POC Received 5/7/2025
POC Approved 5/14/2025
BIC = 5/7/2025 per DB

PRINTED: 04/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055858	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCHO SECO CARE CENTER	144 F STREET GALT, CA 95632

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. The facility census was 91. The sample size was 24. Two (2) complaints #CA00955254 and # CA00956065, and one (1) facility reported incident #CA00954684 were investigated during the Recertification Survey. The Department was unable to substantiate a violation of the regulations for the complaints #CA00955254 and #CA00956065, and facility reported incident #CA00954684.	F 000	Rancho Seco Care Center submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656	F656 Develop/Implement Comprehensive Care Plan How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) On 04/09/25 Resident 49 and Resident 79 care plans were updated to include dysphagia diagnosis.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	05/07/2025

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.

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F 656	Continued From page 1 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure comprehensive care plans for dysphagia (difficulty of swallowing) were developed for two out of 24 sampled residents, Resident 49 and Resident 79. This failure increased Resident 44 and Resident 79's risk of not receiving proper nursing care interventions for dysphagia and had the potential	F 656	How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) Clinical Resource Nurse completed an audit on 05/01/2025 to ensure all current residents with a dysphagia diagnosis/diets had a completed care plan to reflect their dysphagia diagnosis. All residents have the potential to be affected by this deficient practice. No other areas were identified with having this same deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) An in-service was initiated by facility DON on 04/11/2025 to LN staff regarding the importance of completing dysphagia care plans for residents with a dysphagia diagnosis. d) Medical Records / designee will pull the report of new admissions each morning and bring to the clinical meeting 5 days per week to ensure dysphagia care plans have been completed. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	

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F 656	Continued From page 2 to cause choking and aspiration (inhale into the lungs). Findings: In a review of Resident 49's "Admission Record," Resident 49 was admitted in the facility on 3/25/25 with diagnosis that included Acute Respiratory Failure with Hypoxia (difficulty of breathing, low oxygen in the body), and Gastro-Esophageal Reflux (backflow of stomach contents into the mouth). In a review of Resident 79's "Admission Record," Resident 79 was admitted in the facility on 3/3/25 with diagnosis that included Acute Respiratory Failure with Hypoxia, and Pneumonia (lung infection making it difficult to breathe). During a concurrent observation, interview, and record review with Activity Director (AD) in the Dining room on 4/7/25 at 12:15 p.m., Resident 49 was observed to have drunk regular water from a cup. Review of Resident 49's meal ticket indicated, a diet order of nectar thick liquids. The AD confirmed that Resident 49's water should have been thickened (powder or gel, that is added to liquids like water to increase their viscosity and make them thicker) as indicated on his meal ticket as Resident 49 may choke or aspirate if his water is not thickened. During a concurrent observation and interview with the Director of Nursing (DON) in the Dining room on 4/7/25 at 12:45 p.m., Resident 79 was observed to drink hot chocolate from a mug. Resident 79's meal ticket indicated, a diet order of nectar thick liquids. The DON confirmed that	F 656	e) Medical Records / designee will pull the report of new admissions and bring to the clinical meeting 5 days per week to ensure dysphagia care plans have been completed. Any issues identified during the audit will be brought forth to the IDT members and physician for review and resolution. All non-compliance issues identified will be brought forth immediately and reported to the IDT members for review, validation and resolution. DON / designee will do trending/analysis and will report quarterly to the QAPI Committee for further evaluation and/or recommendations. 05/01/2025	

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Resident 79's hot chocolate drink should have been thickened as indicated on his meal ticket as Resident 79 may choke if his hot chocolate drink is not thickened. The DON further stated, they should have followed his diet order for consistency.

In a review of Resident 49's "Order Summary Report," ordered on 3/25/25 indicated, "Dysphagia Level 1 Puree texture, Nectar-thick liquids consistency."

In a review of Resident 79's "Order Summary Report," ordered on 3/21/25 indicated, "Dysphagia Level 3 Advanced Texture, Nectar-thick liquids consistency."

In a review of Resident 49 and Resident 79's electronic medical record with Licensed Nurse 3 (LN 3) on 4/9/25 at 11:35 a.m., indicated no documented evidence a dysphagia care plan was done. LN 3 confirmed a dysphagia care plan was not done for Resident 49 and Resident 79. LN 3 stated a care plan should have been put in place as a means of communication for nursing staff.

In a review of Resident 49 and Resident 79's electronic medical record with the DON on 4/9/25 at 12:42 p.m., indicated no documented evidence a dysphagia care plan was done for Resident 49 and Resident 79. The DON stated a care plan should have been put in place.

In a review of the facility's policy and procedure, titled Comprehensive Care Plans, undated, indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident,

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F 656	Continued From page 4 consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality ..."	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one out of 24 sampled residents (Resident 70) was assisted with nail care as part of her Activities of Daily Living (ADLs- normal daily functions required to meet basic needs) when Resident 70 had long fingernails and toenails. This failure had the potential for Resident 70 to sustain skin injury and/or to acquire an infection, and not achieve her highest practicable well-being. Findings: A review of Resident 70's clinical record indicated Resident 70 was admitted January of 2025 and had diagnoses that included metabolic encephalopathy (a condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function), diabetes (elevated sugar in the blood),	F 677	F677 ADL Care Provided for Dependent Residents How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident #70 had their fingernails trimmed and toes trimmed on 04/10/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) Audit of all residents was completed on 04/09/2025 by MDS LVN / designee to ensure that residents had cleaned, well-trimmed fingernails and toenails. All residents have the potential to be affected by this deficient practice. No other residents were affected by the deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-Service was conducted by DON / DSD to LN and CNA staff from 04/10/2025 through 04/17/2025 regarding the importance of ensuring that all residents have cleaned, well-trimmed fingernails and toenails.	

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F 677	Continued From page 5 abnormalities of gait and mobility, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily lives). A review of Resident 70's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 1/12/25, indicated Resident 70 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 9 out of 15 which indicated Resident 70 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 70's MDS Functional Abilities and Goals, dated 1/12/25, indicated Resident 70 required substantial/maximal assistance with toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene. A review of Resident 70's care plan intervention, dated 1/5/25, indicated, "BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse." During a concurrent observation and interview on 4/7/25 at 11:02 a.m. with Resident 70, in Resident 70's room, Resident 70 had long fingernails and toenails, and some of her toenails were curved and was irritating/poking her other toes. Resident 70 stated it has been more than a month since she asked facility staff to trim her nails and toenails, but they have not done it. Resident 70 further stated it has been uncomfortable for her because her toenails are scratching her skin and were already poking the	F 677	d) LN supervisor / designee review shower sheets and check resident nails the following day to ensure that nails and toenails are being kept cleaned, and well-trimmed. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. How the facility plans to monitor its performance to make sure that solutions are sustained. e) LN Supervisor / designee review shower sheets and check resident nails the following day to ensure that nails and toenails are being kept cleaned, and well-trimmed. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. Non-compliance issues identified will be reviewed and resolved. Administrator and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 04/17/2025	

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F 677	Continued From page 6 other toes. During a concurrent observation and interview on 4/7/25 at 11:07 a.m. with Certified Nurse Assistant (CNA) 3, in Resident 70's room, CNA 3 confirmed that Resident 70 had long fingernails and toenails, and some of her toenails were curved and was irritating/poking her other toes. CNA 3 stated she has already noticed Resident 70's long fingernails and toenails about two weeks ago during Resident 70's showers and had reported it to the nurses. CNA 3 also stated that residents are schedule to receive two showers in a week and she does not know why Resident 70's fingernails and toenails were still not trimmed. CNA 3 further stated that for diabetic residents, the nurses can trim the resident's fingernails and toenails, but for residents who require special tools for their toenails, they would be referred to a podiatrist (a medical specialist who diagnoses and treats conditions affecting the foot, ankle, and related structures of the leg). A review of Resident 70's "Skin Monitoring: Comprehensive CNA Shower Review" sheets indicated the following: 3/6/25: "Does the resident need his/her toenails cut? ...Yes..." Resident 70 was noticed to have scratches on her right shoulder. The sheet was signed by both the CNA and nurse. No intervention was documented. 3/10/25: "Does the resident need his/her toenails cut? ...Yes..." The sheet was signed by both the CNA and nurse. No intervention was documented. 3/13/25: "Does the resident need his/her toenails cut? ...Yes..." The sheet was signed by both the	F 677		

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F 677	Continued From page 7	F 677		

CNA and nurse. No intervention was documented.
3/20/25: "Does the resident need his/her toenails cut? ...Yes..." The sheet was signed by both the CNA and nurse. No intervention was documented.
3/24/25: "Does the resident need his/her toenails cut? ...Yes..." The sheet was signed by both the CNA and nurse. No intervention was documented.
3/31/25: "Does the resident need his/her toenails cut? ...Yes..." The sheet was signed by both the CNA and nurse. No intervention was documented.
4/3/25: "Does the resident need his/her toenails cut? ...Yes..." The sheet was signed by both the CNA and nurse. No intervention was documented.

During a concurrent interview and record review on 4/9/25 at 10:09 a.m. with the Social Services Director (SSD), the list of podiatry referrals was reviewed. The SSD stated the podiatrist would visit the facility every other month and the next scheduled visit would be on 5/1/25. The SSD also stated that they only have two (2) residents referred to the podiatrist as of now and Resident 70 was not included in the list. The SSD further stated either the CNA or nurse could refer the resident to her so the resident would be included on the list for a podiatry visit.

