DON stated the expectation was for all the resident's documents be completed.

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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. 32179 Based on observation, interview, facility document review, and facility P&P review, the facility failed to establish and maintain the infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. * The facility failed to ensure the water management program was established and implemented to include the implementation of measures to prevent the growth of Legionella and other opportunistic pathogens; and a way to monitor the measures they had in place * The facility failed to ensure the staff changed gloves after touching the bedside table and prior to administering eye drop medications for Resident 543 * CNA 4 failed to perform hand hygiene after touching the floor mat with bare hands in Room A These failures had the potential to increase the risk for the spread of infection. Findings: Review of the facility's P&P titled legionella monitoring dated 5/2020 showed infection control committee supports the administrator, Director of nursing and Plant Operation Director with implementation and oversight of this policy including any investigation of issues. Under the section for Control Measures and General Awareness protocol: The facility has considered the ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) industry standard and the CDC (Center and Disease Control) toolkit to evaluate the current facility control measures and determine awareness protocols. Example of systems: resident bathrooms (faucet- hot and cold shower), decorative fountains, evaporative cooling water, ice machine water, hot water storage tanks (domestic and laundry), emergency water storage container, water filters, showerheads and hoses, eye wash station. According to CDC's guidelines for Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings dated 6/26/15, control measures and limits should be established for each control point. You will need to monitor to ensure your control measures are performing as designed. Control limits, in which a chemical or physical parameter must be maintained, should include a minimum and a maximum value. Examples of chemical and physical control measures and limits to reduce the risk of Legionella growth: Water quality should be measured throughout the system to ensure that changes that may lead to Legionella growth (such as a drop in chlorine levels) are not occurring, Water heaters should be maintained at appropriate temperatures, Decorative fountains should be kept free of debris and visible biofilm, Disinfectant and other chemical levels in cooling towers and hot tubs should be continuously maintained and regularly monitored. Surfaces with any visible biofilm (i.e., slime) should be cleaned. Under section Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program is being implemented as designed. This step is called verification. Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program effectively controls the hazardous conditions throughout the building water systems. This step is called validation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 1000 hours, an interview was conducted with Infection Preventionist 1. Infection Preventionist 1 stated she was not aware of the part for implementation and oversight of the legionellae monitoring including any investigation of issues. On 4/4/24 at 1030 hours, an interview and concurrent facility document review was conducted with the Plant Operation Manager. The Plant Operation Manager was asked to show their water management program. The Plant Operation Manager stated if there was no standing water, he did not need to do ongoing testing and control measures. When asked if he could provide any documentation regarding any control measures and general awareness protocol, he stated he did not need to do ongoing control measure. The Plant Operation Manager stated he did the water temperature check for each resident room monthly. The Plant Operation Manager was asked for the following: - documentation if any measures was not met, the corrective action and the contingency response plan. - temperature checks being part of control measures. - when or how the control measures would be applied. The Plant Operation Manager was unable to provide the documentation and verified the finding. 50126 2. Review of the facility's P&P titled Hand Washing and Hand Hygiene dated 11/2020 showed all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. On 4/03/24 at 0834 hours, a medication pass observation and concurrent interview was conducted with LVN 4. LVN 4 was observed putting on gloves, touching the bedside table, then administering the eye drops to both of Resident 543's eyes using the same tissue. LVN 4 stated the gloves should have been changed and hand hygiene should have been performed after touching the bedside table. LVN 4 further stated they should have used a different tissue for each eye when administering eye drops. On 4/03/24 at 1424 hours, an interview was conducted with the DON. The DON verified the gloves should be changed after touching the bedside table and two different tissues need to be used when administering eye drops in both eyes. 49644 3. Review of the facility's P&P titled Hand Washing and Hand Hygiene dated 11/2020 showed the facility considers hand hygiene the primary means to prevent the spread of infections. In most situations, the preferred method of hand hygiene is with alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-85% ethanol or isopropanol after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. On 4/2/24 at 1213 hours, CNA 4 was observed in Room A touching the floor mat with bare hands. CNA 4 grabbed a meal tray and delivered the meal tray to Room B. CNA 4 did not perform hand hygiene after touching the floor mat in Room A. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 1215 hours, an interview was conducted with CNA 4. CNA 4 acknowledged she moved the floor mat without gloves. CNA 4 verified she did not perform hand hygiene after touching the floor mat in Room A. CNA 4 stated she did not know if she should perform hand hygiene. When asked if she had training on hand hygiene, CNA 4 stated she had hand hygiene training before. On 4/4/24 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding.