STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN MANOR SENIOR RESIDENCE	6101 FAIR OAKS BOULEVARD CARMICHAEL, CA 95608

(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification survey. The facility census was 45. The sample size was 17.	F 000	POC Received 5/15/25 POC Approved 6/2/25 BIC = 5/22/25 per A. Ballout	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darrell Price | TITLE: Executive Director | (X6) DATE: 5/15/25

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.

Mountain Manor Senior Residence

2025 Recertification Survey

Plan of Correction

MOUNTAIN MANOR SENIOR RESIDENCE makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. MOUNTAIN MANOR SENIOR RESIDENCE is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes MOUNTAIN MANOR SENIOR RESIDENCE's written credible allegation of compliance for the deficiencies noted.

F 584

1. The corrective actions will be accomplished for residents: 299, 38, 1 and 300 found to have been affected by the uncomfortable noise levels. Primarily focusing on the pm and NOC shifts, identifying the cause of the noise being complained about and educating staff to prevent the excessive noise.

2. The social service team and administrator interviewed other alert residents to see if any others complained about uncomfortable noise levels. No other complaints were reported.

3. All staff will be in serviced by the administrator or designee, on the Home Like Environment policy. Focusing on noise levels in and around resident rooms.

4. The social service team or designee, will use a QA form to interview 10 residents per month for the next 12 months regarding noise levels. The results of the qa interviews will be reported to the QA committee each quarter. Any continued non-compliance will result in additional corrective action and extended monitoring.

5. All corrective action to be completed by 5/26/25.

F 625

1. The corrective action/s will be accomplished for resident 36 by adding completed Bed Hold/Transfer form into the resident's chart specific to the most recent transfer to the hospital.

2. The facility will identify audit the charts for other residents currently at the hospital to ensure the bed hold was properly offered and a bed hold form was properly completed upon transfer to the hospital. No other residents were currently at the hospital.

3. In order to prevent a resident from not being properly offered a bed hold, the nursing staff will be educated by the DON or designee on the new procedure.

- The nurse assigned to the resident who is transferred to the acute will offer the bed hold to the resident (if they are their own RP and capable of answering at the time of transfer), or to the resident's RP by phone (or in person if possible) at the time of transfer. The Bed Hold form will be completed at the time and placed in the resident's chart along with a progress note indicating the bed hold was offered.

4. Medical records will complete an audit of all residents transferred to the hospital for 6 months to ensure that all residents are properly offered a bed hold. After the 6 months, the audit will include 5 residents transferred to the acute per quarter to ensure the bed holds are being offered correctly. The results of the audit will be submitted to the QA committee in the quarterly QA meetings. Any continued non compliance will result in additional corrective action and extended monitoring.

5. The corrective action will be completed by May 26, 2025.

F656:

It is the facility's policy to develop and implement comprehensive person-centered care plans that include measurable objectives and timeframes to meet each resident's medical, nursing, mental and psychosocial needs identified in their comprehensive assessment.

Corrective Action for Affected Residents: On 4/23/25, the care plan for Resident 397 was updated to include interventions addressing insomnia and the use of trazodone.

Identifying other Residents having the Potential to be Affected: On 4/24/25, the Director of Nursing (DON) and Unit Managers conducted a comprehensive review of all current residents receiving medications for sleep/insomnia to ensure appropriate care plan interventions are in place. No other missing care plans were found.

Measures put into place or Systemic Changes:

1. The DON or designee will in-service all Licensed Nurses on the requirement to develop comprehensive care plans that address all medications, including those for

sleep/insomnia, and the importance of updating care plans when new medications are ordered.

Plan to Monitor Performance:

1. Medical Records will audit each resident for complete care plans after admission, when new orders are received, and quarterly to ensure completeness. Any missing care plans will be provided to staff to correct. A record of the audits will be provided to the DON to review and present to the quarterly QA committee. If needed, further corrective action will be created and implemented.

All corrective action will be completed by 5/26/25.

F657:

It is the facility's policy that comprehensive care plans are developed within 7 days after completion of comprehensive assessments and are reviewed and revised by the interdisciplinary team after each assessment, including both comprehensive and quarterly review assessments, and when there are changes in resident condition.

Corrective Action for Affected Residents: On 4/23/25, the Director of Nursing reviewed and revised Resident 397's care plan to include interventions related to the bruising on the right cheek, including monitoring and documentation requirements per physician's order dated 4/18/25.

Identifying other Residents having the Potential to be Affected: On 4/28/25, the Director of Nursing and Unit Managers conducted an audit of all residents with documented changes in condition within the past 30 days to ensure care plans were appropriately updated to reflect changes. No other care plans were found in need of revising.

Measures put into place or Systemic Changes:

1. The Director of Nursing or designee will provide in-service education to all licensed nurses regarding:
    - Care plan development and revision requirements
    - Process for updating care plans when changes in resident condition occur
    - Documentation requirements for care plan updates

Plan to Monitor Performance:

1. Medical Records will audit all SBARs and COC reports to ensure that care plans are updated per this POC. Any missing or unrevised care plans will be presented to the

DON and nurse responsible to be corrected. A record of the audits will be reported to the DON.

2. The Director of Nursing will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of interventions and make changes as needed until substantial compliance is achieved and maintained.

The facility will complete all corrective action with F657 by 5/26/25.

F658:

It is the facility's policy that all medications shall be administered in a safe and timely manner, and that nursing staff will clarify any unclear medication orders with the physician prior to administration.

Corrective Action for Affected Residents: On 4/21/25, LN 2 contacted the physician to clarify the calcium carbonate order for Resident 196. The physician clarified the order to read "calcium carbonate 500mg, give 2.5 tablets by mouth two times a day (total 1250mg per dose) for heartburn." The order was correctly transcribed in the electronic health record and medication administration record. The resident received the correct dosage following clarification.

Identifying other Residents having the Potential to be Affected: On 4/28/25, the Director of Nursing (DON) and medical records conducted an audit of all current medication orders for all residents to identify any unclear or multiple-dose medication orders requiring clarification. No other medication orders requiring clarification were found.

Measures put into place or Systemic Changes: The DON or designee will in-service all Licensed Nurses on:

- The requirement to clarify any unclear medication orders prior to administration
- Proper documentation of medication orders
- The facility's medication administration policy and procedure
- The process for contacting physicians for order clarification
- The importance of maintaining professional standards of quality in medication administration

The facility's Medication Administration Policy has been updated to include a specific section on order clarification requirements and procedures.

Plan to Monitor Performance: Medical records will audit all new orders for existing residents and all admission orders for new residents to ensure all orders are written

properly and are clear for nurses. Any orders needing clarification will be reported to the DON and the nurse responsible to be corrected right away.

The Director of Nursing will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee quarterly for 2 quarters or until compliance is maintained.

All corrective action will be completed by 5/26/25.

F676:

It is the facility's policy to provide necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish, including the provision of appropriate communication tools to maintain effective communication with residents who have language barriers.

Corrective Action for Affected Residents: On 4/21/25, the communication board for Resident 247 was located and placed in the resident's room right after it was discovered missing.

Identifying other Residents having the Potential to be Affected: On 4/22/25, the Social Services Director conducted a facility-wide audit of all current residents to identify those with communication barriers requiring communication boards or other assistive devices. No other residents were identified with language barriers.

Measures put into place or Systemic Changes:

1. The Administrator or designee will in-service all licensed nurses, certified nursing assistants, and direct care staff regarding:
    - The importance of following care plans for residents with communication barriers
    - Proper use and storage of communication boards
    - Protocol for immediately reporting missing or damaged communication devices
2. The Social Services department was in-serviced by the administrator on 5/14/25 to check on any residents with communication barriers daily in order to ensure all necessary interventions remain in place.

Plan to Monitor Performance:

1. The DSD or designee (in conjunction with Social Services) will conduct daily audits of residents requiring communication boards for 2 weeks, then weekly for 1 month, and monthly thereafter to ensure devices are present and properly utilized.

The Social Services Director will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee quarterly for 2 quarters or until substantial compliance is achieved and maintained. The QAPI committee will make recommendations for additional interventions or modifications as needed.

All corrective action will be completed by 5/26/25.

F695

It is the facility's policy to ensure that residents who need respiratory care receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Corrective Action for Affected Residents: On 4/21/25, Licensed Nurse 3 immediately adjusted Resident #24's oxygen flow rate to 2 liters per minute as ordered by the physician.

Identifying other Residents having the Potential to be Affected: On 4/21/25, the Director of Nursing initiated a facility-wide audit of all residents receiving oxygen therapy to ensure oxygen flow rates match physician orders. No other residents were found with 02 rates lower than the ordered amount.

Measures put into place or Systemic Changes:

1. The Director of Nursing or designee will conduct an in-service for all licensed nurses by 5/26/25 regarding:
    - Proper oxygen administration
    - Importance of following physician orders accurately
    - Documentation requirements for oxygen therapy
    - Protocol for monitoring residents receiving oxygen therapy
    - Nurses will start to confirm the O2 flow amount during med-pass and chart accordingly on the eMAR.

Plan to Monitor Performance:

1. The DON, DSD, or designee will utilize a QA form each week for 6 weeks and then monthly thereafter for at least 1 year to check at least 5 residents on 02 to make sure they are receiving according to the MD order.
2. Medical records will audit the eMAR entries for 3 months to ensure the nurses are charting properly.
3. The DON will report on the findings from the QA forms to the quarterly QA committee in order to ensure compliance. Any continued non-compliance will result in additional corrective action.

All corrective action will be completed by 5/26/25.

F755

It is the facility's policy to provide pharmaceutical services including procedures that assure accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident, and to maintain accurate records of controlled substances.

Corrective Action for Affected Residents: The DON audited the controlled drug records for residents 24 and 197. The counts were correct, however, the time listed on the controlled drug record did not match the time input into the eMAR. No corrective action is possible at the present time as the record cannot be changed. The nurse who input the inconsistent timing will be in-serviced on the requirement.

The controlled drug record was missing many of the signatures by incoming and outgoing nurses during shift change (although the drug counts were good). No immediate corrective action is possible as the possible corrective action is to make sure the nurses will sign the record appropriately moving forward. The licensed nurses will all be in-serviced in order to ensure proper signing of the controlled drug record.

The narcotic medication that was removed from the ekit was done almost perfectly, but was missing the time on the slip. The time the drug was removed from the ekit was clarified with the nurse and added to the slip.

Identifying other Residents having the Potential to be Affected:

All of the ekit slips were reviewed by the DON and no other slips were found to be incomplete.

Medical Records performed an audit of the controlled drug records and no other charting was found to be non-compliant.

The above corrective action for the controlled drug record signatures covers all residents.

Measures put into place or Systemic Changes:

1. The DON will in-service all Licensed Nurses on:

- Proper documentation requirements for controlled substance administration
- Completion of shift-to-shift controlled medication counts
- Emergency kit medication removal documentation procedures
- Review of facility policies on controlled substances and medication administration

Plan to Monitor Performance:

1. The DSD will monitor the controlled drug records at each cart to ensure they are signed by the outgoing and incoming nurses properly. Checks will be done daily for 1 month and then weekly for the next 4 months to ensure continued compliance.
2. The DON will audit emergency kit logs weekly for 4 weeks, then monthly for 3 months to ensure complete documentation.
3. Random controlled substance reconciliation audits will be conducted by the Consultant Pharmacist during monthly visits.

The Director of Nursing will report audit findings to the Quality Assurance and Performance Improvement (QAPI) committee quarterly for review and recommendations. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained.

All corrective action to be completed by 5/26/25.

F761

It is the facility's policy to ensure all drugs and biologicals are properly labeled, stored, and maintained in accordance with professional standards and manufacturer guidelines, including appropriate labeling, dating of multi-dose medications, proper storage separation, and removal of expired medications.

Corrective Action for Affected Residents: On 4/21/25, the following immediate actions were taken:

- All unlabeled medications were properly destroyed and replaced with properly labeled medications.
- The expired ceftriaxone was removed and destroyed.
- All multi-dose medications without opening dates were discarded and replaced with properly labeled medications.
- All loose tablets were disposed of using drug buster
- All topical medications were relocated to appropriate storage areas.

Identifying other Residents having the Potential to be Affected: All residents have the potential to be affected by improper medication storage and labeling practices. On 4/21/25, the DON and Licensed Nurses completed a facility-wide audit of all medication carts, medication rooms, and storage areas to ensure compliance with medication labeling and storage requirements. No other medications were found to be stored improperly.

Measures put into place or Systemic Changes:

1. The DON or designee will in-service all Licensed Nurses on:

- Proper medication labeling requirements
- Dating and storage of multi-dose medications
- Proper storage separation of medications by route of administration
- Monitoring expiration dates
- Procedure for handling expired medications
- Documentation requirements for opening dates on medications

Plan to Monitor Performance:

1. The DSD will conduct weekly medication storage audits for 4 weeks, then monthly for 3 months to ensure:

- All medications are properly labeled
- Multi-dose medications are dated when opened
- Medications are properly stored by route of administration
- No expired medications are available for use

2. The Director of Nursing will review audit results weekly for 4 weeks, then monthly for 3 months.

3. Any identified issues will be corrected immediately, and additional education provided as needed.

The DON will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee quarterly for review and recommendations until substantial compliance is achieved and maintained for 3 consecutive months.

All corrective action to be completed by 5/26/25

F-802

1. Dietary Aides 1 and 2 were both educated by the CDM on the proper usage of a 2-compartment sink and were quizzed on it to ensure proper response and understanding.
2. All dietary staff were educated by the CDM on the proper use of the 2-compartment sink with quizzing to ensure proper response and understanding.
3. Signage indicating the proper usage of the 2-compartment sink was posted above the area in the kitchen and all staff were educated by the CDM on consulting the dietary policy and procedure manual should any questions come up.
4. The CDM will use a QA form and quiz at least 3 dietary workers per month on the proper usage of the 2-compartment sink for 12 months. The audit will be reported to the quarterly QA meeting. Any continued non compliance will result in further corrective action.
5. All corrective action to be completed by 5/26/25.

F803

It is the facility's policy that all menus meet the nutritional needs of residents, are prepared in advance, followed as written, and reflect the religious, cultural, and ethnic needs of residents. All therapeutic diets are to be served according to the menu spreadsheet and physician orders.

Corrective Action for Affected Residents: On 4/23/25, the Registered Dietitian reviewed the nutritional status of Residents 11, 21, 35, and 17 who received incorrect CCHO desserts, and Residents 1, 2, 3, 7, 15, 18, 20, 21, 25, 28, 30, 38, 39, 41, and 396 who did not receive super soup for fortified diets, and Residents 6 and 17 who received incorrect portion sizes. No adverse effects were identified. The Certified Dietary Manager immediately corrected portion sizes and therapeutic diet components for all affected residents.

Identifying other Residents having the Potential to be Affected: On 4/23/25, the Registered Dietitian conducted a comprehensive review of all residents receiving therapeutic diets to ensure proper menu items and portion sizes were being provided. The CDM reviewed all current therapeutic diet orders against the menu spreadsheet to ensure alignment.

Measures put into place or Systemic Changes:

1. The CDM will in-service all dietary staff:
    - Proper portion sizes for therapeutic diets
    - Following menu spreadsheets accurately
    - Importance of therapeutic diet compliance
    - Proper documentation of menu substitutions
2. Kitchen staff will measure protein portions using standardized serving utensils and scales to ensure accurate portions.

Plan to Monitor Performance:

1. The CDM or designee will audit 10 therapeutic diet trays daily for 2 weeks, then 3x/week for 2 weeks, then weekly for 1 month to ensure compliance with menu spreadsheet and proper portions.
2. The RD will conduct weekly random audits of 5 therapeutic diet trays for 4 weeks, then monthly for 2 months.
3. Results of all audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee quarterly by the Food Service Director. The QAPI committee will analyze data for patterns and trends and make recommendations for continued monitoring or modification of plan as needed until substantial compliance is achieved and maintained.

All corrective action to be completed by 5/26/25.

F812

It is the facility's policy to procure food from approved sources and store, prepare, distribute and serve food in accordance with professional standards for food service safety.

Corrective Action for Affected Residents: On 4/21/25, the following immediate actions were taken:

- The ice machine was thoroughly cleaned and sanitized and then replaced due to age related wear and tear.
- The can opener blade was replaced
- All scratched non-stick cooking pans were removed from service and replaced
- All improperly dated/labeled food items were discarded
- All opened food packages found without proper seals were discarded
- The thawing meat was properly labeled with pull date and use by date
- All spoiled produce were discarded
- The resident's food refrigerator freezer was cleaned and a sign was placed to indicate the freezer compartment was not to be used (it wasn't anyway).

Identifying other Residents having the Potential to be Affected: All residents have the potential to be affected by these practices. A facility-wide audit was completed on 4/22/25 of all food storage areas, equipment, and food items to ensure compliance with food safety standards. No other areas were found not compliant.

Measures put into place or Systemic Changes:

1. The Certified Dietary Manager (CDM) will in-service all dietary staff on:

- Proper cleaning procedures for the ice machine
- Equipment inspection and maintenance procedures
- Food storage, labeling, and dating requirements
- Proper food package sealing
- Thawing procedures and documentation
- Produce inspection and storage
- Temperature monitoring requirements

2. The Maintenance Supervisor will be in-serviced by the CDM on proper ice machine cleaning procedures per manufacturer's guidelines.
3. The Director of Nursing will in-service all nursing staff on proper temperature monitoring and documentation for resident unit refrigerators/freezers.

Plan to Monitor Performance:

1. The CDM or designee will conduct weekly audits for 4 weeks, then monthly for 12 months of:

- Ice machine cleanliness
- Equipment condition
- Food storage practices
- Temperature logs
- Food labeling compliance

2. The Director of Nursing or designee will audit resident unit refrigerator/freezer temperature logs daily for 4 weeks, then weekly for 12 months.
3. Results of all audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee quarterly for review and additional interventions as needed until substantial compliance is achieved and maintained for 3 consecutive months.

All corrective action to be completed by 5/26/25

F868

1. The Medical Director missed one of the quarterly QA meetings due to a last-minute emergency on the day of the QA meeting. Immediate corrective action is not possible at the present time.
2. With only one QA committee in the building, the above immediate corrective action covers any risk to all residents.
3. The QA committee will be educated by the Administrator to ensure all members of the QA committee join for the QA meeting at least quarterly. If a required member of the committee misses a meeting, another meeting will be scheduled during that quarter as a make-up.
4. The Administrator will use a QA form to audit the attendance and participation in the QA meeting each quarter to ensure all required members are in attendance and

will review with the QA committee each meeting. Any continued non-compliance will result in further corrective action.
5. Corrective action to be completed by 5/26/25.

F880

1. Enhanced barrier precautions were put into place for residents 1, 246, 147, 26, 296, 297, 298, and 396 on 4/23/25 and 4/24/25. CAN 5 was instructed to perform hand hygiene immediately after being informed of the violation.
2. The infection preventionist and DON reviewed the charts of all residents to ensure all residents requiring EBP had the precautions in place. No other residents who required EBP were found to not have them in place. No other staff were observed non-compliant in hand hygiene.
3. The infection preventionist was in-serviced by the DON and Administrator on the EBP requirements, specifically what conditions require EBP. All licensed nurses were also in-serviced on the requirements for what conditions require EBP.
   The nursing IDT team will start to review all residents upon admission to confirm EBP is in place for all residents requiring it.
   All direct care staff (licensed nurses and C.N.A.) will be in serviced by the DON or designee on proper hand hygiene.
4. The infection preventionist will use a QA form to review the charts of 10 residents per week for 5 months to check to see if EBP is necessary, and if so, that it is in place for the resident. A record of the review will be presented to the quarterly qa committee each quarter. Continued noncompliance with EBP will result in additional corrective action.
5. All corrective action to be completed by 5/26/25.

F881

1. The antibiotic order for resident 247 was discontinued on 4/23/25.
2. All other antibiotic orders were reviewed by the DON and infection preventionist and no other residents were found to be on antibiotics without proper justification.
3. All licensed nurses and medical records will be in-serviced on antibiotic stewardship in order to check to ensure there is proper justification for the usage of any antibiotic.
4. The infection preventionist will use a QA form to review all antibiotic orders for 3 months to ensure there is proper justification for the antibiotic usage. The review will be done in communication with the pharmacist and the MD. The audit results

will be presented to the quarterly QA committee. Any continued non-compliance will result in additional corrective action and extended monitoring.

5. All corrective action will be completed by 5/26/25.

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a comfortable noise level for four residents (Resident 299, Resident 38, Resident 1, and Resident 300) of a census of 45. This failure decreased the facility's potential to maintain the residents' comfort level and sleep. Findings: A review of an admission record indicated Resident 299 was admitted to the facility in April 2025 with a diagnosis of insomnia (trouble falling asleep or staying asleep). A review of Resident 299's "Order Summary Report," dated 4/12/25, indicated Resident 299 had the capacity to make healthcare decisions. During an interview on 4/23/25 at 8:40 a.m. with Resident 299, Resident 299 stated staff in the evening shift (3 p.m. - 11:30 p.m.) left the room door open at bedtime and had to be reminded to close it because of the hallway's noise. Resident 299 added the certified nursing assistants	F 584		

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F 584	Continued From page 2	F 584		

constantly yelled for each other from each hallway end while performing resident care. Resident 299 tried to sleep by 9 p.m. but could not fall asleep until 10 p.m. or 11 p.m. due to yelling and when staff eventually closed the door, yelling again continued through the night.

A review of an admission record indicated Resident 38 was admitted to the facility in February 2025.

A review of Resident 38's Brief Interview for Mental Status score (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 2/24/25, indicated Resident 38's BIMS score was 10 out of 15 with a partially intact memory.

During a concurrent observation and interview on 4/23/25 at 8:51 a.m. with Resident 38, Resident 38's privacy curtain was drawn fully around the bed. Resident 38 stated closing the curtains helped reduce the hallway noises coming from people talking and doors closing. Resident 38 further stated "It's loud here, anytime of the day or night. It sounds like the staff are having a party every so often during the night shift, loud and laughing and screeching. I try to adapt, but enough is enough."

A review of an admission record indicated Resident 1 was admitted to the facility in February 2025 with a diagnosis of insomnia.

A review of Resident 1's BIMS score, dated 2/18/25, indicated Resident 1's BIMS score was 14 out of 15 with intact memory.

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During an interview on 4/23/25 at 9:31 a.m. with Resident 1, Resident 1 stated the noise was bothersome all the time and there were "... issues resting because it's so noisy." Resident 1 reported to staff the noise, the sound level got better for a day or two, then became intolerable again. Resident 1 further stated it sounded like staff were having a fundraiser with someone "... calling out real loud" and it occurred during day and night shifts.

A review of an admission record indicated Resident 300 was admitted to the facility in April 2025.

During an observation on 4/23/25 at 10:09 a.m. in Resident 300's room, Resident 300's head was covered with a blanket while lying in bed.

During an interview on 4/23/25 at 1:11 p.m. with Resident 300, Resident 300 stated placing a blanket over the head muffled out noises. Resident 300 further stated the irritating noises came from staff and residents in the hallway and the noise was worse at daytime.

During an interview on 4/23/25 at 2:29 p.m. with the Director of Nursing (DON), DON stated the facility did not want residents to experience issues with loud noises during late hours. DON further stated residents needed rest and a calm environment to heal.

A review of the facility's policy titled, "Quality of Life - Homelike Environment," revised in May 2017, indicated, "The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These

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MOUNTAIN MANOR SENIOR RESIDENCE	6101 FAIR OAKS BOULEVARD CARMICHAEL, CA 95608

(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 584	Continued From page 4 characteristics include ... comfortable noise levels."	F 584		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a bed hold notification upon transfer to hospital to one of 17 sampled	F 625		

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residents (Resident 36), when Resident 36 was transferred to hospital without a bed hold notification on 3/4/25, 3/11/25, and 4/15/25.

This failure decreased the facility's potential to protect Resident 36's right in bed hold and return to facility.

Findings:

A review of Resident 36's "Admission Record," indicated Resident 36 was admitted to the facility in 2025 with a diagnosis of congestive heart failure (a condition where the heart's pumping action is weakened, making it difficult to meet the body's needs).

A review of Resident 36's "Census List," dated 4/23/25, indicated Resident 36 was discharged on 3/4/25, 3/11/25, and 4/15/25.

A review of Resident 36's "SBAR (Situation, Background, Assessment, and Recommendation) Communication Form and Progress Note," dated 3/4/25 and 4/15/25, indicated Resident 36 was sent out to the hospital on 3/4/25 and 4/15/25.

During a concurrent interview and record review on 4/23/25 at 2:40 p.m. with Medical Record (MR), Resident 36's "Bed Hold Policy and Notification" was reviewed. MR stated usually the nurse would call the family and ask for a bed-hold. MR confirmed she could not find any documentation of the bed hold notice in the progress note or in the attachment.

During a concurrent interview and record review on 4/23/25 at 3:49 p.m. with MR, Resident 36's

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F 625	Continued From page 6 "Bed Hold Policy and Notification" was reviewed. MR confirmed the bed hold notification was incomplete since there was no date and time, no name of the person who notified, no indication of agreeing, holding request, or declining the bed hold, and no signature from Resident 36 on 3/4/25, 3/11/25, and 4/15/25 when discharged to the hospital. A review of the facility's policy titled, "Bed-Hold and Returns," dated 3/2017, indicated, "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy."	F 625		
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 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		

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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 interview and record review, the facility failed to develop a comprehensive person-centered care plan for one of 17 sampled residents (Resident 397), when the care plan did not address Resident 397's insomnia (trouble falling asleep or staying asleep) and trazodone (a medication to treat insomnia).

This failure decreased Resident 397's potential to receive appropriate care, services, and treatment.

Findings:

A review of Resident 397's medical record

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F 656	Continued From page 8 indicated he was admitted to the facility on 4/10/25 with multiple diagnoses including dementia (a progressive state of decline in mental abilities), depression, anxiety, and personal history of other mental and behavioral disorders. A review of Resident 397's medical record indicated a physician's order for trazodone 50 milligrams (mg; a unit of measure), give 25 mg at bedtime for insomnia, ordered on 4/13/25. During a concurrent interview and record review on 4/23/25 at 10:09 a.m. with Licensed Nurse 1 (LN 1), Resident 397's care plans were reviewed. LN 1 stated she did not see a specific care plan developed for Resident 397's sleep or insomnia. During a concurrent interview and record review on 4/23/25 at 10:56 a.m. with the Director of Nursing (DON), Resident 397's care plans were reviewed. DON stated the expectation was to see a care plan developed for sleep or insomnia and confirmed there was none. A review of the facility's policy and procedure titled, "Comprehensive Person-Centered Care Plans," revised in December 2016, indicated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		

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F 657	Continued From page 9 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the care plan for one of 17 sampled residents (Resident 397), when Resident 397 sustained a bruise (an injury or mark where the skin has not been broken but is darker in color, often as a result of being hit by something) to the right cheek. This failure decreased the facility's potential to provide Resident 397 with a person-centered care plan that meets the changed care needs.	F 657		

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F 657	Continued From page 10 Findings: A review of Resident 397's "Admission Record," indicated Resident 397 was admitted to the facility in April 2025 with a diagnosis of vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to your brain). A review of Resident 397's "SBAR (situation, background, assessment, recommendation) Communication Form and Progress Note," dated 4/17/25, indicated Resident 397 had a change of condition that resulted in bruising to face. A review of Resident 397's physician's order, dated 4/18/25, indicated an order to monitor Resident 397's discoloration on the right cheek every shift. During an interview on 4/22/25 at 1:35 p.m. with Licensed Nurse 4 (LN 4), LN 4 stated if a resident had a change of condition, the expectation was to create a SBAR, make a progress note, and update the care plan. During a concurrent interview and record review on 4/23/25 at 1:53 p.m. with the Director of Nursing (DON), Resident 397's care plan dated 4/18/25 was reviewed. DON confirmed Resident 397's care plan did not indicate a bruising in his right cheek and stated her expectation was nurses should have updated the care plans whenever residents had a change of condition. A review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," revised in December 2016, indicated, "... Assessments of	F 657		

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F 657	Continued From page 11 residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services in accordance with acceptable professional standards of quality for one of 17 sampled residents (Resident 196), when Licensed Nurse 2 (LN 2) did not clarify a physician's order with multiple dosages prior to administering medication. This failure had the potential to result in Resident 196 not receiving the correct dosage of medication and worsening of their clinical condition. Findings: During a medication pass observation on 4/21/25 at approximately 9 a.m., LN 2 was observed preparing six medications for Resident 196 including calcium carbonate (a medication to treat heartburn) 500 milligrams (mg, a unit of measurement), one tablet. A review of Resident 196's medical record indicated a physician's order for calcium	F 658		

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F 658	Continued From page 12 carbonate 1250 (500 Ca) mg (calcium carbonate), give one tablet by mouth two times a day for heartburn, ordered 4/10/25. During an interview on 4/21/25 at 1:23 p.m. with LN 2, LN 2 stated he prepared and administered one tablet calcium carbonate for a total of 500 mg, not 1250 mg, to Resident 196. LN 2 stated the dose ordered by the physician was unclear and should have been clarified prior to administration to ensure the correct dose was given to Resident 196. During an interview on 4/22/25 at 12:42 p.m. with the Director of Nursing (DON), DON stated nursing staff were expected to clarify an order with the physician if it was not clear. DON further stated whenever in doubt, nurses should contact the doctor. A review of the facility's policy and procedure titled, "Administering Medications," revised in December 2012, indicated, "Policy Statement: Medications shall be administered in a safe and timely manner ... Policy Interpretation and Implementation ... 5. If a dosage is believed to be inappropriate or excessive for a resident ... the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns."	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to	F 676		

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F 676	Continued From page 13 ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the plan of care for one of 17 sampled residents (Resident 247), when Resident 247's communication board was not available for use during provision of care.	F 676		

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F 676	Continued From page 14 This failure decreased the facility's potential to meet Resident 247's ability to communicate her needs. Findings: A review of an admission record indicated Resident 247 was admitted to the facility in April 2025 with a diagnosis of chronic respiratory failure. A review of Resident 247's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/5/25, indicated Resident 247 had adequate ability to see and hear with a Brief Interview of Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 out of 15 with no memory problems. A review of Resident 247's communication care plan, dated 4/7/25, indicated Resident 247 had communication barrier due to language used. The care plan further indicated Resident 247 communicated only in Russian and one of the interventions indicated that staff should use a communication board to effectively communicate with Resident 247. During a concurrent observation and interview on 4/21/25 at 8:45 a.m. with Licensed Nurse 1 (LN 1), inside Resident 247's room, Resident 247 was seated on her bed and responded in her native language when asked. No communication board was available, and LN 1 stated Resident 247 only spoke Russian.	F 676		

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F 676	Continued From page 15 During a concurrent observation and interview on 4/21/25 at 1:41 p.m. with Social Worker 1 (SW 1), inside Resident 247's room, SW 1 stated she communicated with Resident 247 using a communication board as written in her assessment. SW 1 searched for the communication board and confirmed it was not inside Resident 247's room. During a concurrent observation and interview on 4/22/25 at 8:30 a.m. with LN 4, LN 4 was inside Resident 247's room and was unable to respond back when asked by Resident 247. LN 4 confirmed there was no communication board that can be used inside Resident 247's room and stated communicating with Resident 247 was difficult without a communication board. During an interview on 4/23/25 at 1:59 p.m. with the Director of Nursing (DON), DON confirmed Resident 247's care plan included the use of a communication board as an intervention for the staff to utilize when communicating with Resident 247. DON stated implementing Resident 247's care plan was vital to provide appropriate care. A review of the facility's policy titled, "Translation and/or Interpretation of Facility Services," revised in 5/2017, indicated, "Non-bilingual staff will be provided with communication boards for routine communications with residents who have language or communication barriers ... The Director of Social Services, or their designee, will serve as the coordinator of the facility's language access program, overseeing the implementation and monitoring of language access services."	F 676		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		

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F 695	Continued From page 16 § 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 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 provide respiratory care services according to professional standards of quality for one of 17 sampled residents (Resident 24), when Resident 24's administered oxygen was not consistent with the physician's order. This failure decreased the facility's potential to follow the physician's order when providing respiratory services. Findings: A review of Resident 24's "Admission Record," indicated Resident 24 was admitted to the facility in December 2024 with a diagnosis of anxiety disorder. A review of Resident 24's "Order Summary Report," dated 2/27/25, indicated an order for oxygen use two liters per minute (l/min, unit of measurement) via nasal cannula as needed for shortness of breath. During a concurrent observation and interview on 4/21/25 at 12:45 p.m. with Resident 24, Resident	F 695		

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F 695	Continued From page 17 24 was sitting up in bed with her oxygen set at one l/min. Resident 24 stated she was still short of breath even with her oxygen on. During a concurrent interview and record review on 4/21/25 at 12:50 p.m. with Licensed Nurse 3 (LN 3), Resident 24's physician order was reviewed. LN 3 confirmed Resident 24's oxygen concentrator was set to one l/min and stated Resident 24's physician order was two l/min of oxygen as needed. During an interview on 4/23/25 at 1:59 p.m. with the Director of Nursing (DON), DON stated her expectation was nurses should have followed the doctor's order accurately to prevent complications from occurring and to be able to provide proper care to residents. A review of the facility's policy titled, "Oxygen Administration," revised in 10/2010, indicated, "Provide safe oxygen administration ...verify ...physician's order ... the rate of oxygen flow, route, and rationale."	F 695		
F 755 SS=E	Pharmacy 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	F 755		

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	555889	A. BUILDING _____ B. WING _____	04/24/2025

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F 755	Continued From page 18 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: 1. Controlled substance medications (medication with a high potential for abuse and addiction) were accurately accounted on the medication administration record (MAR) and the Controlled Drug Record (CDR) for two of four randomly selected residents (Resident 24 and Resident 197); 2. Controlled drug shift-to-shift count records (a record used to reconcile inventory of controlled medications in the medication cart by the outgoing and incoming nurse during a shift change) were routinely signed by the off-going and on-coming nursing shifts; and 3. Removal of narcotic medication from the	F 755		

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F 755	Continued From page 19	F 755		

emergency kit (e-kit; a kit/box containing medications and supplies for immediate use during a medical emergency) was accurately and completely documented.

These failures decreased the facility's potential to have accurate accountability of controlled medications, prevent abuse or misuse of these medications, and meet the residents' therapeutic needs or worsening of their medical conditions for a census of 45 residents.

Findings:

1. The controlled medication CDRs for four random residents receiving as-needed controlled medications were requested for review during the survey.

Resident 24 had a physician's order for hydrocodone/APAP (a narcotic medication to treat pain) 5/325 milligrams (mg, a unit of measurement), take one tablet every four hours as needed for moderate pain, take two tablets every four hours as needed for severe pain, dated 2/2/25. The CDR indicated hydrocodone/APAP was removed from the medication cart on the following dates and times, but their respective administrations were not documented on the MAR: one tablet on 4/15/25 at 9:23 p.m., one tablet on 4/18/25 at 10:45 a.m., and one tablet on 4/20/25 at 9:10 a.m.

Resident 197 had a physician's order for hydrocodone/APAP 10/325 mg, take one tablet every eight hours as needed for pain, dated 4/16/25. The CDR indicated one tablet hydrocodone/APAP was removed from the medication cart on 4/19/25 at 8 p.m. but the

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F 755	Continued From page 20 administration was not documented on the MAR. During an interview on 4/22/25 at 12:55 p.m. with the Director of Nursing (DON), the DON stated nurses were educated to document every pill that was removed from the bubble pack on the CDR in order to not lose any medication. DON further stated the MAR should reflect the administered dose. A review of the facility's policy and procedure (P&P) titled, "Controlled Substances," revised in December 2012, indicated, "Policy Interpretation and Implementation ... 4. If the count is correct, an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance ... This record must contain ... l. Signature of nurse administering medication." A review of the facility's P&P titled, "Administering Medications," revised in December 2012, indicated, "Policy Interpretation and Implementation ... 20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug." 2. During a concurrent interview and record review on 4/21/25 at 12:03 p.m. with Licensed Nurse 1 (LN 1), the controlled drug shift-to-shift count records, dated April 2025, for Medication	F 755		

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Cart B were reviewed. The record indicated missing signatures by the off-going and on-coming nurse for various shifts. LN 1 acknowledged and confirmed the finding and stated the nurses should have signed between shifts to document there were no discrepancies. A review of the Controlled drug shift-to-shift count records, dated 4/1/25 to 4/21/25, indicated a total of 11 missing signatures (for the dates indicated) between nursing shift changes.

During a concurrent interview and record review on 4/21/25 at 1:51 p.m. with LN 1, the controlled drug shift-to-shift count records, dated April 2025, for Medication Cart C were reviewed. The controlled drug shift-to-shift count records, dated 4/1/25 to 4/21/25, indicated four missing signatures by the outgoing and incoming nurse for each shift. LN 1 acknowledged and confirmed the finding.

During an interview on 4/22/25 at 12:54 p.m. with the DON, the DON stated the on-coming and off-going nurses were expected to both sign to endorse that the narcotic count in the medication cart was accurate to ensure accountability.

A review of the facility's P&P titled, "Controlled Substances," revised in December 2012, indicated, "Policy Interpretation and Implementation ... 9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together ..."

3. During a concurrent observation and interview on 4/21/25 at 10:58 a.m. with Infection Preventionist/Interim Staff Development (IP), the medication storage room was inspected. A

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F 755	Continued From page 22 narcotic e-kit with a red plastic tie (indicating it had been opened) was identified. Inside the e-kit was a log indicating one tramadol (a narcotic medication used to treat pain) 50 mg tablet had been removed, but the date and time of the removal was not documented. IP stated nursing staff were expected to fill out the log in full, including the date and time. During an interview on 4/22/25 at 12:42 p.m. with the DON, DON stated nursing staff were expected to fill out the e-kit log completely whenever they removed medication. A review of the facility's P&P titled, "Emergency Medications," revised in April 2007, indicated, "Policy Interpretation and Implementation ... 7. Required documentation after dispensing an emergency medication is the same as for any other medication. 8. Any medication that is removed from the emergency kit must be documented on the emergency medication administration log."	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		

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F 761	Continued From page 23 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure: 1. Multi-dose medications were dated with an open and discard date to confirm they were not used beyond the discard date; 2. Prescription medications were appropriately labeled with a pharmacy label or name to correctly identify which resident they were for; 3. Medications with different routes of administration were stored in accordance with facility policy and procedures (P&P); and 4. Expired medications were not available for resident use. These failures increased the residents' potential to unsafely receive inadequately labeled medications with reduced potency, past their discard date, and through the wrong route of administration for a census of 45 residents. Findings: During a concurrent observation and interview on	F 761		

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F 761	Continued From page 24 4/21/25 at 10:58 a.m. with the Infection Preventionist/Interim Staff Development (IP), the medication storage room was inspected. IP confirmed the following findings: - One bottle Sea Aloe (a natural supplement used to boost energy and support digestive health), four Novolog Flex Pens (a fast-acting insulin to treat diabetes-a disorder characterized by difficulty in blood sugar control and poor wound healing), and four Lantus Solostar Pens (long-acting insulin to treat diabetes) were identified without pharmacy labels. IP stated the medications should have had pharmacy labels on them to indicate which residents they were for; and - One ceftriaxone (an antibiotic to treat infection) two grams/50 milliliters (g/ml, a unit of measurement) intravenous (administered through the vein), expired on 4/9/25 and one vial of Tubersol (a medication used to diagnose tuberculosis-a serious infectious disease primarily affecting the lungs) opened and unlabeled with an open date, were also identified. IP stated the ceftriaxone should have been given to the Director of Nursing (DON) for destruction and the Tubersol needed to be labeled with an open date because it was only stable for 30 days once used. A review of the manufacturer's labeling for Tubersol, revised on 3/18/22, indicated, "11. Storage, Stability and Disposal ... A vial of Tubersol which has been entered and in use for 30 days should be discarded." A review of the facility's P&P titled, "Storage of Medications," revised in April 2007, indicated, "Policy Interpretation and Implementation ... 3. Drug containers that have missing, incomplete, improper or incorrect labels shall be returned to	F 761		

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the pharmacy for proper labeling before storing. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed."

A review of the facility's P&P titled, "Labeling of Medication Containers," revised in April 2007, indicated, "Policy Interpretation and Implementation ... 3. Labels for individual drug containers shall include all necessary information, such as: a. The resident's name; b. The prescribing physician's name; c. The name, address, and telephone number of the issuing pharmacy; d. The name, strength, and quantity of the drug; e. The prescription number (if applicable); f. The date that the medication was dispensed; g. Appropriate accessory and cautionary statements; h. The expiration date when applicable; and I. Directions for use ... 10. Expired medications must not be stored in the medication carts or med rooms. All expired medications must be properly disposed of."

A review of the facility's P&P titled, "Administering Medications," revised in December 2012, indicated, "Policy Interpretation and Implementation ... 9. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container ... 14. Insulin pens will be clearly labeled with the resident's name or other identifying information ..."

During a concurrent observation and interview on 4/21/25 at 11:50 a.m. with Licensed Nurse 1 (LN 1), Medication Cart (Med Cart) B was inspected. LN 1 confirmed the following findings:

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F 761	Continued From page 26 - One vial of professional monitoring blood glucose test strips (used to measure blood sugar levels) and one pouch of budesonide (a medication used to treat asthma-a chronic respiratory disease characterized by inflammation and narrowing of the airways, making breathing difficult) inhalation suspension 0.5 milligrams/2 milliliters (mg/ml, a unit of measurement) opened and unlabeled with an opened date, were identified. LN 1 confirmed the manufacturer's labeling on the test strips indicating "Use within 4 months of opening the vial," and stated it should have been labeled with a date on the vial. LN 1 also confirmed the manufacturer's labeling on the budesonide inhalation solution indicating " ... Once the foil envelope is opened, use the ampules within 2 weeks" and stated the pouch did not have an opened date, but should have. - Inspection of the drawers in the med cart containing oral medications identified one bag of rivastigmine (a medication to treat Alzheimer's disease, a condition that affects memory and mental processes) transdermal (applied topically to the skin) patches 9.5 mg/25 hours and one bag lidocaine 5 percent (%; unit of measure) patches. LN 1 confirmed the medications were used topically and were comingled with the oral medications and stated the patches were to be stored separately with the inhaled medications. - Further inspection inside the drawers identified four loose tablets and capsules. LN 1 stated loose pills were to be disposed of in a drug buster (a substance used to inactivate medication and prevent its removal and diversion). During a concurrent observation and interview on 4/21/25 at 1:51 p.m. with LN 1, Med Cart C was inspected. The following items were identified opened and unlabeled with opened dates: one	F 761		

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F 761	Continued From page 27 vial of professional monitoring blood glucose test strips, one pouch of budesonide 0.5 mg/2 ml inhalation solution, two Stiolto Respimat (a medication used to treat lung disease) 2.5/2.5 microgram (mcg, a unit of measurement) inhalers, one Combivent Respimat (a medication to treat lung disease) 20/100 mcg inhaler, one Anoro Ellipta (a medication used to treat lung disease) 62.5/25 mcg inhaler, and one Breyna (a medication used to treat asthma) 80/4.5 mcg inhaler. LN 1 confirmed the findings and the manufacturer's labeling on each medication that indicated shorter expiration dates once used or opened. During the same inspection of Med Cart C with LN 1, one vial nitroglycerin (a medication used to treat chest pain) 0.4 mg sublingual (under the tongue) tablets was identified without a pharmacy label. LN 1 confirmed the finding and stated the medication should have had a label on it to indicate which resident it was for. A review of the manufacturer's labeling for Stiolto, revised in January 2025, indicated, "After assembly, the Stiolto Respimat inhaler should be discarded at the latest 3 months after first use or when the locking mechanism is engaged, whichever comes first." A review of the manufacturer's labeling for Combivent Respimat, revised in April 2025, indicated, "After assembly, the Combivent Respimat inhaler should be discarded at the latest 3 months after first use or when the locking mechanism is engaged, whichever comes first." A review of the manufacturer's labeling for Breyna, revised in September 2020, indicated, "Throw away Breyna when the counter reaches zero ("0") or 3 months after you take Breyna out	F 761		

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F 761	Continued From page 28 of its foil pouch, whichever comes first." During an interview on 4/22/25 at 12:44 p.m. with the DON, DON stated medications should have labels with at least a resident's name before storing them in the medication storage room or med carts. DON added loose pills and expired medications needed to be removed and disposed of and medications with shorter expirations after use needed to be marked with opened dates. DON further stated she did not have any concern with staff storing patches with oral medications. A review of the facility's P&P titled, "Storage of Medications," revised in April 2007, indicated, "Policy Interpretation and Implementation ... 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner ... 5. Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications."	F 761		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the	F 802		

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F 802	Continued From page 29 functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure two food service personnel were able to safely and effectively carry out the functions of the food and nutrition services, when Dietary Aide (DA) 1 and DA 2 were unable to verbalize the process of manual dishwashing by using two-compartment sinks correctly. This failure had the potential to place 45 out of 45 highly susceptible residents who received food from the kitchen at risk for food-borne illness. Findings: During an interview on 4/21/25 at 9:30 a.m. with DA 1, DA 1 was asked about the manual dishwashing process. DA 1 stated the steps were wash, sanitize, rinse and air-dried and answered with the same steps three times. DA 1 did not know the wash and rinse water temperature during the manual washing, was not sure how long the dishes submerge in the sanitizer solution and then stated a few minutes. DA 1 further stated the concentration for the sanitizer should be 200 parts per million (ppm; concentration measurement units). During an interview on 4/21/25 at 9:30 a.m. with Certified Dietary Manager (CDM), CDM confirmed and stated DA 1's answer was not correct, and stated the correct steps were wash,	F 802		

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F 802	Continued From page 30	F 802		

rinse, sanitize and air-dried. CDM further stated staff, especially the dishwasher, should have a good knowledge about manual dishwashing.

During an interview on 4/22/25 at 9:40 a.m. with DA 2, DA 2 was asked about the manual dishwashing process. DA 2 verbalized the process of dishwashing using a two-compartment sink. DA 2 stated the steps were wash, rinse, sanitize and that he would take the large bucket from the shed for the sanitizer as third compartment sink. DA 2 also stated during the sanitizing step, the dishes would submerge in the sanitizer for one to two seconds and repeated the same answer twice. DA 2 further stated the concentration of the sanitizer should be at 200-400 ppm.

During an interview on 4/23/25 at 8:45 a.m. with Registered Dietitian (RD), RD stated the dishwashers should have a good knowledge about manual dishwashing in case the dishwashing machine was not working or there was an emergency.

A review of the facility's policy and procedure (P&P) titled, "3-Compartment Procedure for Manual Dishwashing," dated 2023, indicated the steps were wash, rinse, sanitize and air-dried. P&P also indicated the water temperature of the wash and rinse steps were 110-120 degrees Fahrenheit (F; unit of measure), and the immersion time was 60 seconds for the dishes in the sanitizer during the sanitizing process.

A review of DA 1's employee file indicated DA 1's date of hire (DOH) was on 5/24/15.

A review of DA 2's employee file indicated DA 2's

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MOUNTAIN MANOR SENIOR RESIDENCE	6101 FAIR OAKS BOULEVARD CARMICHAEL, CA 95608

(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 802	Continued From page 31 DOH was on 11/30/20. A review of DA 1's and DA 2's competency audits titled, "Verification of Job Competency Equipment Competency," dated 2/25, indicated both DA 1 and DA 2 were checked off by CDM. The competency further indicated DA 1 and DA 2 were competent to the procedure of three-compartment sink manual dishwashing by demonstration. A review of the facility's document titled, "Dietary In-Service, Topic: Cleaning and Sanitizing Dishes, Utensils, Pots and Pans," completed on 2/25 by CDM, indicated the in-service included the 3-Compartment Sink (manual dishwashing) procedure. It also indicated DA 1 and DA 2 attended the in-service. A review of the facility's undated document titled, "Job Description: Food & nutrition Services Aide," indicated, "... the Food and nutrition Services (Dietary) Aide ... follows posted cleaning schedules utilizing proper sanitation and cleaning methods. Practices Safety, infection control, and emergency procedures according to community standards ..." A review of the facility's undated document titled, "Job Description: Director of Food & Nutrition Services (DFNS) (same as CDM)," indicated, "... DFNS ... Responsibilities ... Plan and conducts departmental ... in-service education programs for the nutrition services (dietary) staff ... Maintains competencies for Food & Nutrition Staff ... required by Standards of practice and state law, necessary to work safely and adequately ..."	F 802		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		

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F 803	Continued From page 32 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the menu was followed for the therapeutic diet (a modification of a regular diet, tailored to fit the nutritional needs of a particular person - may be part of a treatment or medical condition and usually prescribed by a physician) during the lunch meals on 4/21/25 and 4/22/25, when:	F 803		

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F 803	Continued From page 33 A. During a dining observation on 4/21/25: 1. Three residents (Residents 11, 21 and 35) on Consistent Carbohydrate (CCHO) diet (a therapeutic diet to manage diabetic disease and/or to stabilize blood sugar level) got pineapple Bavarian cream square instead of pineapple tidbits as listed on menu; and 2. Resident 17 with CCHO diet received pudding instead of CCHO dessert. B. During a meal service distribution on 4/22/25: 1. 15 residents (Residents 1, 2, 3, 7, 15, 18, 20, 21, 25, 28, 30, 38, 39, 41, and 396) with fortified (add extra calories and nutrients) diet (diet designs for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status) did not receive super soup as fortified food; and 2. Two residents (Residents 6 and 17) on a large portion diet received three ounces (oz., a unit of measure) of meat instead of four oz. These failures had the potential to result in compromising the medical and nutritional status of 19 out of 45 residents who received meals from the facility's kitchen. Findings: A. During a dining observation for lunch meal on 4/21/25 at 12:13 p.m., it was noted as follows: 1. Resident 11, 21, and 35 with CCHO diet received pineapple Bavarian cream square for dessert. A concurrent review of the facility's spreadsheet (a menu in excel sheet format that indicated what items and portions to be served for each prescribed/therapeutic diet) titled, "Week 1	F 803		

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F 803	Continued From page 34 Monday, [Facility's Name], Therapeutic Spreadsheet," indicated CCHO diet should have received pineapple tidbits for dessert. During an interview on 4/21/25 at 12:35 p.m. with the Certified Dietary Manager (CDM), CDM confirmed and stated CCHO diets should get pineapple tidbits. 2. Resident 17 with CCHO diet with regular texture and nectar thicken liquids (slightly thicker than thin liquid, such as apricot nectar or cream-based soup for individual who has swallow difficulty with thin liquids) was observed receiving pudding as dessert. A concurrent review of the facility's spreadsheet titled, "Week 1 Monday, [Facility's Name], Therapeutic Spreadsheet," indicated CCHO diet should have received pineapple tidbits. During an interview on 4/23/25 at 8:45 a.m. with Registered Dietitian (RD), RD reviewed the menu spreadsheet and stated Resident 17 should have received pineapple tidbits and not pudding. RD further stated Resident 17 was on regular food texture, therefore, Resident 17 should receive pineapple tidbits and not pudding for dessert. B. During the lunch meal distribution on 4/22/25 at 12:13 p.m., it was noted as follows: 1. 15 residents (Resident 1, 2, 3, 7, 15, 18, 20, 21, 25, 28, 30, 38, 39, 41, and 396) with fortified diet did not receive super soup as fortified food. A concurrent review of the facility's spreadsheet titled, "Week 1, Tuesday, [Facility's Name], Therapeutic Spreadsheet," indicated fortified diet should provide super soup.	F 803		

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F 803	Continued From page 35 2. Residents 6 and 17 were on large portion with their diets receiving three oz. of meat instead of four oz. A concurrent review of the facility's spreadsheet titled, "Week 1 Tuesday, [Facility's Name], Therapeutic Spreadsheet," indicated a large portion diet should give four oz. of pork for lunch. During an interview on 4/22/25 at 1:24 p.m. with CDM and RD, they acknowledged the issues found during tray line and dining observation. CDM confirmed the issues and stated his expectation for staff was to follow the menu, spreadsheet and tray ticket because the meal provided to the residents should match the diet as ordered. During a follow up interview on 4/23/25 at 8:45 a.m. with RD, RD stated the rationale for fortified food was for the residents who needed extra calories and/or protein without overwhelming residents with more foods to meet their nutritional needs. RD further stated the dietary staff needed to provide the correct portion size for the protein as stated on the menu or spreadsheet. RD explained the large portion with diets was for either residents' preferences or they needed more protein to meet their nutritional needs. A review of the facility's "Diet Manual," dated 2023, indicated, "Fortified Diet is designed for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status. Large Portions Follow the regular diet .... calories will equal about 2500 -2800 calories by adding 120-130 grams of protein and 295-315 grams of carbohydrates.	F 803		

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F 803	Continued From page 36 Controlled Carbohydrate Diet (CCHO) a meal plan without specific calorie levels ... to keep a stable blood sugar throughout the day." A review of the facility's undated document titled, "Job Description: Director of Food and Nutrition Services (Certified Dietary Manager)," indicated the Director of Food and Nutrition Services "Supervises the food preparation and service of resident meals according to written menus and standardized recipes." A review of the facility's undated document titled, "Job Description: Food and Nutrition Services Aides (Dietary Aides)," indicated the dietary aides "prepares hot and cold foods and beverage ... following menu and recipes for regular, texture modified and therapeutic diets ... checks resident's trays for proper and accurate food items ..."	F 803		
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.	F 812		

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F 812	Continued From page 37 §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 ensure food was prepared, stored, served, or distributed in accordance with professional standards of food service safety, when: 1. The ice machine was not clean; 2. The blade of the can opener was not well maintained; 3. Significant scratches were found on the cooking surfaces on the nonstick cooking pans with coating; 4. Significant amount of food items were found with inconsistent dating practices in the reach-in refrigerators, dry storage and walk-in freezer; 5. Opened food packages were found not resealed properly; 6. The thawing meat was found with no pull date to indicate when the meat thawing started; 7. Produce food items were found not fresh; and 8. The resident's food refrigerator was found with two issues: a. The freezer section was not clean; and b. The monitor system of the refrigerator and freezer was not practiced correctly. These failures had the potential to cause food contamination and food borne illness among the 45 medically vulnerable residents who consumed food from the kitchen and resident's refrigerator in the facility. Findings:	F 812		

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F 812	Continued From page 38 1. During a concurrent observation and interview on 4/21/25 at 10:33 a.m. with the Maintenance Supervisor (MS), MS stated he was responsible to clean the ice machine once a month, his last cleaning was completed on 3/23/25, and he changed the water filter every six months. MS took apart the top machinery part of the ice machine and took down the water curtain (a component that controls the water flow over the evaporator surface, ensuring the ice is made uniformly). A yellow-orange substance was noted inside the water curtain and could be removed easily with a paper towel. MS took out the water trough (a component that holds water within the ice maker) and a pink substance was noted on the top and could be removed easily with a paper towel. Significant amount of black and yellow substances were noted on the bottom of the evaporator unit (the core component where ice formation takes place) and could be removed with wiping of the paper towel. The surface area was also rough to touch. MS confirmed all the findings and stated he got the training from the manufacture's technician when he started working in the facility eight months ago. During an interview on 4/23/25 at 8:45 a.m. with Registered Dietitian (RD), RD stated the ice machine should be cleaned monthly because the ice machine made ice and ice was food. A review of the facility's policy and procedure (P&P) titled, "Ice machine Cleaning Procedures," dated 2023, indicated, "... Clean inside ice machine with sanitizing agent per manufacturer's instructions." A review of the [Manufacturer name] Ice	F 812		

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F 812	Continued From page 39 Machines manual, revised in 9/2019, indicated, "Use of nylon brush or cloth to descale (remove of lime scale and mineral deposits) side walls, evaporator plastic parts including top, bottom, and sides ... When sanitizing, pay particular attention to the following areas: side walls, base (area above water trough), evaporator plastic parts-including top, bottom and sides, bin or dispenser ..." According to 2022 Food and Drug Administration (FDA) Food Code, on section 4-602.11 Equipment Food-Contact Surface and Utensils, it stated equipment like ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms (a living thing that is so small it must be viewed with a microscope, such as bacteria or algae). In addition, on Section 4-202.11 Food-Contact Surfaces, it stated, "... The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food-contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts ..." and "... Multiuse Food-Contact Surfaces shall be: 1. Smooth; 2. Free of breaks, open seams, cracks, chips, inclusions, pits ..." 2. During a concurrent observation and interview	F 812		

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F 812	Continued From page 40 on 4/21/25 at 9:13 a.m. with the Certified Dietary Manager (CDM), CDM confirmed the blade of the can opener was chipped with the metal surface worn off and stated the blade was worn out and needed to be replaced. During an interview on 4/23/25 at 8:45 a.m. with RD, RD stated the blade should have been replaced when it chipped and worn off. RD further stated the risk for chipping blade might have physical contamination and the metal material might fall into the content of the food when opening the cans. A review of the facility's P&P titled, "Can Opener and Base," dated 2023, indicated, "... Proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shavings and shredding can result from a dull cutting blade ... Replace blade on can opener as needed ..." 3. During a concurrent observation and interview on 4/21/25 at 9:10 a.m. with CDM, CDM confirmed two non-stick coating pans were found with scratches on the cooking surface and stated they should be replaced with new pans. During an interview on 4/21/25 at 9:05 a.m. with RD, RD stated the cooking pans with scratches needed to be replaced because it might lead to physical contamination if the coating piece fell off from the scratches into the food. A review of the facility's P&P titled, "Sanitization," dated 2001, indicated, "... All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair ... free from chips that may affect their use or proper cleaning ..."	F 812		

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F 812	Continued From page 41 4. During a concurrent observation and interview on 4/21/2025 at 8:28 a.m., 9:36 a.m., and 10:02 a.m. with CDM, CDM confirmed the following food items in the reach-in refrigerators, dry storage and the walk-in freezer had inconsistent dating practices: - An opened bag 1/3 full of parsley (no opened and used by dates). CDM confirmed the bag's manufacturer used by date of 3/29/25 and stated the parsley was passed the used by date and should have been discarded; - An opened bag 1/2 full of salad mix stored in a zip lock bag (no opened and used by dates); - A bag sandwich with label of M&C (meat and cheese) and a date of 4/20/25. CDM stated the date was the prepared date and it should have a used by date and was good for three days; - A tub of lime pudding with label of opened date of 4/20/25 (no used by date); - An opened tub of fruit salad with an opened date of 4/17/24 (no used by date); - An opened tub of cottage cheese with an opened date of 4/19/25 (no used by date); - An opened tub of sour cream with an opened date of 4/19/25 (no used by date); - One opened bag of cereal with an opened date of 4/6/25, and three opened bags of cereal without opened and used by dates. CDM stated the opened food items should have opened and used by dates; - One opened bag of frozen diced ham with opened date of 4/8/24 (no used by date); - One opened bag of frozen veggie rotini pasta (no opened and used by dates); and - One opened bag of frozen cinnamon rolls with an opened date of 4/6/25 (no used by date).	F 812		

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F 812	Continued From page 42	F 812		

CDM confirmed the findings and stated the opened food packages should have opened and used by dates, and the prepared food should have prepared date and used by date.

