STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555928	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Skilled Nursing Facility	9825 Glen Center Drive San Diego, CA 92131

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36765 Based on observation, interview, and record review, the facility did not ensure food items were labeled and dated/not expired. In addition, there were produce items with mold. These failures had the potential to cause food-borne illness for the residents. Findings: An initial tour/observation of the facility's kitchen with the chef was conducted on [DATE] at 8:45 A.M. The following items were found unlabeled/undated: 1 package of fresh mushrooms with no date received; 1 bowl of a white, unidentified sauce (later identified as tartar sauce) in the refrigerator with no label, no date mixed/or use by date; 1 tray of individual salad dressing not labeled or dated; 3 cans (6.88 lbs each) of garbanzo beans, banana pudding, and canned peaches with no received by date or use by date; 2 bags of marble rye bread with no received by dates or use by dates; 1 bag of hamburger buns and and 1 bag of Texas toast bread with no expiration dated and no received by date. The following items were found to be expired: 1 box of vanilla shakes expired on [DATE]; 3 gallon container of sherbet expired on [DATE]; 3 gallon container of chocolate ice cream expired on [DATE]; (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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NAME OF PROVIDER OR SUPPLIER Ridgeview Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 9825 Glen Center Drive San Diego, CA 92131	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 package of hot dog buns expired on [DATE]; 2 bags of pre-packaged salad greens expired on [DATE]; 1 commercially-prepared, wrapped chocolate sheet cake expired on [DATE]. The following items were found to be moldy: 1 box with fresh red onions, 4 of the onions were black/moldy. An interview with the chef was conducted on [DATE] at 9 A.M. The chef stated, Food items need to be dated and labeled and fresh produce needs to be checked for mold and freshness. Expired foods can cause illness. An interview was conducted on [DATE] at 8:21 A.M. with the Director of Nursing (DON). The DON stated, It is important for food to be labeled and dated so residents don't get spoiled food. It can make them sick. Moldy food is not acceptable. An interview was conducted on [DATE] at 11:17 A.M., with the Registered Dietician (RD). The RD stated, Expired food items can be bad for the residents, they can cause health conditions. Items should have a received by date and a use by date. Staff is supposed to check fresh produce when it comes in. According to the 2022 Federal FDA Food Code, section ,d+[DATE].17 (A) (B) (C) (D) indicate .the day the original container is opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date .mark the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises . A review of the facility's policy, dated [DATE], titled, Food Storage, indicated, Policy: Upon delivery all food items should be inspected for safe transport and quality upon receipt . Procedure: All products should be inspected for safety and quality and be dated upon receipt, when open, and when prepared. Use-by dates on all food stored in refrigerators and use dates according to the timetable in the Dry, Refrigerated and Freezer Charts .Leftovers should be dated .Remember to cover, label and date! Any expired or outdated food products should be discarded . Fresh vegetables .1. fresh vegetables should be checked and sorted for ripeness .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to ensure a documented means of communication for coordination of care for one of one resident (Resident 4), reviewed for hospice (end of life), care was in place. This failure had the potential to disrupt continuity of care between the facility and the hospice agency. Findings: Resident 4 was readmitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's Admission Record. On 5/06/24 at 9:21 A.M., an observation was conducted of Resident 4, within his room. Resident 4 was dressed and sitting in a wheelchair. Resident 4 stated he was having difficulty hearing, because his hearing aids were not working at the time. On 5/6/24, Resident 4's clinical record was reviewed. According to the physician orders, dated 11/20/23, Resident 4 was admitted to hospice. According to the Minimum Data Set (MDS-a clinical assessment tool), dated 3/8/24, a cognitive score of 7 was listed, indicating cognition was severely impaired. The functional status indicated Resident 4 required moderate assistance with transferring from bed to chair, sitting to standing, and personal care. The Hospice visiting calendar was reviewed from March 1, 2024, through May 6, 2024. The calendar indicated a hospice health aid (HHA) visited the