During an interview on 4/9/25 at 12:56 p.m. with the Director of Staff Development (DSD), the DSD stated that residents' nail care should be assessed and done on shower days. The DSD also stated that if a resident has diabetes, the nurses will do the fingernail and toenail care

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F 677	Continued From page 8 which would include nail filling. The DSD then stated that when the staff would need special tools because of the condition of the nails, the resident would have to be referred to a podiatrist. The DSD further stated if nail care was not done for a resident, it would be a risk for skin injury and possible infection issues. During an interview on 4/9/24 at 3:26 p.m. with the Director of Nursing (DON), the DON stated that resident's fingernails and toenails should be kept nice and clean. The DON also stated she would expect nail care to be done every day. The DON further stated that the risk if residents have long fingernails and toenails were possible infection and skin injury. A review of the facility's policy and procedures (P&P) titled, "Activities of Daily Living (ADLs)", undated, indicated, "...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene."	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679	F679 Activities Meet Interest/Needs Each Resident How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident #30 plan of care was updated to include alternate activities on 04/11/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) Activities Director completed an audit on 04/17/2025 to ensure that residents have activities offered. All residents in the facility have the potential to be affected by this deficient practice. No other residents were identified.	

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F 679	Continued From page 9 by: Based on interview, and record review, the facility failed to ensure one out of 24 sampled residents (Resident 30) was provided with an ongoing activity program that meet psychosocial needs (a combination of mental health, emotional, spiritual, or behavioral needs that are important to a person) when Resident 30 was not provided with any activity that met her psychosocial needs from 2/17/25 to 3/3/25 and from 3/6/25 to 3/24/25. These failures had the potential for Resident 30 to not achieve her highest mental, emotional, spiritual, and psychosocial well-being. Findings: A review of Resident 30's clinical record indicated Resident 30 was admitted September of 2019 and had diagnoses that included dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions causing memory loss and confusion), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 30's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/23/25, indicated Resident 30 was rarely/never understood. A review of Resident 30's MDS Preferences for Customary Routine and Activities, dated 8/30/24, indicated that it was	F 679	What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-Service was initiated by facility Administrator on 04/11/2025 to Activities Director regarding the importance of offering residents activities. e) DON and/or designee will conduct weekly random audits of residents activities charting to ensure that residents are offered activities. Issues identified during these audits will be brought forth to the five-day a week clinical department manager meeting for review, validation and immediate correction. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. f) DON and/or designee will conduct weekly random audits of residents activities charting to ensure that residents are offered activities. Issues identified during these audits will be brought forth to the five-day a week clinical department manager meeting for review, validation and immediate correction. All non-compliance issues identified will be corrected immediately and reported to the Administrator for review, validation and resolution.	

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F 679	Continued From page 10 very important for Resident 30 to have books, newspapers, and magazines to read, to listen to music she likes, to be around animals such as pets, to be kept up with the news, to do things with groups of people, to do her favorite activity, to go outside to get fresh air when the weather was good, and was somewhat important for her to participate in religious services or practices. A review of Resident 30's care plan, dated 2/24/25, indicated, "Resident engages in activities of interest/choice and engages in self-initiated leisure activities." A review of Resident 30's care plan goal, dated 2/24/25, indicated, "Resident will participate in 1-2 out of room activities a week x [for] 90 days. Resident will engage in 2-3 in room activities a week x 90 days." A review of Resident 30's care plan intervention, dated 2/24/25, indicated, "Invite, encourage and assist as needed to activities of choice.interest [sic] as tolerated by the resident." During an observation on 4/7/25 at 10:05 a.m., in Resident 30's room, Resident 30 was observed lying on her bed, eyes were closed, and breathing was unlabored (something natural, flowing, or relaxed, and doesn't require effort). Resident 30 did not respond to greetings. There was no noted music playing in the room. During another observation on 4/8/25 at 2:23 p.m., in Resident 30's room, Resident 30 was again observed lying on her bed, eyes closed, and breathing was unlabored. Resident 30 again did not respond to greetings. There was no noted music playing in the room. During another observation on 4/9/25 at 9:23	F 679	DON will do trending/analysis and will report quarterly to the QAPI Committee for further evaluation and/or recommendations. 04/17/2025	

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F 679	Continued From page 11	F 679		

a.m., in Resident 30's room, Resident 30 was again observed lying on her bed, awake, but again did not respond to greetings. There was no noted music playing in the room and the television was turned off.

During a concurrent interview and record review on 4/9/25 at 10:33 a.m. with the Activities Director (AD), Resident 30's activity records were reviewed. The AD confirmed that Resident 30 was not provided any activity that meets her psychosocial needs from 2/17/25 to 3/3/25 and from 3/6/25 to 3/24/25. The AD stated the goal for Resident 30 was to maintain her activity level and she thinks that not getting activities from 2/17/25 to 3/3/25 and from 3/6/25 to 3/24/25 would not maintain Resident 30's level of activity.

During an interview on 4/9/24 at 3:26 p.m. with the Director of Nursing (DON), the DON stated that residents who were unable to attend activity should be provide with bedside activity to keep them engaged. The DON also stated that having a resident who was not provided with any activity that meets her psychosocial needs for multiple weeks should not happen. The DON further stated that the risk if the resident was not provided with ongoing activity that meets psychosocial needs would be possible decline or loss of the activity level, and self-isolation which might lead to depression.

During a review of the facility's policy and procedure (P&P) titled, "Activities", undated, the P&P indicated, "It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and

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F 679	Continued From page 12 preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community...4.Activities may be conducted in different ways: a. One-to-One Programs. b. Person Appropriate - activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for. c. Program of Activities - to include a combination of large and small groups, one-to-one, and self-directed as the resident desires to attend...6.Residents are encouraged, but not mandated, to participate in scheduled activities...9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs...13. The facility will consider accommodations in schedules, supplies and timing in order to optimize a resident's ability to participate in an activity of choice..."	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	F 684	F 684 Quality of Care How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident # 346 right ankle wound care was completed on 04/08/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) Audit of current residents with wounds was completed on 04/11/2025 by Medical Records Director to ensure that residents had their treatments completed consistently. All residents have the potential to be affected by this deficient practice. No other residents were affected by the deficient practice.	

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F 684	Continued From page 13 facility failed to ensure one out of 24 sampled residents (Resident 346) received treatment and care in accordance with professional standards of practice, facility's policy and procedures (P&P), and physician's order when Resident 346's right ankle wound care order was not consistently done. This failure possibly resulted in Resident 346 experiencing right ankle pain, increased bleeding on the right ankle, increased confusion, increased heart rate (beat), and elevated temperature and ultimately getting Resident 346 transferred to an acute hospital and was diagnosed with right ankle infection. Findings: A review of Resident 346's clinical record indicated Resident 346 was initially admitted January of 2023 and had diagnoses that included multiple sclerosis (MS- a chronic, unpredictable disease of the nervous system which causes communication problems between the brain and the body leading to a range of symptoms, including vision problems, balance difficulties, fatigue, and cognitive changes), malnutrition (state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily lives), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A review of Resident 346's Minimum Data Set	F 684	What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-Service was conducted by DON to Licensed Nurses on 04/17/2025 regarding the importance of ensuring that all residents treatments are done consistently. d) LN Supervisor will review treatment administration records to ensure treatments are being completed. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. e) LN Supervisor and/or designee will review treatment administration records to ensure treatments are being completed. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. Non-compliance issues identified will be reviewed and resolved.	

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F 684	Continued From page 14 (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 1/25/25, indicated Resident 346 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 346 had an intact cognition (mental process of acquiring knowledge and understanding). During an interview on 4/7/25 at 9:53 a.m. with Resident 346, Resident 346 stated she has a wound on her right ankle which got infected because the staff was not cleaning it as often as what the doctor ordered. Resident 346 further stated she was sent to an acute hospital when her right ankle wound got infected. A review of Resident 346's care plan, dated 11/30/24, indicated, "Resident has actual impairment to skin integrity r/t [related to] surgical wound on right ankle..." A review of Resident 346's care plan intervention, dated 12/2/24, indicated, "Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx [signs and symptoms] of infection, maceration [softening and breakdown of skin due to prolonged exposure to moisture] etc. to MD [medical doctor]." A review of Resident 346's physician's order, started on 1/30/25 and discontinued on 3/14/25, indicated, "right ankle wound: Cleanse with normal saline [a mixture of sodium chloride and water commonly used in cleaning wounds], pat dry, apply calcium alginate with silver [wound dressing], wrap with kerlix [a type of bandage]. in the evening AND as needed as soiled or dislodged."	F 684	DON and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 04/17/2025	

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F 684	Continued From page 15 A review of Resident 346's physician's order, started 3/14/25 and was held starting 3/19/25, indicated, "right ankle wound: Cleanse with Dakins 1/4 strength (wound care product) pat dry, apply calcium alginate with silver, wrap with kerlix. in the evening..." A review of Resident 346's treatment administration records (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident) for February and March 2025 indicated the treatment of Resident 346's right ankle wound was not done on 2/5/25, 2/10/25, 2/15/25, 3/8/25, and 3/15/25. During a concurrent interview and record review on 4/9/25 at 10:58 a.m. with the Nurse Supervisor (NS), Resident 346's clinical records were reviewed. The NS confirmed that Resident 346's right ankle wound care order was not consistently done. The NS stated Resident 346's right ankle wound care should be done consistently every evening because if not, it might cause a wound infection, or the wound might get worst which possibly could cause hospitalization. The NS further stated the physician's order for wound care should always be followed and nurses should document if the resident refused treatment. A review of Resident 346's progress note, dated 3/19/25, indicated, "MD [medical doctor] notified d/t [due to] increase confusion, increase HR [heart rate], and elevated temp [temperature]. Orders to transfer to hospital for further evaluation. Res [Resident 346] refused initial	F 684		

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F 684	Continued From page 16	F 684		

transfer. Res finally agreed after 3 LNs [licensed nurse] attempt. Resident left with paramedics to [name of acute hospital] via gurney @ 0740 [7:40 a.m.]. Res called son prior to leaving. Res was noted to be anxious and crying while assisted onto the gurney and leaving. Able to calm res down..."

A review of Resident 346's hospital discharge summary, dated 3/19/25, indicated, "[Resident 346] was admitted on 3/19/2025 for right ankle pain and increased bleeding from her right ankle. Wound vac [Wound vacuum- a machine that works by removing excess fluid and debris from the wound helping with wound healing] placement was deferred on 3/23 due to concern for possible infection with green purulence [containing pus] at the surgical site per Wound Care evaluation. Wound cultures 3/24 grew MRSA [Methicillin-resistant Staphylococcus aureus- a type of infection that is resistant to many common antibiotics] and Pseudomonas [a type of bacterial infection], and patient was treated with 7 day course of IV [intravenous- through a vein] Fortaz [a medication used to treat infection] and IV Vancomycin [a medication used to treat infection]."

During an interview on 4/9/25 at 12:56 p.m. with the Director of Staff Development (DSD), the DSD stated that nurses must follow the frequency of wound treatment per the physician's order. The DSD also stated that if it was not documented, it would imply that it was not done. The DSD further stated that the risk if wound treatment was not done consistently were skin breakdown, possible wound infection and worsening of the wound.

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F 684	Continued From page 17 During an interview on 4/9/24 at 3:26 p.m. with the Director of Nursing (DON), the DON stated that she would expect staff to follow the wound treatment ordered by the physician. The DON further stated if wound treatment was not consistently done, it would be a risk for slow wound healing, wound infection, worsening of the wound, and/or development of wound complication(s). A review of the facility's P&P titled, "Wound Treatment Management", undated, indicated, "To promote wound healing of various types of wound, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician's orders...1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change." A review of the facility's P&P titled, "Provision of Quality of Care", undated, indicated, "...the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans...1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being."	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690	F 690 Bowel/Bladder Incontinence, Catheter, UTI How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident # 346 suprapubic catheter care was completed on 04/09/2025.	

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F 690	Continued From page 18 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one out of 24 sampled residents (Resident 364) received treatment and care in accordance with professional standards of practice, and facility's policy, procedure (P&P), and physician's orders when Resident 346's	F 690	How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) Audit of current residents with catheters was completed on 04/11/2025 by Medical Records Director to ensure that residents had their catheter care completed consistently. All residents have the potential to be affected by this deficient practice. No other residents were affected by the deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-Service was conducted by DON to Licensed Nurses on 04/17/2025 regarding the importance of ensuring that all residents catheter care are done consistently. d) DON and/or designee will review treatment administration records to ensure catheter care is being completed. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality	

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F 690	Continued From page 19 suprapubic catheter (a tube that drains urine from the bladder through a small incision in the lower abdomen) care and treatment was not done consistently. This failure had the potential to result in suprapubic catheter site infection, clogging of the catheter, and possible development of suprapubic catheter complications. Findings: A review of Resident 346's clinical record indicated Resident 346 was initially admitted January of 2023 and had diagnoses that included multiple sclerosis (MS- a chronic, unpredictable disease of the nervous system which causes communication problems between the brain and the body leading to a range of symptoms, including vision problems, balance difficulties, fatigue, and cognitive changes), malnutrition (state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly), neuromuscular dysfunction of bladder (the nerves and muscles in the urinary bladder don't work together properly), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily lives), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A review of Resident 346's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 1/25/25, indicated Resident 346 had a Brief Interview for Mental Status (BIMS- a tool to	F 690	assurance system. e) DON and/or designee will review treatment administration records to ensure catheter care is being completed. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. Non-compliance issues identified will be reviewed and resolved. DON and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 04/17/2025	

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F 690	Continued From page 20 assess cognition) score of 15 out of 15 which indicated Resident 346 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 346's MDS Bladder and Bowel conditions, dated 1/25/25, indicated Resident 346 has "Indwelling catheter [a flexible tube inserted into the bladder and left in place to drain urine] (including suprapubic catheter...)" During an interview on 4/7/25 at 1:55 p.m. with Resident 346, Resident 346 stated she has a catheter in place and staff would miss days of care and treatment. A review of Resident 346's care plan, dated 10/16/23, indicated, "The resident has Suprapubic Catheter related to: Neurogenic bladder." A review of Resident 346's care plan goal, dated 4/15/24, indicated, "The resident will be/remain free from catheter-related trauma through review date." A review of Resident 346's physician's order, dated 11/29/24, indicated, "Flush suprapubic catheter with 60 cc [cubic centimeter- unit of measurement] saline [a mixture of sodium chloride and water] every shift for prevent sedimentation and clogging." A review of Resident 346's treatment administration records (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident) for January and March 2025 indicated the care of Resident 346's suprapubic catheter was not done on the following shifts: 1/3/25- day shift	F 690		

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F 690	Continued From page 21 1/8/25- night shift 1/12/25- evening shift 1/15/25- evening shift 1/22/25- night shift 1/28/25- night shift 3/5/25- night shift 3/8/25- evening shift 3/15/25- evening shift 3/15/25- night shift A review of Resident 346's physician's order, dated 11/30/24, indicated, "Cleanse suprapubic insertion site every evening shift related to NEUROMUSCULAR DYSFUNCTION OF BLADDER..." A review of Resident 346's TAR for January, February, and March 2025 indicated the treatment of Resident 346's suprapubic catheter insertion site was not done on 1/21/25, 2/3/25, 2/25/25, 2/26/25, 3/8/25, and 3/17/25. During a concurrent interview and record review on 4/9/25 at 10:58 a.m. with the Nurse Supervisor (NS), Resident 346's clinical records was reviewed. The NS confirmed that Resident 346's suprapubic catheter care and treatment order was not done consistently. The NS stated Resident 346's suprapubic catheter care and treatment should be done consistently per the physician's order to prevent possible suprapubic catheter site infection and/or clogging of the catheter. During an interview on 4/9/25 at 12:56 p.m. with the Director of Staff Development (DSD), the DSD stated that nurses must follow the frequency of suprapubic catheter site care and	F 690		

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F 690	Continued From page 22 suprapubic catheter flushing per the physician's order. The DSD also stated that if it was not documented, there would be no proof that it was not done. The DSD further stated that the risk if suprapubic catheter care and treatment was not consistently done were possible site infection, and the catheter might get clogged causing other catheter related complications. During an interview on 4/9/24 at 3:26 p.m. with the Director of Nursing (DON), the DON stated that she would expect staff to follow the suprapubic catheter care and treatment frequency ordered by the physician. The DON further stated that if suprapubic catheter care and treatment was not consistently done, it would be a risk for infection of the suprapubic catheter, risk for catheter clogging, and development of suprapubic catheter complications like UTI (Urinary tract infection- an infection in the bladder/urinary tract). A review of the facility's P&P titled, "Suprapubic Catheterization", undated, indicated, "1. The care and maintenance of suprapubic catheters shall be in accordance with physician orders..." A review of the facility's P&P titled, "Provision of Quality of Care", undated, indicated, "...the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans...1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being."	F 690		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h)	F 694	F 694 Parenteral/IV Fluids How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident # 3 PICC line was changed on 04/30/2025.	

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F 694	Continued From page 23 § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to change the peripherally inserted central catheter (PICC) line (a thin flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart to deliver medications) dressing for one of 24 sampled residents (Resident 3). This failure had the potential to result in a serious infection and/or further health complications. Findings: A review of Resident 3's "Admission Record" indicated, Resident 3 was admitted in 2025 with diagnoses that included Osteomyelitis (an infection of the bone). A review of Resident 3's "Minimum Data Set" (MDS - an assessment tool used to guide care) Cognitive (having full understanding) Patterns, dated 3/31/25, indicated Resident 3 had a Brief Interview for Mental Status (a tool to assess a person's full understanding) score of 13 out of 15 which indicated Resident 3 was able to understand. During a concurrent observation and interview with Resident 3 on 4/7/25 at 9:17 a.m., Resident	F 694	How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) Audit of current residents with PICC lines was completed on 05/02/2025 by Clinical Resource Nurse to ensure that residents had their PICC lines changed completed consistently. All residents have the potential to be affected by this deficient practice. No other residents were affected by the deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-Service was conducted by DON to Licensed Nurses on 04/17/2025 regarding the importance of ensuring that all residents PICC lines are changed. d) DON and/or designee will review treatment administration records to ensure PICC lines are changed. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality	