A review of the facility's P&P titled, "Procedure for Refrigerated Storage," dated 2023, indicated, "... food items should be dated so that the older items are used first ... and dating the packages or containers will facilitate this practice."

A review of the facility's P&P titled, "Procedure for Freezer Storage," dated 2023, indicated, "... All frozen food should be labeled and dated ..."

A review of the facility's P&P titled, "Labeling and Dating of Foods," dated 2023, indicated, "... All food items in the storeroom, refrigerator, and freezer need to be labeled and dated ... Newly opened food items will need to be closed and labeled with an open date and used by the date ... All prepared food needs to be ... labeled and dated ..."

5. During a concurrent observation and interview on 4/21/25 at 8:28 a.m., 9:36 a.m., and 10:02 a.m. with CDM, the reach-in refrigerators, dry storage, and the walk-in freezer were found to have the following:
- One opened bag of ½ full refrigerated salad mix stored in a zip lock bag but not sealed;
- Four opened bags of dry cereal stored in zip lock bags but not sealed;
- One opened bag of frozen diced ham stored in a zip lock bag and not completely sealed;
- One opened bag of frozen veggie rotini pasta stored in a zip lock bag and not completely sealed; and
- One opened bag of frozen cinnamon rolls stored

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F 812	Continued From page 43 in a zip lock bag and not completely sealed. CDM confirmed the findings and stated the opened food packages should be kept sealed tightly. During an interview on 4/23/25 at 8:45 a.m. with RD, RD stated the opened food packages should have been resealed tightly to avoid contamination and to keep the food fresh. A review of the facility's P&P titled, "Storage of Food and Supplies," dated 2023, indicated, "... Dry food items which have been opened ... will be tightly closed, labeled, and dated." A review of the facility's P&P titled, "Procedure for Freezer Storage," dated 2023, indicated, "... store frozen food sin an airtight moisture-resistant wrapper such as a plastic bag ... to prevent freezer burn ..." A review of the facility's P&P titled, "Storing Produce," dated 2023, indicated, "... Keeping fresh vegetables tightly wrapped with as little air in the bag/container as possible will keep them fresh longer ..." 6. During a concurrent observation and interview on 4/21/25 at 8:41 a.m. with Cook (CK) 1, a bucket was found at the reach-in refrigerator containing a beef steak with a label stated, "use by date of 4/21/25 for dinner". CK 1 stated the beef steak was pulled out from the freezer for thawing and the practice for thawing meats was staff should put a pulled-out date and a used by date. During an interview on 4/23/25 at 8:45 a.m. with	F 812		

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RD, RD stated staff should pull the frozen meat from the freezer in advance and thaw it in the refrigerator. RD further stated staff should have labeled the thawing meat with pull out date and use by date.

A review of the facility's P&P titled, "Thawing of Meats," dated 2023, indicated, "... Label defrosting meat with pull and use by date ..."

7. During a concurrent observation and interview on 4/21/25 at 9:36 a.m. with CDM, seven out of 16 tomatoes were found at the dry storage with black and white fuzzy indented spots. CDM confirmed the finding and stated, "look like they (refer to the dietary staff) did it again, not checking the vegetables." CDM also confirmed one out of 45 oranges with green and white fuzzy spots and stated the orange needed to be thrown away.

During an interview on 4/23/25 at 9:13 a.m. with RD, RD stated the produce should be kept fresh and staff should check them before use.

A review of the facility's P&P titled, "Storing Produce," dated 2023, indicated, "Check boxes of fruit and vegetables for rotten, spoiled items ... Throw away all spoiled items ..."

8. During a concurrent observation and interview on 4/21/25 at 12:54 p.m. with Infection Preventionist (IP), IP confirmed the two issues found in the Resident's food refrigerator located in the nursing station:
a. A dry frozen spill in the freezer and the freezer did not have a thermometer to monitor the temperature; and
b. A review of the "Resident Food Fridge Temp

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F 812	Continued From page 45 (Temperature) Log," dated March 2025 and April 2025, had: - No entries from 3/16/25 to 3/31/25 and 4/16/25 to 4/21/25 for AM (morning) shift; - No entries on PM (evening) shift for March 2025 and April 2025; and - The temperature entries for the freezer at 40 degrees Fahrenheit (F; a unit of measure) for March 2025 and April 2025. IP confirmed there was a spill in the freezer, agreed it was not clean, and stated there was no thermometer for the freezer. IP reviewed the temperature log for March 2025 and April 2025, confirmed the record of freezer temperature of 40 degrees F and stated it was not correct, and it should be at zero-degree F. IP confirmed there were no temperature recorded from 3/16/25 to 3/31/25 and 4/16/25 to 4/21/25 for AM shift and no temperature recorded for the PM shift in March 2025 and April 2025. IP further stated the charge nurse was responsible to monitor the refrigerator and freezer temperatures every AM and PM shift. A review of the facility's P&P titled, "Refrigerators and Freezers," dated 12/2014, indicated, "... Acceptable temperature ranges ... less than 0 degree F for freezer ... designated employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening ... the supervisor will take immediate action if temperatures are out of range ... Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary ..."	F 812		
F 868 SS=D	QAA Committee	F 868		

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F 868	Continued From page 46 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 868		

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Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee was composed of the required committee members for a census of 45 residents.

This failure decreased the facility's potential to identify, monitor, implement and enhance the quality of care for residents.

Findings:

During a concurrent interview and record review on 4/23/25 at 10:42 a.m. with the Administrator (ADM), the facility's quarterly Quality Assurance and Performance Improvement (QAPI) meeting, dated April 2024 was reviewed. ADM confirmed the Medical Director (MD) did not attend the quarterly QAPI team meeting held in April 2024.

A review of the facility's document titled, "QA [Quality Assessment] Sign-In Sheet," dated 4/9/24, indicated the MD name and signature were missing as part of the QAA committee for the quarterly QAPI meeting on 4/9/24.

A review of the facility's undated document titled, "QA Committee Information," indicated the MD was one of the required QAA Committee members.

A review of the facility's undated policy titled, "2024/2025 Quality Assurance & Performance Improvement (QAPI) Plan for [facility's name]," indicated, "The QAPI Committee, which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirement and continuous improvement in quality of care and customer satisfaction."

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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 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:	F 880		

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F 880	Continued From page 49 (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: Based on observation, interview, and record review, the facility failed to implement infection control practices for a census of 45 residents, when: 1. Enhanced Barrier Precautions (EBPs) were not implemented for Resident 1, Resident 246, Resident 147, Resident 26, Resident 296, Resident 297, Resident 298, and Resident 396; and 2. Certified Nurse Assistant 5 (CNA 5) did not	F 880		

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follow proper hand hygiene protocol while passing lunch trays to residents.

These failures had the potential to spread infections among residents.

Findings:

A review of an admission record indicated Resident 1 was admitted to the facility in February 2025 with a diagnosis of chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing).

A review of Resident 1's "Progress Notes," dated 3/27/25, indicated on 3/26/25 Resident 1 was sent to the hospital for sustaining a deep laceration to her left lower extremity (LLE) and returned back the same day with sutures.

During a concurrent observation, interview, and record review on 4/21/25 at 2 p.m. with Licensed Nurse 3 (LN 3), Resident 1's physician orders were reviewed. LN 3 confirmed Resident 1 had an order for EBPs due to LLE wound. LN 3 stated the EBPs order was not followed because there was no sign posted outside or inside Resident 1's room and there were no personal protective equipment (PPE-equipment worn by healthcare workers for protection from hazards including infections) available to use inside the room.

During an interview on 4/21/25 at 2:25 p.m. with the Infection Preventionist (IP), IP confirmed Resident 1's EBPs order should have been started and implemented due to her LLE wound to prevent infection.

A review of Resident 246's "Admission Record,"

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indicated he was admitted to the facility in April 2025 with a diagnosis of cellulitis (bacterial infection of the skin and underlying tissues) on buttock.

A review of Resident 246's "Order Summary Report (OSR)," dated 4/20/25, indicated an intravenous (IV, inside a vein) antibiotic vancomycin (used to treat bacterial infections) 1.25 grams (g; a unit of measurement) to be given daily until 5/12/25. The OSR further indicated an order for care of a peripherally inserted central catheter (PICC, a long thin tube inserted into a vein in the upper arm threaded up to a large vein near the heart) line in the left upper arm (LUA).

During an interview on 4/21/25 at 2:25 p.m. with the IP, IP confirmed Resident 246 had a PICC line in the LUA. IP stated the PICC line was considered an indwelling medical device, and EBPs should have been ordered and implemented right away according to the facility's policy.