resident two times a week, on Tuesday and Fridays, the social service worker (SSW) visited one time a week, and a chaplain visited once a month. The calendar did not indicate how often the hospice licensed nurse (LN) was scheduled to visit. The Hospice Communication Log was reviewed from 2/26/24 through 5/6/24. Entries were made by LNs every week and by the HHAs twice a week. According to the Hospice Communication Log, there was no documentation that a LN visited Resident 4, between 4/5/24 and 4/17/24, (14 days). On 5/06/24 at 3:34 P.M., an interview and record review was conducted with a Hospice licensed nurse (H-LN 1). The H-LN 1 stated all hospice visits should be listed on the Hospice calendar within the resident's record. The H-LN 1 stated Resident 4 was scheduled to have a H-LN visit, once a week on Thursdays. The H-LN 1 was informed there was no documentation on the Hospice calendar or the Hospice Communication Log that a Hospice nurse visited the resident between 4/5/24 and 4/17/24. The H-LN 1 reviewed their records and stated a H-LN visited the resident on 4/12/24, and it should have been documented on the Communication Log, kept within the resident's chart. The H-LN 1 stated a Visit Note Report was prepared by the Hospice nurse, indicating the visit was made on 4/12/24. The facility's chart was reviewed, and no Hospice Visit Note could be located within the chart. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/06/24 at 3:50 P.M., an interview and record review was conducted with the medical records director (MRD). The MRD could not locate any documented evidence of a Hospice Visit Note, dated 4/12/24, had been faxed over. The MRD stated, The hospice agency had not sent it to me yet. On 5/06/24 at 3:59 P.M., an interview and record review was conducted with licensed nurse 1 (LN 1). LN 1 stated the Hospice calendar was used, so staff knew when Hospice came to visit the resident. LN 1 stated the Hospice Communication log was important as a communication tool between hospice and the facility staff. LN 1 reviewed the Hospice Communication Log and stated it looked like there was no Hospice nurse visit between 4/5/24 and 4/17/24. LN 1 stated if a hospice nurse visited, they were expected to write a note, so staff knew what the resident's assessment was at the time. LN 1 stated if a hospice nurse visited and did not document it, there was the potential for harm, because no communication or collaboration existed between hospice staff and the facility's staff. On 5/6/24 at 4:08 P.M., LN 1 produced a Hospice Visit Note dated 4/12/24 and 4/30/24, with a fax stamp of 5/6/24 at 10:24 A.M. LN 1 stated the Hospice Visit Notes were faxed over this morning and found in a folder. LN 1 stated the MRD just located them and they will place the Hospice Notes in Resident 4's clinical record. On 5/06/24 at 4:10 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated if a Hospice nurse did not document the visit, it was not conducted. The DON stated she expected all hospice visits to be listed on the Hospice calendar and a hospice note to be made on the Hospice Communication log at the conclusion of the visit. The DON stated the documentation on the Communication Log was important for the facility's staff for coordinating care and being aware of recent changes, so a continuum of care could be provided. Per the facility's policy, titled Hospice Documentation, dated November 2017, .The records maintained by Hospice staff shall be included in the facility's resident health record .7. The various Hospice staff shall write progress notes and/or make entries in the health record during each visit, such as Registered Nurse, Home Health Aid, Social Worker, Chaplain and volunteers .These entries must confirm the services rendered in accordance with the resident's terminal illness .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to offer COVID-19 (a highly contagious virus) vaccine booster (an extra dose of the vaccine after an original is administer), to four out of five residents (Residents 4, 6, 114, and 116) reviewed for infection control. As a result, residents were at risk of contracting a potentially life-threatening infection. Findings: 1. Resident 4 was readmitted to the facility on [DATE], with diagnoses which included pneumonia due to SARS-Associated Coronavirus (COVID-19), per the facility's Admission Record. On [DATE], Resident 4's clinical record was reviewed. Resident 4 had a Responsible Party (RP-a legal document assigning a specific person to make medical and financial decisions on the resident's behalf), listed to make medical decisions. According to the facility's COVID-19 Vaccination Informed Consent Form, dated [DATE], listed original COVID-19 shots were provided in 2021, and one booster was given in [DATE]. An inquiry if an additional COVID vaccine booster was requested, was documented as a decline, with no. When the resident returned to the facility on [DATE], from the hospitalization related to a COVID-19 infection, there was no documented evidence a follow-up COVID-19 vaccination was offered. On [DATE] at 11:04 A.M., an interview was conducted with Resident 4's RP. The RP stated Resident 4 was in the hospital with pneumonia and COVID-19 infection, and she was sure the facility would have provided him a COVID-19 booster on his return. The RP could not recall if the facility asked her for consent, but said she would have signed anything to prevent Resident 4 from being infected again, because he could have died . 2. Resident 6 was admitted to the facility on [DATE], with diagnoses which included fracture of the right femoral head (hip fracture), with surgical replacement of artificial right hip, per the facility's Admission Record. On [DATE], Resident 6's clinical record was reviewed. According to the facility's COVID-19 Vaccination Informed Consent Form, Resident 6 had original COVID-19 shots in 2021, with two additional boosters in [DATE]. The next section, consenting to receive a COVID-19 booster was blank, not indicating if the resident agreed to a vaccine booster or not. On [DATE] at 3:58 P.M., an interview was conducted with Resident 6. Resident 6 stated if the facility offered a COVID-19 booster, he would want to have it. Resident 6 could not recall if he was ever offered the COVID-19 booster. 3. Resident 114 was admitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the bronchus or lung (cancer in the lungs), per the facility's Admission Record. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], Resident 114's clinical record was reviewed. According to the facility's COVID-19 Vaccination Informed Consent Form, Resident 114 had an original COVID-19 shot in 2021. There was no documentation of any booster vaccines. The next section, consenting to receive a COVID-19 booster was blank, not indicating if the resident agreed to a vaccine booster or not. On [DATE] at 10:28 A.M., an interview was conducted with Resident 114. Resident 114 stated, Yes, I would want to have a COVID-19 booster. I can't remember if anyone offered me one. 4. Resident 116 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD-ineffective gas exchange in the lungs), per the facility's Admission Record. On [DATE], Resident 116's clinical record was reviewed. According to the facility's COVID-19 Vaccination Informed Consent Form, Resident 116's original COVID-19 shot was in 2021. There was no documentation of any booster vaccines. The next section, consenting to receive a COVID-19 booster was blank, not indicating if the resident agreed to a vaccine booster or not. On [DATE] at 3:52 P.M., an interview was conducted with Resident 116. Resident 116 stated, No, I was never offered a COVID booster, but would have refused it anyway, due to a past reaction, my doctor told me never to get another one. On [DATE] at 2:55 P.M. an interview and record review was conducted with the Infection Control Nurse (ICN). The ICN stated she started at the facility three weeks ago and was still getting settled in. The ICN stated she had no spread sheet of which residents had received various vaccinations and which residents refused vaccines. The ICN stated she would have to go into each resident's medical record to learn their vaccine status. The ICN stated she knows each resident should be provided vaccines on admission such as tuberculosis, influenza, pneumococcal, and COVID-19., and again on re-admission. The ICN stated the facility's plan was to have an outside pharmacy administered the vaccines, but they required 20 plus residents for vaccinations, before they will come to the facility. The ICN stated their current census was 14, so by the time they get to 20 residents, some of the residents were preparing for discharge. The ICN continued, stating all residents should be offered vaccinations, along with written information with the risks and benefits for those vaccinations. The ICN stated the COVID-19 vaccine should have been offered, and if accepted, it should have been provided. The ICN stated by not offering and providing the COVID-19 vaccine, residents were at risk of contracting the virus and becoming ill. On [DATE] at 4:17 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the COVID-19 vaccine should have been offered to all residents on admission or re-admission. The DON stated by not offering or providing the COVID-19 vaccine, residents were at risk of infection, which could be harmful. According to the facility's policy, titled, COVID-19 Immunization Guidelines for Residents, dated [DATE], Ridgeview Health Center shall educate and offer the COVID-19 vaccine to all residents/representatives unless contraindicated by the physician This shall be documented in the resident's medical record .the facility shall arrange for administration as soon as feasible possible .