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F 694	Continued From page 24 3's PICC line dressing was dated 3/27/25. Resident 3 stated he was unsure of when the dressing was last changed. During a concurrent observation and interview with the Director of Nursing (DON) on 4/7/25 at 10:57 a.m., the DON verified the PICC line dressing was dated 3/27/25. The DON stated, "PICC line dressings should be changed every seven days." The DON further stated, "The dressing should have been changed on or before 4/3/25." Lastly, the DON stated, "The expectation is for PICC line dressings to be changed weekly." A review of the "Medication Administration Record" dated, 4/1/25 indicated a physician's order for, "PICC line to right upper arm dressing change every week ..." A review of the facility policy titled, "PICC/Midline/CVAD Dressing Change" dated 2024 indicated, "It is the policy of this facility to change peripherally inserted central catheter (PICC), midline or central venous device (CVAD) dressing weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes."	F 694	assurance system. e) DON and/or designee will review treatment administration records to ensure PICC lines are changed. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. Non-compliance issues identified will be reviewed and resolved. DON and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 05/02/2025	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695	F 695 Respiratory/Tracheostomy Care and Suctioning How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident # 49 oxygen order was changed on 04/26/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken:	

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F 695	Continued From page 25 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow a physician's order for oxygen therapy for one of 24 sampled residents (Resident 49). This failure had the potential to result in hypoxia (a state where tissues in the body, including the brain, don't receive enough oxygen) and/or shortness of breath. Findings: A review of Resident 49's "Admission Record" indicated, Resident 49 was admitted to the facility in 2022 with diagnoses that included chronic obstructive pulmonary disease and respiratory failure (lung disease that makes it difficult to breathe) with hypoxia. A review of Resident 49's "Minimum Data Set" (MDS - an assessment tool used to guide care) Cognitive (having full understanding) Patterns, dated 3/29/25, indicated Resident 49 had a Brief Interview for Mental Status (a tool to assess a person's full understanding) score of 12 out of 15 which indicated Resident 49 was able to understand. During a concurrent observation and interview with Resident 49 on 4/9/25 at 1:07 p.m., Resident 49's oxygen was set at three liters per minute. Resident 49 stated, "I don't know what my	F 695	b) Audit of current residents with oxygen orders was completed on 05/02/2025 by Clinical Resource Nurse to ensure that residents had the correct liters flow per their MD order. All residents have the potential to be affected by this deficient practice. No other residents were affected by the deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-Service was conducted by DON to Licensed Nurses on 04/17/2025 regarding the importance of ensuring that all residents oxygen orders are followed. d) LN Supervisor and/or designee will review oxygen orders to ensure the liters are being followed. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. e) LN Supervisor and/or designee will review oxygen orders to ensure the liters are being followed. Any issues identified during these audits will be brought forth to the five-day a week department	

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F 695	Continued From page 26 oxygen is supposed to be set at, the nurses handle that." During a concurrent observation, interview, and record review with Licensed Nurse 3 (LN 3) on 4/9/25 at 1:14 p.m., LN 3 verified Resident 49's oxygen level was set at three liters per minute. LN 3 then verified the physician's order that indicated, four liters of oxygen per minute. LN3 stated, "His oxygen should have been set at four liters and not three." A review of the "Order Summary" dated 4/3/25, indicated a physician's order for, "Oxygen therapy at four liters per minute ..." A review of Resident 49's "Care Plan" dated 3/25/25 indicated to, "Administer oxygen per MD (Medical Doctor) order." During a concurrent interview and record review with the Respiratory Therapist (RT) on 4/9/25 at 1:19 p.m., the RT verified Resident 49's oxygen should have been set at four liters and had no order to titrate (to adjust up or down). The RT stated, "The O2 (oxygen) should have been set at four liters." During an interview with the Director of Nursing (DON) on 4/10/25 at 11:57 a.m., the DON stated, "If a resident has an order for four liters of oxygen, the expectation is that the order is followed." A review of the facility policy titled, "Oxygen Administration" dated 2025 indicated, "Oxygen is administered under orders of a physician ..."	F 695	manager morning meeting for review, validation and immediate correction. Non-compliance issues identified will be reviewed and resolved. DON and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 05/02/2025	
F 755	Pharmacy	F 755		

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F 755 SS=E	Continued From page 27 Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the	F 755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident #8 and Resident #59 discontinued medications were removed from the cart immediately on 04/09/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) An audit of all medication carts was completed on 05/01/2025 by Nurse Supervisor to ensure all discontinued medications were removed from the cart and logged for destruction. All residents have the potential to be affected by this deficient practice. No other residents were identified to have this same deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-Service was conducted by DON to Licensed Nurses on 04/17/2025 regarding the importance of ensuring that all resident's discontinued medications were removed from the medication cart. d) DON and/or designee will conduct random audits of medication carts for discontinued medications. Any issues identified during these audits will be brought forth to the five-day a week	

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F 755	Continued From page 28 completed and/or discontinued controlled medications (substances that have the potential for abuse and addiction and are therefore regulated by law) were remove from the medication cart and destroyed by two licensed facility staff nurses for two of 24 sampled residents, Resident 8 and Resident 59 when, controlled medications not being used were found in two medication carts. These failures had the potential for diversion (obtain or use of prescription medicines such as controlled medications illegally), medication errors, and/or misuse of controlled medications in the facility. Findings: In a review of Resident 8's "Admission Record," Resident 8 was admitted to the facility on 2/9/24 with diagnoses that included Radiculopathy, Lumbar Region (symptoms arise from compression or irritation of a nerve root. This often results in pain, numbness, tingling, and weakness), unspecified convulsions (rapid, involuntary muscle contractions and relaxation) and muscle spasm. During a concurrent observation and interview with Licensed Nurse 4 (LN 4) on 4/8/25 at 1:05 p.m., of the medication cart for LN 4, found was Resident 8's bubble pack (also known as unit dose packaging, typically sealed in compartments with protective bubbles) of Ativan 0.5 mg tablets with forty pills that remained in the pack. LN 4 stated, Resident 8's electronic medical record indicated there was no current/active order for Ativan 0.5 mg as the dose	F 755	department manager morning meeting for review, validation and immediate correction. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. e) DON and/or designee will conduct random audits of medication carts for discontinued medications. Any issues identified during these audits will be brought forth to the five-day a week department manager morning meeting for review, validation and immediate correction. Non-compliance issues identified will be reviewed and resolved. DON and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 05/01/2025	

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F 755	Continued From page 29	F 755		

was completed on 2/20/25. LN 4 stated the medications should have been surrendered to the Director of Nursing (DON) for destruction. LN 4 further stated not removing the unused medications was a diversion temptation.

During an interview with the DON on 4/8/25 at 1:31 p.m., the DON stated, any narcotics or psychotropic medications (used to treat mental health disorder) that were completed or discontinued should be removed from the medication cart and should have been given to the DON by the nurses for destruction. The DON confirmed the physician ordered "Ativan 0.5 mg tablets for 14 days" for Resident 8, and the bubble pack should have been surrendered to the DON when the 14 days was completed on 2/20/25. The DON further stated that together with the Pharmacy Consultant (PC), they destroy the unused discontinued/completed dose of controlled medications when order is complete.

A review of Resident 8's "MD Orders" with the start date of 2/6/25, indicated, "Ativan Oral Tablet 0.5 MG (Lorazepam)," had an end date of 2/20/25.

In a review of Resident 59's "Admission Record," Resident 59 was admitted to the facility on 12/2/22 with diagnoses that included Dementia (decline in memory), Psychotic disturbance (severe mental disorder), and pain.

During a concurrent observation and interview with LN 3 on 4/9/25 at 11:35 a.m., of the medication cart for LN 3, observed were two bubble packs identified as belonging to Resident 59. One bubble pack of Ativan 0.5 mg tablets had

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F 755	Continued From page 30	F 755		

four tablets that remained, and one bubble pack of Ativan 0.5 mg tablets had twenty-six pills that remained. LN 3 confirmed the two bubble packs of Ativan found in her medication cart for Resident 59 and stated the bubble packs should have been removed from the cart since both medications had been completed last year and the packs should have been given to the DON for destruction. LN 3 further stated it's not safe to keep completed and/or discontinued controlled medications in the medication cart as it may persuade other nursing staff to take it.

During a concurrent interview and review of Resident 59's electronic medical records with the DON on 4/9/25 at 12:42 pm., the DON confirmed that the two separate bubble packs of Ativan 0.5 mg tablets for Resident 59 had been discontinued/completed in 2024. The DON stated the completed/discontinued controlled medications should have been removed from the medication cart along with the "Controlled Drug Record," (CDR-record keeping). The DON further stated the medications, and the CDR should be signed by two licensed nurses and given to the DON to secure until destruction for safety purposes.

During an interview with the PC on 4/9/25 at 2:30 p.m., the PC stated, all completed/discontinued controlled medications should have been surrendered to the DON as soon as the medications had been completed or discontinued for proper destruction.
During a review of Resident 59's CDR, dated 1/30/24, the CDR indicated, the last dose of Ativan 0.5 mg tablet was given on 11/1/24.