A review of Resident 147's "Admission Record," indicated Resident 147 was admitted to the facility in 2025 with diagnoses including right leg cellulitis and right ankle and foot osteomyelitis (a bone infection characterized by inflammation of the bone tissue).

A review of Resident 147's "OSR," dated 4/23/25, indicated Resident 147 had an open wound dressing on the right arm, left wrist, and left front arm, a surgical site to right foot, and wound care to bilateral feet.

During a concurrent observation and interview on 4/22/25 at 8:23 a.m. with CNA 6, CNA 6

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confirmed and stated there were no EBPs signage or PPEs placed by Resident 147's room.

During a concurrent observation and interview on 4/23/25 at 8:39 a.m. with LN 6, LN 6 confirmed there was no EBP signage or PPE cart available in front of Resident 147's room.

During an interview on 4/24/25 at 9:42 a.m. with the IP, IP stated Resident 147 had a wound dressing and should have EBPs in place.
A review of an admission record indicated Resident 26 was admitted to the facility in March 2025 with a diagnosis of liver abscess (a puss-filled mass in the liver that can develop from infection or injury).

A review of Resident 26's care plan, dated 4/4/25, indicated Resident 26 had a biliary drain (tubing that allows bile to flow out from a blocked bile duct into a collection bag outside the body; bile is a digestive liquid made by the liver).

During an observation on 4/21/25 at 9:02 a.m., Resident 26 was noted with a biliary drain, located in the right upper quadrant (abdominal area where the liver is located), and draining grayish white fluid. Resident 26 also had a PICC line in the right upper arm (RUA) with two access ports for instilling medications. No EBPs signage was noted around or inside Resident 26's room.

A review of Resident 26's "OSR," 4/23/25, indicated Resident 26's RUA PICC line was monitored for signs of infection, and dressing changes were ordered on 4/14/25.

A review of an admission record indicated Resident 296 was admitted to the facility in April

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2025 with diagnoses including end stage renal disease (a serious condition where the kidneys have lost their ability to filter waste from the blood) with dependence on renal dialysis (a life-sustaining treatment for people with kidney failure, replacing the function of healthy kidneys in filtering waste and excess fluid from the blood), and Methicillin Resistant Staphylococcus Aureus infection (MRSA - an infection caused by a type of staph bacteria that become resistant to many antibiotics)

During a concurrent observation and interview on 4/21/25 at 9:22 a.m. with Resident 296, Resident 296 stated he was recently transferred from the hospital and had MRSA in his left subcostal (below the rib) dialysis port. Resident 296 further stated the dialysis port was closed and a new one was inserted in his right subcostal area. No EBPs signage was noted around or inside Resident 296's room.

A review of Resident 296's "OSR," dated 4/23/25, indicated Resident 296 had capacity to make healthcare decisions, an order for EBPs on 4/16/25, and an order to monitor the dialysis port on the right upper chest for infection on 4/14/25. The OSR further indicated Resident 296 started receiving intravenous vancomycin three days a week at the dialysis center for MRSA infection on 4/18/25.

A review of an admission record indicated Resident 297 was admitted to the facility in April 2025 with a diagnosis of left foot open wound.

During a concurrent observation and interview on 4/21/25 at 9:51 a.m. with Resident 297, Resident 297's left foot was connected to a wound vacuum

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(wound vac -a medical device that uses suction to help wounds heal), wrapped in gauze dressing and covered with a sock. Resident 297 stated the hospital's doctor said the success of the current wound vac treatment was very important while Resident 297 was at the facility; otherwise, Resident 297 would have to undergo an amputation of the left foot. No EBPs signage was noted around or inside Resident 297's room.

A review of Resident 297's "OSR," dated 4/23/25, indicated Resident 297 had capacity to make healthcare decisions and an order for a wound vac connected to the left plantar foot ulcer (an open wound or sore) for treatment on 4/19/25.
A review of an admission record indicated Resident 298 was admitted to the facility in April 2025 with a diagnosis of liver cirrhosis (a disease where healthy liver tissue is replaced by scar tissue).

During an observation on 4/21/25 at 8:34 a.m. with Resident 298, Resident 298 was noted with a feeding tube covered by dressing near his upper abdominal midline. No EBPs signage was noted around or inside Resident 298's room.

A review of Resident 298's "OSR," dated 4/23/25, indicated Resident 298 had a gastrointestinal tube inserted into his abdomen, for which cleansing and dressing treatments were ordered on 4/14/25. The OSR further indicated orders for EBPs on 4/10/25.

During a concurrent interview and record review on 4/21/25 at 2:11 p.m. with LN 5, Resident 26's, 296's, 297's, and 298's OSRs were reviewed. LN 5 confirmed both Resident 296 and Resident 298 had orders for EBPs and stated residents with

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wound vac equipment, indwelling medical devices, and MRSA should be placed on EBPs, and a sign should be placed outside the residents' rooms to alert staff to don PPE prior to providing direct care.

During an interview on 4/22/25 at 8:17 a.m. with the IP, IP confirmed Residents 26, 296, 297, and 298 had indwelling medical devices, wound vacs, or MRSA and were not placed on EBPs. IP stated Resident 26, Resident 296, Resident 297, and Resident 298 should have been placed on EBPs and had PPE available in their rooms; otherwise, not following the EBPs procedure might cause the spread of infections to vulnerable residents.

During an interview on 4/23/25 at 10:29 a.m. with the Director of Nursing (DON), DON stated the EBPs policy was not correctly followed for residents requiring it. DON further stated staff might spread infection to medically fragile residents if EBPs were not in place or appropriate PPEs were not used.
A review of Resident 396's "Admission Record," indicated Resident 396 was admitted to the facility in April 2025 with a diagnosis of left lower leg open wound.

During a concurrent observation and interview on 4/21/25 at 9:08 a.m. with Resident 396, Resident 396's right leg was connected to a wound vac and her left leg was wrapped in an ace bandage. Resident 396 stated she had wounds on both legs.

During a concurrent observation and interview on 4/21/25 at 1:57 p.m. with LN 2, LN 2 confirmed no EBPs signage was noted around or inside Resident 396's room.

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F 880	Continued From page 56 During an interview on 4/21/25 at 2:13 p.m. with the IP, IP stated Resident 396 should have been placed on EBP. A review of the facility's policy titled, "Enhanced Barrier Precaution," revised in 8/22, indicated, "Enhanced Barrier Precautions (EBP) are used as an infection prevention and control intervention ... EBPs are indicated for residents with wounds and/or indwelling medical devices ... Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required ... PPE is available outside of the resident rooms." 2. During an observation on 4/21/25 at 12:40 p.m. in Hall 1, CNA 5 was passing lunch trays to resident rooms. CNA 5 passed the lunch trays to seven residents. No hand hygiene was observed in between the distribution of lunch trays. During an interview on 4/21/25 at 12:46 p.m. with CNA 5, CNA 5 confirmed he did not perform hand hygiene while passing the lunch trays. CNA 5 stated he should have performed hand hygiene in between passing meal trays to prevent the spread of germs among residents. During an interview on 4/23/25 at 9:10 a.m. with the IP, IP stated staff were expected to do handwashing or sanitizing in between serving meals to residents. A review of the facility's policy titled, "Handwashing/Hand Hygiene," revised in August 2015, indicated, "Use an alcohol-based hand rub ... alcohol; or ... soap ... and water for the following situations: ... Before and after eating or handling food; ... Before and after assisting a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 57 resident with meals ..."	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow the Antibiotic Stewardship Program for one of 17 sampled residents (Resident 247), when Resident 247 was prescribed an antibiotic without adequate clinical and laboratory findings for its use. This failure increased Resident 247's potential for an unnecessary administration of an antibiotic without appropriate indication. Findings: A review of an admission record indicated Resident 247 was admitted to the facility in April 2025. A review of Resident 247's hospital admission order, dated 4/3/25, indicated Resident 247 was admitted to the facility with no urinary tract infection (UTI) diagnosis. A review of Resident 247's "Order Summary	F 881		

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F 881	Continued From page 58	F 881		

Report," dated 4/7/25, indicated an order for levofloxacin (an antibiotic used to treat bacterial infections) 250 milligrams (mg, unit of measurement) one tablet daily for 14 days for chronic UTI, then half tablet daily to be given until 5/21/25 for UTI prophylaxis.

A review of Resident 247's "Medication Administration Record," indicated Resident 247 was administered levofloxacin 250 mg one tablet daily from 4/7/25 to 4/20/25, then half tablet daily from 4/21/25 to 4/24/25.

A review of Resident 247's medical file indicated a sample of urinalysis with culture was collected from Resident 247 on 3/27/25 at the hospital. Resident 247 had asymptomatic bacteriuria (presence of bacteria in urine without UTI symptoms) and no indication of an antimicrobial treatment.

A review of Resident 247's "Physician Assistant (PA) Note," dated 4/8/25, indicated Resident 247 was started on an antibiotic for UTI per hospital urine culture report and had no UTI symptoms.

During a concurrent interview and record review on 4/23/25 at 9:10 a.m. with the Infection Preventionist (IP), Resident 247's physician order, progress notes, PA notes, and hospital urinalysis with culture lab result were reviewed. IP confirmed Resident 247's antibiotic order was started on 4/7/25 for UTI and was based only on the urinalysis lab test done at the hospital. IP stated Resident 247 did not complain of frequent painful/burning sensation when urinating, there was no strong odor in her urine, and had no fever at the facility. IP further stated according to the urine culture lab result, Resident 247 was

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F 881	Continued From page 59 asymptomatic (had no symptoms) and there was no indication for an antimicrobial treatment. A review of the facility's policy titled, "Antibiotic Stewardship," revised in December 2016, indicated, "The purpose of Antibiotic Stewardship Program is to monitor the use of antibiotics in residents ... laboratory results and current clinical situations will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be ... modified or discontinued."	F 881		