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F 755	Continued From page 31 During a review of Resident 59's CDR, dated 4/11/24, the CDR indicated the last dose of Ativan 0.5 mg tablet was given on 9/16/24. In a review of the facility's policy and procedure, titled "Discontinued Medications," dated 11/17, indicated, "1 ... If a prescriber discontinues a medication, the medication container is removed from the medication cart immediately. 2. Medication awaiting disposal or destruction are stored in a locked secure area designated for that purpose until destroyed or disposed of through an authorized destruction center or licensed reverse distributor as allowed by regulations ..."	F 755		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prepare pureed foods (food that has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding) by methods that conserve nutritive value, flavor, and appearance for ten out of 91 residents (Resident 25, Resident 26, Resident 28, Resident 30, Resident 48, Resident 49, Resident 54, Resident 64, Resident 81, and	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Dietary Cook 1 disposed of the pureed that was made with water on 04/07/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) Registered Dietician / designee completed an audit of resident meals on 05/02/2025 looking at preparation of pureed food to ensure it was prepared according to the recipe to maintain nutritional value. All residents have the potential to be affected by this deficient practice. No other residents were affected.	

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F 804	Continued From page 32 Resident 347) when the recipes were not followed, and water was used to thin the pureed foods. Failure to ensure the flavor and nutritional value of food may result in decreased intake, weight loss and decreased nutritional value further compromising the medical status of residents. Findings: During an observation on 4/8/25, at 9:20 a.m., with Dietary Cook (DC) 1 in the kitchen, DC 1 was observed preparing pureed food for the lunch menu, which included: pasta, meatballs with gravy, and spinach. No pureed diet recipes were seen at the cook's station. During an observation of the preparation of pureeing the pasta, DC 1 poured an unmeasured amount of pasta into a blender. When asked, DC 1 stated that it was about five cups of pasta. DC 1 proceed to mix with an unmeasured amount of water. No measuring tools were used. During an observation of the preparation of brown gravy, DC 1 used approximately 12 ounces (oz, a unit of measure) of dry gravy mix to an unmeasured amount of water in a steam table pan, mixed it by hand, and left the gravy on the steam table covered (indicating it was complete). During an observation of pureeing the meatballs, DC 1 added an unspecified number of meatballs and three cups of water that the meatballs had boiled in (cooking juice). DC 1 proceeded to add	F 804	What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-Service was completed by the Registered Dietician / designee to Dietary Staff on 04/11/2025 through 04/15/2025 regarding the importance of following the recipe for pureed food to ensure that residents are provided the correct nutritional content. d) Registered Dietician / designee completed an audit of resident meals on 05/02/2025 looking at preparation of pureed food to ensure it was prepared according to the recipe to maintain nutritional value. All issues identified will be brought forth to the DON and/or designee for immediate review and resolution. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. f) Registered Dietician / designee completed an audit of resident meals on 05/02/2025 looking at preparation of pureed food to ensure it was prepared according to the recipe to maintain nutritional value. All issues identified will be brought forth to the DON and/or designee for immediate review and resolution.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 33 three tablespoons (tbsp, a unit of measure) of dry gravy mix to the blender. DC 1 blended the items which resulted in a watery consistency. DC 1 added six more meatballs and another cup of cooking juice to the blender for further blending and transferred the pureed meatballs to the steam table and covered. During an observation of the preparation of pureeing the spinach, DC 1 added an unmeasured amount of spinach, four cups of water plus, an unmeasured amount of prepared spices, and ¼ cup of butter to the blender. DC 1 blended the mix and was unhappy with the texture. DC 1 added another cup of water and continued to blend. The pureed spinach was transferred to a steam table pan, covered, and placed on the steam table. During an interview on 4/9/25, at 3:12 p.m., with the Registered Dietitian (RD), the RD confirmed adding water to pureed food can dilute the taste and change the nutrient content of the meal. A review of the facility's document titled, "REGULAR PUREED DIET/IDDSI LEVEL #4," dated 2024, indicated, "Water is not used because it dilutes flavors and results in a poorly accepted product." A review of the facility's undated recipe titled, "RECIPE: PUREED MEATS," from "Healthcare Menus Direct," indicated, "Puree ...to paste consistency before adding any liquid. Gradually add warm liquid (low sodium broth or gravy)." A review of the facility's undated recipe titled, "RECIPE: PUREED VEGETABLES," from	F 804	Issues identified will be reported to the Administrator and/or DON for immediate resolution. Dietary Manager and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 05/02/2025	

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	055858	A. BUILDING _____ B. WING _____	C 04/11/2025

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F 804	Continued From page 34 "Healthcare Menus Direct," indicated, "Puree ...to paste consistency before adding any liquid. Gradually add warm liquid (low sodium broth or gravy)."	F 804		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow physician's diet orders regarding fluid consistency for two of 24 sampled residents, Resident 49 and Resident 79. This failure placed Resident 49 and Resident 79 at risk for choking, aspiration (inhale into the lungs) and the possible development of pneumonia (a lung infection making it difficult to breathe). Findings: A review of Resident 49's "Admission Record," indicated Resident 49 was admitted in the facility on 3/25/25 with the diagnosis that included Acute Respiratory Failure with Hypoxia (difficulty of breathing, low oxygen in the body), and Gastro-Esophageal Reflux (backflow of stomach contents into the mouth). A review of Resident 49's Minimum Date Set	F 807	F807 Drinks Avail to Meet Needs/Prefs/Hydration How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident #49 and Resident #79 were provided with thickened beverages according to their diet orders on 04/07/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) Registered Dietician / designee completed an audit of resident meals on 05/02/2025 looking to ensure the correct beverage consistency is provided to the residents. All residents have the potential to be affected by this deficient practice. No other residents were affected. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) In-Service was completed by the Registered Dietician / designee to Dietary Staff on 04/11/2025 through 04/15/2025 regarding the importance of following the meal tray diet order to ensure that residents are provided the correct beverages according to their diet.	

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F 807	Continued From page 35 (MDS, an assessment tool used to guide care) Cognitive Patterns K- Swallowing/Nutritional Status, dated 3/18/25, indicated, "Coughing or choking during meals or when swallowing medications ...C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) ..." A review of Resident 49's "Order Summary Report," ordered on 3/25/25 indicated, "Dysphagia (difficulty in swallowing) Level 1 Puree texture, Nectar-thick liquids consistency." A review of Resident 79's "Admission Record," indicated Resident 79 was admitted in the facility on 3/3/25 with the diagnosis that included Acute Respiratory Failure with Hypoxia, and Pneumonia. A review of Resident 79's MDS, Cognitive Patterns K, dated 3/6/25, indicated, "C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)." A review of Resident 79's "Order Summary Report," ordered on 3/21/25 indicated, "Dysphagia Level 3 Advanced, texture, Nectar-thick liquids consistency." During a concurrent observation and interview with the Activity Director (AD) in the Dining room on 4/7/25 at 12:15 p.m., Resident 49 drank regular water from a cup. Resident 49's meal ticket indicated, a diet order of nectar thick liquids. The AD confirmed that Resident 49's water should have been thickened (powder or gel, that is added to liquids like water to increase	F 807	d) Registered Dietician / designee completed an audit of resident meals on 05/02/2025 looking to ensure the correct beverage consistency is provided to the residents. All issues identified will be brought forth to the DON and/or designee for immediate review and resolution. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. f) Registered Dietician / designee completed an audit of resident meals on 05/02/2025 looking to ensure the correct beverage consistency is provided to the residents. All issues identified will be brought forth to the DON and/or designee for immediate review and resolution. Issues identified will be reported to the Administrator and/or DON for immediate resolution. Dietary Manager and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 05/02/2025	

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F 807	Continued From page 36 their viscosity and make them thicker) as indicated on his meal ticket because Resident 49 may choke or aspirate if his water is not thickened. During a concurrent observation and interview with the Director of Nursing (DON) in the Dining room on 4/7/25 at 12:45 p.m., Resident 79 coughed after he drank his hot chocolate from a mug. Resident 79's meal ticket indicated, a diet order of nectar thick liquids. The DON acknowledged that Resident 79 coughed after he drank his hot chocolate drink and stated his drink should have been thickened as indicated on his meal ticket as he may choke if his drink is not thickened. The DON further stated, they should have followed his diet order for consistency. A review of the facility's policy and procedure, titled "Nutritional Management of Thickened Liquids," dated 2023, indicated, "Dysphagia, or difficulty swallowing ... Aspiration is, often, the result of dysphagia and prevention of aspiration is the goal when utilizing thickened liquids. Thickened liquids help to slow the movement of liquids/drinks, allowing resident to have better control over their swallow ..."	F 807		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State	F 808	F808 Therapeutic Diet Prescribed by Physician How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Resident #30 was provided a fortified meal on 04/07/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken:	

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F 808	Continued From page 37 law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide food in accordance with the physician's prescribed diet for one out of 24 sampled residents (Resident 30) when Resident 30's prescribed fortified diet (a diet designed to increase the calorie level of foods commonly consumed by resident) was not followed. This failure had the potential for Resident 30 to continuously lose weight, to negatively affect Resident 30's medical condition, and for Resident 30 to not achieve his highest practicable well-being. Findings: A review of Resident 30's clinical record indicated Resident 30 was admitted September of 2019 and had diagnoses that included dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions causing memory loss and confusion), dysphagia (swallowing difficulties), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 30's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/23/25, indicated Resident 30 was rarely/never	F 808	b) Registered Dietician / designee completed an audit of residents with fortified diet orders on 04/11/2025 to ensure those residents had the appropriate fortified meal provided. All residents have the potential to be affected by this deficient practice. No other residents were affected. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: d) In-Service was completed by the Registered Dietician / designee to Dietary Staff on 04/11/2025 through 04/15/2025 regarding the importance of following the meal tray diet order to ensure that residents are provided the correct meal according to their diet. d) Registered Dietician / designee completed an audit of resident meals on 05/02/2025 looking to ensure the correct beverage consistency is provided to the residents. All issues identified will be brought forth to the DON and/or designee for immediate review and resolution. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	

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F 808	Continued From page 38 understood. A review of Resident 30's MDS Functional Abilities, dated 2/23/25, indicated Resident 30 needed substantial/maximal assistance with eating. A review of Resident 30's care plan intervention, revised 2/28/22, indicated, "Diet as ordered." A review of Resident 30's physician's order, dated 6/18/24, indicated, "Dysphagia Level 1 Puree texture [food that has been blended or mashed to a smooth, uniform, and soft consistency], Thin consistency, fortify diet" During a concurrent observation and interview on 4/7/25 at 1:14 p.m. with Certified Nurse Assistant (CNA) 3, in Resident 30's room, CNA 3 was observed assisting Resident 30 with her lunch meal. Resident 30's meal ticket was checked and indicated, ..."Alert: >FORTIFIED DIET..." There was no observed extra butter or other means of fortifying Resident 30's meal on the meal tray. CNA 3 confirmed the observations. During another concurrent observation and interview on 4/8/25 at 1:04 p.m. with CNA 1, in Resident 30's room, CNA 1 was observed assisting Resident 30 with her lunch meal. CNA 1 confirmed that Resident 30's meal ticket indicated, ..."Alert: >FORTIFIED DIET..." CNA 1 also confirmed that Resident 30's meal tray did not contain extra butter or other means of fortifying Resident 30's meal. During an interview on 4/8/25 at 1:16 p.m. with Facility Cook (FC) 1, FC 1 stated she was the cook for 4/8/25 lunch meal. FC 1 further stated that for residents who had an order of fortified	F 808	f) Registered Dietician / designee completed an audit of resident meals on 05/02/2025 looking to ensure the correct beverage consistency is provided to the residents. All issues identified will be brought forth to the DON and/or designee for immediate review and resolution. Issues identified will be reported to the Administrator and/or DON for immediate resolution. Dietary Manager and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 05/02/2025	

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F 808	Continued From page 39	F 808		

diet, they would place a little packet of extra butter in the resident's meal tray to use for meal fortification.

During an interview on 4/9/25 at 2:44 p.m. with the Registered Dietician (RD), the RD stated that fortified diet is prescribed to add extra calories for patients to eat. The RD also stated she would expect the diet order of residents to be followed. The RD further stated that the risk if a fortified diet order for a resident was not followed would be that the resident would not get enough calories causing the resident to lose weight.

A review of Resident 30's "Weight and Vitals Summary" indicated Resident 30 had weights as follows:
9/5/24- 103 lbs. [pounds- unit of measurement]
10/3/24- 101 lbs.
11/5/24- 95 lbs.
12/6/24- 96 lbs.
1/8/25- 91 lbs.
2/5/25- 87 lbs.
3/6/25- 83 lbs.
4/3/25- 80 lbs.

During an interview on 4/9/25 at 3:26 p.m. with the Director of Nursing (DON), the DON stated she would expect resident's diet order to be followed. The DON further stated that if the resident was not getting enough calories, it would be a risk for malnutrition and other nutritional problems.

A review of the facility's policies and procedures (P&P) titled, "Therapeutic Diet Orders", undated, indicated, "The facility provides all residents with foods in the appropriate form and/or the

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F 808	Continued From page 40 appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences...5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed."	F 808	F812 Food Procurement,Store/Prepare/Serve-Sanitary How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) Opened and undated food items removed and thrown away on 04/07/2025.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide food storage and preparation, as well as maintain kitchen equipment and the kitchen environment in accordance with professional standards for food	F 812	b) The rough textured scratch was repaired by Maintenance Supervisor on 05/07/2025. c) The walk-in refrigerator floor was repaired by Maintenance Supervisor on 05/07/2025. d) The fruit and vegetable cleaning sink was repaired by Maintenance Supervisor on 05/07/2025. e) The ceiling cracks above the food service area were repaired by Maintenance Supervisor on 04/11/2025. f) The fruit and vegetable cleaning sink was repaired to have an airgap by Maintenance Supervisor on 05/07/2025. g) The wet metal bowls and steam table pans were removed, washed and left to air dry on 04/07/2025. h) The discolored fry pan and cutting board were removed and thrown away on 04/07/2025. i) The can opener was removed and thrown away on 04/07/2025. j) The discolored and cracked beverage lids pan and cutting board were removed and thrown away on 04/07/2025. k) The large mixer was removed and cleaned on 04/07/2025.	

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F 812	Continued From page 41 service safety when: 1. One bag of grits was found open and left unsealed, and was without open and use-by dates, 2. Kitchen environment was not maintained (e.g. walk-in refrigerator floor sealant was worn off with areas of missing metal and texture coating, kitchen walls and ceiling had areas of missing texture and paint, and showed signs of water damage), 3. Fruit and vegetable sink lacked an air gap (a backflow prevention device that prevents contaminated water from re-entering the sink), 4. Five metal bowls and nine steam table pans were stacked and stored wet, 5. Small wares were not discarded when damaged (e.g. fry pan surface covered in light and dark markings and scratches, discolored white cutting board, discolored water container lids -some with cracked and chipped plastic, and the tip of a can opener had missing metal), and 6. Mixer stand was stored with off-white crusted build-up, and dark reddish-brown rust colored debris behind mixing bowl. These findings had the potential to cause food borne illness for 91 residents eating the facility prepared meals. Findings: 1. During a concurrent observation and interview on 4/7/25, at 9:14 a.m., within the initial kitchen tour with the Registered Dietitian (RD), one bag of Quaker grits in the dry storage was observed opened but lacked an open date and was not resealed. The RD confirmed it lacked an open	F 812	How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: l) All residents have the potential to be affected by this deficient practice. No other areas were identified as having this same deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: m) In-Service was provided by the Registered Dietician to the dietary staff on 04/11/2025 through 04/15/2025 regarding the importance of labeling and dating food items, ensuring that staff are monitoring properly air drying items before placing them for storage. In-Service was provided by the Administrator to the Maintenance Department staff on 05/07/2025 regarding the importance of making rounds in all of the necessary areas in the kitchen and that there is no buildup on equipment that items needing repair are reported immediately in an effort to avoid foods becoming affected. n) Dietary Manager and/or designee to conduct random audits of the kitchen to look for food that may be unlabeled or undated and checks that equipment is stored properly, clean and not discolored along with items requiring to be reported for repair/replacement. Any issues identified will be reviewed, validated and immediately corrected.	

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F 812	Continued From page 42 date, and it was not tightly sealed and stated, " ...a bug could still get into it." During a review of the facility's policy and procedure (P&P) titled, "STORAGE OF FOOD AND SUPPLIES", dated 2020, indicated, "Dry food items which have been opened ...will be tightly closed, labeled and dated." A review of Food and Drug Administration's 2022 Food Code, section 3-501.17 (D)(3), titled "Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking" indicated that, "Marking the date or day the original container is opened in a food establishment, 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 ..." was required. 2. During a concurrent observation and interview on 4/7/25, at 9:23 a.m., within the initial kitchen tour with the RD, a rough textured scratch, measuring approximately 3 feet (ft, unit of measure) in length and 2 inches (in, unit of measure) wide, was located behind a meat slicer and found on the wall in the dishwashing and storage area. The RD confirmed the damaged area and stated that it could harbor bacteria because it is not a smooth surface. The RD confirmed the wall required to be repaired/repainted. During an observation on 4/7/25, at 9:37 a.m., the walk-in refrigerator floor had a peeled and worn-out surface of missing paint, metal, and/or floor sealants. The floor was patchy with white, metal silver tones, dark brown, and reddish-brown rust-colored variations and	F 812	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. o) Dietary Manager and/or designee to conduct random audits of the kitchen to look for food that may be unlabeled or undated and checks that equipment is stored properly, clean and not discolored along with items requiring to be reported for repair/replacement. Any issues identified will be reviewed, validated and immediately corrected. Dietary Manager and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations until negative trends resolve. 05/07/2025	

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F 812	Continued From page 43 textures affecting the entire surface of the floor. During an interview on 4/7/25, at 3:45 p.m., with Maintenance Supervisor (MS), MS stated they are aware of the condition of the walk-in refrigerator floor. MS stated maintenance needs should be communicated through the computer repair log system. MS stated the kitchen staff are responsible for logging their maintenance requests in the computer system to ensure it is logged, tracked and completed. During an observation on 4/7/25, at 9:43 a.m., the white wall to the left of the fruit and vegetable cleaning sink was observed discolored to a yellowish-light brown color, with peeled paint, and crumbling textures. An exposed pipe from the wall had white deposits, and dark brown debris at all joining points (where a pipe connects to a nut, bolt or other pipe fitting). During a concurrent observation and interview on 4/8/25, at 10:46 a.m., with Dietary Aide (DA) 1 in the kitchen, the ceiling above the food service area was observed with two cracks. One measured approximately 3 ft. in length by 1 in. wide, and the second was 2 ft. in length by 2 in. wide with exposed white, flaking paint and warped, brownish discolored surfaces. DA 1 stated the cracks and water damage formed on the ceiling after the heavy rains from the past winter. During an interview on 4/9/25, at 10:20 a.m., with the RD, regarding the kitchen environment and structural damage, RD stated, "A cracked, and moist environment will promote bacteria growth."	F 812		

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F 812	Continued From page 44 During a review of the facility's "DIRECT SUPPLY TELS: WORK HISTORY REPORT," dated 10/31/24 to 3/31/25, indicated no requests had been made for maintenance to paint or repair the kitchen walls and ceiling, or repair the walk-in refrigerator floor. A review of the Food and Drug Administration's 2022 Food Code, section 4-202.16, titled "Nonfood-Contact Surfaces" indicated that, "NonFOOD-CONTACT SURFACES shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance." It further stated that "Hard-to-clean areas could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms." 3. During a concurrent observation and interview on 4/7/25, at 9:43 a.m., with MS, within the initial kitchen tour, the fruit and vegetable preparation sink lacked an airgap. MS confirmed there was no airgap. A review of Food and Drug Administration's 2022 Food Code, section 5-202.13, titled "Backflow Prevention, Air Gap" indicated that, "During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system ...To prevent the introduction of this liquid into the water supply through back siphonage, various means may be used ...Providing an air gap between the water	F 812		

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supply outlet and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow."

4. During a concurrent observation and interview on 4/7/25, at 9:47 a.m., within the initial kitchen tour with the RD, five metal bowls were stacked wet above the stove. The RD confirmed they were not properly stored and should be air dried before storing. Also, nine steam table pans were stored stacked wet under a food preparation table. The RD confirmed they were not properly stored, and the wet environment could lead to bacteria growth.

During a review of the facility's P&P titled, "DISH WASHING", dated 2018, indicated, "Dishes are to be air dried in racks before stacking and storing."

5. During a concurrent observation and interview on 4/7/25, at 9:39 a.m., within the initial kitchen tour with the RD, a discolored fry pan was observed with light and dark markings, and scratches covering the cooking surface of the pan. The RD confirmed that it should not be used and should have been thrown away.

During an observation on 4/7/25, at 9:50 a.m., within the initial kitchen tour with the RD, a white cutting board with light brown discoloration, and a dark brown smear was found stored in a cutting board rack. The RD stated the white board was used for cutting bread and cheese, and believed the discoloration was due to beets (a food the cutting board was not intended for). With a gloved hand, deep blade markings could be felt on the board.

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F 812	Continued From page 46 During a review of the facility's P&P titled, "SANITATION", dated 2018, indicated in the following bullet, "17. After each use, chopping boards shall be thoroughly cleaned and sanitized." A review of Food and Drug Administration's 2022 Food Code, section 4-501.12, titled "Cutting Surfaces" indicated that "Cutting 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 foods that are prepared on such surfaces." During an observation on 4/7/25, at 10:00 a.m., within the initial kitchen tour with the RD, a can opener was found lying near the cook's dishwashing sink. The pointed blade had visible signs of metal peeling and was worn. The blade had an uneven surface when felt by a gloved finger. During a review of the facility's P&P titled, "CAN OPENER AND BASE", dated 2018, indicated, "Replace blade on can opener as needed." A review of Food and Drug Administration's 2022 Food Code, section 4-202.15, titled "Can Openers" indicated that "Once can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized."	F 812		

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A review of Food and Drug Administration's 2022 Food Code, section 4-501.11, titled "Good Repair and Proper Adjustment" indicated that "The cutting or piercing parts of the can openers may accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury."

During an observation on 4/7/25, at 10:19 a.m., within the initial kitchen tour with the RD, several beverage pitcher lids were found with dark brown discoloration, as well as cracked and chipped plastic on the inside brim of the lid that would contact beverages.

During a review of the facility's P&P titled, "SANITATION", dated 2018, indicated in the following bullets, "9. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks and chipped areas. 10. Plastic ware, china and glassware that becomes unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded."

6. During a concurrent observation and interview on 4/7/25, at 10:09 a.m., within the initial kitchen tour with the RD, a large mixer was found covered by a black bag. An off-white, hardened, crusted build-up and reddish-brown rust discoloration was found adhered to the back of the mixer behind the mixer bowl. The RD confirmed it was dirty and needed to be cleaned.

A review of Food and Drug Administration's 2022 Food Code, section 4-601.11, titled "Equipment, Food-Contact Surfaces, Nonfood-Contact

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F 812	Continued From page 48 Surfaces, and Utensils" indicated that, "The objective to cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic	F 812	F880 Infection Prevention & Control How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880	a) On 04/09/2025 CNA 1 and CNA 2 immediately put on PPE required for Resident 73's Enhanced Barrier Precaution. b) On 04/08/2025 Licensed Nurse 9 immediately cleaned and disinfected the blood pressure cuff. c) On 04/08/2025 Licensed Nurse 1 removed and disposed of the excess treatment supplies from the treatment cart. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: d) Infection Prevention Nurse Consultant completed an audit on 04/09/2025 of staff to ensure no other staff were identified with having the same deficient practice of not wearing enhanced barrier precaution PPE. No other areas were identified with having the same deficient practice. e) Infection Prevention Nurse / designee completed an audit on 04/09/2025 of staff to ensure no other licensed nurses were identified with having the same deficient practice of not cleaning and disinfecting the blood pressure cuff between residents.	

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F 880	Continued From page 49 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880	No other areas were identified with having the same deficient practice. f) Infection Prevention Nurse / designee completed an audit on 04/09/2025 of staff to ensure no other licensed nurses were placing excessive treatment supplies back into the treatment cart. No other areas were identified with having the same deficient practice. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: g) DON in-served Licensed Nurses on 04/17/2025 regarding the importance of wearing enhanced barrier precaution PPE, cleaning and disinfecting resident equipment between uses and not putting excess treatment supplies back into the treatment cart. h) Infection Preventionist and/or designee will conduct random audits of staff to ensure that enhanced barrier precaution PPE is worn, disinfecting of resident equipment between uses and excess treatment supplies are not placed back into the treatment cart. All non-compliance issues identified during these audits will be brought forth to the department managers five days a week morning meeting for review, validation and immediate correction. Infection Preventionist will do a trending/analysis and will report quarterly to the QAPI Committee for further evaluation and/or recommendation/s. How the facility plans to monitor its performance to make sure that solutions	

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F 880	Continued From page 50 Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 91 when: 1. Two facility staff did not wear required personal protective equipment (PPE) when they performed resident care for Resident 73 who was on enhanced barrier precaution (EBP- also known as enhanced standard precaution/ESP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use); 2. A facility staff, Licensed Nurse (LN) 9 did not disinfect a blood pressure cuff after using it on three residents, Resident 47, Resident 68 and Resident 80; and, 3. Excess treatment supplies remaining from Resident 85's wound care treatment were placed back into the treatment cart. These failures had the potential to spread germs and cause infection among residents, staff, and visitors. Findings: 1.A review of Resident 73's clinical record indicated Resident 73 was admitted February 2024 with diagnosis that included End Stage Renal Disease (a severe condition where the kidneys have permanently stopped functioning, necessitating dialysis or a kidney transplant to survive). Dialysis (treatment for individuals with	F 880	are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: i) Infection Preventionist and/or designee will conduct random audits of staff to ensure that enhanced barrier precaution PPE is worn, disinfecting of resident equipment between uses and excess treatment supplies are not placed back into the treatment cart. All non-compliance issues identified during these audits will be brought forth to the department managers five days a week morning meeting for review, validation and immediate correction. Infection Preventionist will do a trending/analysis and will report quarterly to the QAPI Committee for further evaluation and/or recommendation/s. 04/17/2025	

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kidney failure, replacing the kidneys' function of filtering blood and removing waste products and excess fluid) three days per week.

A review of Resident 73's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/22/24, indicated Resident 73 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 10 out of 15 which indicated Resident 73 had moderate cognitive impairment.

A review of Resident 73's active order, dated 12/5/24, indicated, "Use Enhanced barrier precautions during resident's care due to Arteriovenous (AV) (refers to the connection or relationship between arteries and veins) shunt (a direct connection between an artery and a vein, bypassing the normal capillary network.) for Dialysis.

A review of Resident 73's care plan indicated, "staff will follow EBP during care include: dressing, bathing/showering, transferring ..."

During an observation on 4/9/25 at 11:10 a.m. of Resident 73's room, there was a sign posted above the resident's names outside the door indicating EBP with an orange circle sticker beside Resident 73's name. Certified Nurse Assistant (CNA) 1 and CNA 2 were observed dressing Resident 73 and transferring Resident 73 to a wheelchair for dialysis pick up, wearing gloves but not wearing gowns.

During an interview on 4/9/25 at 11:12 a.m. with CNA 1 and CNA 2, CNA 1 and CNA 2 both

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confirmed the orange circle sticker was next to Resident 73's name, and indicated Resident 73 was on EBP. CNA 1 and CNA 2 confirmed the sign specified a gown and gloves were to be worn for dressing and transferring residents on EBP. CNA 2 confirmed "he should have worn a gown." CNA 1 did not verbally respond, but nodded head up and down while walking away.

During an interview on 4/9/25 at 11:29 a.m. with the Infection Preventionist (IP), the IP stated the expectation from staff for residents on EBP included wearing a gown and gloves for changing and transferring residents. The IP confirmed the facility process included posting a sign outside the residents' rooms with an orange sticker next to the resident's name. The IP confirmed Resident 73 had an EBP sign outside the resident's room and an orange sticker was next to Resident 73's name which indicated Resident 73 was on EBP. The IP confirmed CNA 1 and CNA 2 should have worn gowns while dressing and transferring Resident 73 to the wheelchair.

During an interview on 4/10/25 at 1:37 p.m., with the Director of Nursing (DON), the DON stated the expectation for EBP is for staff to wear a gown and gloves to avoid transmitting or passing infection or communicable disease from staff to patient or patient to patient. The DON stated handwashing is per standard precautions.

A review of the facility In-Service (professional development activities given to employees while they are employed to enhance their skills and knowledge) records for EBP, indicated CNA 1 had received in-service training on EBP on 3/24/25 and CNA 2 on 4/1/2025 prior to this

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observation.

A review of the facility's policies and procedures (P&P) titled, "Enhanced Barrier Precautions", undated, indicated, "Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-resistant organisms that employs targeted gown and glove use during high contact resident care activities." 1a. "All staff receive training on enhanced barrier precaution upon hire and at least annually ... 4. High-contact resident care activities include: a. Dressing, b. Bathing, c. Transferring ..."

2. During an observation of a medication administration on 4/8/25 at 3:25 p.m., in Resident 47's room, LN 9 used a blood pressure cuff for Resident 47 prior to giving him his medications. LN 9 did not clean and disinfect the blood pressure cuff.

During an observation of a medication administration on 4/8/25 at 3:46 p.m. in Resident 68's room, LN 9 was observed to use the same blood pressure cuff on resident 68 that she had used for Resident 47 without disinfecting it between the two residents.

During an observation of a medication administration on 4/8/25 at 3:56 p.m., in Resident 80's room, LN 9 used the same blood pressure cuff on Resident 80 without disinfecting it after using it on Resident 47 and Resident 68.

During an interview on 4/8/25 at 4:27 p.m. with LN 9, LN 9 acknowledged that she had not disinfected the blood pressure cuff between use

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with Resident 47, Resident 68 and Resident 80.

A review of the facility's policy and procedure titles, "Cleaning and Disinfection of Resident-Care Equipment," undated, indicated, "Multiple-resident use equipment shall be cleaned and disinfected after each use."

3. During a wound care observation which started on 4/8/25 at 10:06 a.m. with LN 1, in Resident 85's room, LN 1 pulled out treatment supplies from the treatment cart B for Resident 85's wound treatment and placed the supplies, which included multiple packs of silicone foam dressings (a non-adhesive wound dressing), an opened pack of small gauze sponges (a disposable medical supply used primarily in wound care and surgery to absorb fluids, clean wounds, and provide a protective barrier) in a paper packaging, and an opened pack of large gauze sponges in a paper packaging, on a bedside table. LN 1 then pulled the bedside table with treatment supplies inside Resident 85's room and performed the wound treatment. During Resident 85's wound treatment, LN 1 has used some of the silicone foam dressings, some of the small gauze sponges, and some of the large gauze sponges. After performing the wound treatment, LN 1 pulled the bedside table with excess treatment supplies which included multiple packs of silicone foam dressings, an opened pack of small gauze sponges in a paper packaging, and an opened pack of large gauze sponges in a paper packaging, and placed the supplies back into treatment cart B, next to other treatment supplies.

During a subsequent interview on 4/8/25 at 10:45

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p.m. with LN 1, LN 1 confirmed that the excess treatment supplies remaining from Resident 85's wound care treatment, which included multiple packs of silicone foam dressings, an opened pack of small gauze sponges in a paper packaging, and an opened pack of large gauze sponges in a paper packaging were all placed back into treatment cart B, next to other treatment supplies. LN 1 stated she should have not placed the excess supplies back into the treatment cart because it could contaminate the other supplies inside the treatment cart.

During an interview on 4/9/25 at 12:34 p.m. with the IP, the IP stated excess treatment supplies remaining from a wound care treatment should not be placed back into the treatment cart because it would be a risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another). The IP further stated the excess treatment supplies remaining from a wound treatment that could not be sanitized should be thrown out.

During an interview on 4/9/25 at 3:26 p.m. with the DON, the DON stated if a staff takes out anything from the treatment cart, it should not be placed back in the cart, unless it was sanitized properly. The DON further stated that it was not a good practice to place excess treatment supplies remaining from a wound treatment back in the treatment cart because of the risk for cross-contamination and the spread of infection.

A review of the facility's P&P titled, "Clean Dressing Change", undated, indicated, "It is the policy of this facility to provide wound care in a

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	055858	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANCHO SECO CARE CENTER	144 F STREET GALT, CA 95632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 56 manner to decrease potential for infection and/or cross contamination..."	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the call light system was accessible for two out of 24 sampled residents (Resident 85 and Resident 39) when the call light buttons were observed not within reach. This failure had the potential to result in residents' needs not being met and prevent the residents' communication for assistance when needed. Findings: 1a. A review of Resident 85's clinical record indicated Resident 85 was admitted November of 2024 and had diagnoses that included dementia (a progressive state of decline in mental abilities). A review of Resident 85's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated	F 919	F919 Resident Call System How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a) On 04/07/2025 CNA 3 moved Resident #85 and Resident #39's call light within reach. How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken: b) On 04/08/2025 DSD and/or designee completed an audit ensuring that no further residents had call light out of reach. There were no other areas identified with the same deficient practice. All other rooms were observed to have call lights within reach. What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur: c) An in-service was initiated by facility DSD on 04/10/2025 to licensed nurses and CNAs regarding the importance of keeping the call light within resident's reach. d) Department Managers will conduct random audits of call lights during their facility guardian angel rounds to ensure they are within resident's reach. All issues identified will be corrected	

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F 919	Continued From page 57 2/21/25, indicated Resident 85 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 6 out of 15 which indicated Resident 85 had a severely impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 85's MDS Functional Abilities, dated 2/21/25, indicated Resident 85 was dependent with eating, oral hygiene, toileting hygiene, and shower/bathing self, and needed substantial/maximal assistance with upper and lower body dressing, and personal hygiene. A further review of Resident 85's MDS Functional Abilities indicated Resident 85 was dependent with chair/bed-to-chair transfer, and tub/shower transfer, and needed substantial/maximal assistance with rolling left and right and sit to lying. During a concurrent observation and interview on 4/7/25 at 10:14 a.m. with Resident 85, in Resident 85's room, Resident 85 was observed lying on bed, awake, and his call light button was on the floor, on the bottom of his bed. Resident 85 stated he's able to use his call light button if he needed help. Resident 85 further stated he did not know where his call light button was at. During a concurrent observation and interview on 4/7/25 at 11:11 a.m. with Certified Nurse Assistant (CNA) 3, in Resident 85's room, CNA 3 confirmed that Resident 85's call light button was on the floor, on the bottom of his bed. CNA 3 stated the call light button should be placed where Resident 85 could reach it. 1b. A review of Resident 39's clinical record indicated Resident 39 was initially admitted	F 919	immediately and brought forth to the five day a week department manager meeting for review and resolution. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action must be evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. e) Department Managers will conduct random audits of call lights during their facility guardian angel rounds to ensure they are within resident's reach. All issues identified will be corrected immediately and brought forth to the five day a week department manager meeting for review and resolution. All issues identified will be corrected immediately and brought forth to the five day a week department manager meeting for review and resolution. Administrator and/or designee will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 04/10/2025	

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F 919	Continued From page 58	F 919		

September of 2024 and had diagnoses that included metabolic encephalopathy (a condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily lives).

A review of Resident 39's MDS Cognitive Patterns, dated 2/24/25, indicated Resident 39 had BIMS score of 6 out of 15 which indicated Resident 39 had a severely impaired cognition. A review of Resident 39's MDS Functional Abilities, dated 2/24/25, indicated Resident 39 was dependent with toileting hygiene, shower/bathing, lower body dressing, and personal hygiene, and needed substantial/maximal assistance with oral hygiene and upper body dressing. A further review of Resident 39's MDS Functional Abilities indicated Resident 39 needed substantial/maximal assistance with rolling left and right, sit to lying, and lying to sitting on the side of bed.

A review of Resident 39's care plan intervention, dated 9/24/24, indicated, "Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. Resident needs prompt response to all requests for assistance."

During an observation on 4/7/25 at 10:28 a.m. in Resident 39's room, Resident 39 was observed lying on bed, awake, and his call light button was on the floor, at the bottom of his bed. Resident 75

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stated he did know where his call light button was at.

During a concurrent observation and interview on 4/7/25 at 11:12 a.m. with CNA 3, in Resident 39's room, CNA 3 confirmed that Resident 39's call light button was on the floor, at the bottom of his bed. CNA 3 confirmed that Resident 39 was able to use call light button when needed help. CNA 3 stated that the call light button should be placed within Resident 39's reach.

During an interview on 4/9/25 at 12:56 p.m. with the Director of Staff Development (DSD), the DSD stated call light buttons should be placed within the reach of the resident. The DSD further stated if the call light button is not within the residents' reach, the residents would not be able to ask for help or assistance whenever they need assistance which could lead to potential accidents like falls resulting to injury.

During an interview on 4/9/25 at 3:26 p.m. with the Director of Nursing (DON), the DON stated she would expect that call light buttons were placed within the reach of the residents so residents could use it when they need to call for assistance.

A review of the facility's policies and procedures titled, "Call Lights: Accessibility and Timely Response", undated, indicated, "5. Staff will ensure the call light is within reach of resident and secured, as needed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident ' s room."