POC Received 1/31/25
POC Approved 2/4/25
BIC = 1/30/25 per A. Ballout

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555555	A. BUILDING _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKATON VILLAGE CARE CENTER	3939 WALNUT AVE. 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's census was 33. The sample size was 22.	F 000	Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed because it is required by the provisions of Federal and State law. This response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
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	**F584 Safe/Clean/Comfortable/ Homelike Environment** Maintenance staff fixed residents drawer and light switch so resident could use independently. Maintenance supervisor performed an audit on all drawers and light switches in residents rooms and no other deficient practice was noted. The Safe Environment policy states the facility will provide a	2/9/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Healthcare Administrator | (X6) DATE: 1/31/2025

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

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F 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 homelike environment for one of 22 sampled residents (Resident 248), when the light switch behind Resident 248's bed was broken and kept in a non-operational drawer. This failure had the potential to negatively impact Resident 248's psychosocial well-being, ability to read, and access to personal belongings. Findings: A review of Resident 248's "Resident Face Sheet" indicated she was admitted to the facility on 12/29/24 with a diagnosis of right femur (the large bone in the upper part of your leg) fracture. A review of Resident 248's "Physician Order Report," dated 12/1/24-12/31/24, indicated she had the capacity to understand choices and make health care decisions. During a concurrent observation and interview on 1/6/25 at 10:57 a.m. with Resident 248 in her room, Resident 248's wall light behind her bed	F 584	safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Staff was provided an in-service by the administrator on the Safe Environment policy on 1/21/25-1/23/25 to include how to alert Maintenance Department of any needed repairs via TELS, email or phone call. Maintenance Supervisor will add a Monthly Inspection for all safe functioning of furnishings in a patient room to the TELS maintenance system. The results of the inspection will be given to the administrator. Results will be reported at QAPI for the next 3 months or until 90% compliance is reached.	

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F 584	Continued From page 2 was broken and the light's switch was kept in the nightstand's top drawer. Resident 248 stated the nightstand's top drawer was "stuck" and she could not open it on her own. Resident 248 further stated it bothered her that she could not turn on the light to read or reach her personal items without calling for assistance and she asked staff to fix the light and drawer several times. During a concurrent observation and interview on 1/06/25 at 1:05 p.m. with Licensed Nurse 2 (LN 2) in Resident 248's room, LN 2 confirmed the nightstand's top drawer was "very hard" to open and the light switch was not operational. LN 2 stated Resident 248 should be able to open the drawer on her own to reach her personal items and to turn on the light. LN 2 further stated it was very important that Resident 248 feels welcomed and comfortable and to maintain as much independence as possible. During a concurrent observation and interview on 1/8/25 at 10:16 a.m. with the Director of Environmental Services (DES) in Resident 248's room, DES confirmed the light switch was broken and stated the expectation was it should have been a priority repairing the items because it might have affected the quality of residents' stay at the facility. DES further stated the goal was to keep residents' environment as comfortable and homelike as possible. A review of the facility's policy titled, "Safe Environment," revised 1/2025, indicated, "The facility will provide: A ... homelike environment, allowing the resident to use his or her personal belongings ... adequate levels of illumination suitable for tasks the resident chooses to perform	F 584		

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F 584	Continued From page 3 ... maintain all mechanical, electrical ... equipment ... in safe operating condition."	F 584	**F656 Develop/Implement Comprehensive Care Plan** Resident 148 care plan was updated to reflect use of continuous oxygen at two liters per minute. Resident no longer resides in the facility. Comprehensive care plans of residents on oxygen were reviewed by the Health Information Coordinator and no other residents were affected by this deficient practice. Licensed Nurses were in-serviced by the Director of Staff Development (DSD)/Health Information Coordinator (HIC) on the development and implementation of a comprehensive care plan, per policies: Baseline Care Plan and Interdisciplinary Team/ Care Plan Process on 1/24.25. The QI Nurse will also in-service licensed nurses on individualized care plans.	2/1/2025
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 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	F 656		

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F 656	Continued From page 4 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a person-centered care plan for one of 22 sampled residents (Resident 148), when Resident 148's care plan did not indicate he was receiving oxygen therapy. This failure decreased the facility's potential to meet Resident 148's care needs. Findings: A review of Resident 148's "Resident Face Sheet" indicated he was admitted to the facility in December 2024 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and dependence on supplemental oxygen. During an observation on 1/8/25 at 2:35 p.m. in Resident 148's room, Resident 148 was observed receiving oxygen at two liters per minute via nasal cannula (a device that gives you additional oxygen through your nose). A review of Resident 148's "General Order,"	F 656	The Health Information Coordinator will audit oxygen care plans for residents utilizing supplemental oxygen weekly. The audit findings will be submitted to the DON. The result of the audits will be reported at quarterly QAPI and will continue for 3 months time or until 90% compliance is reached.	

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F 656	Continued From page 5 dated 1/3/25, indicated Resident 148 was on oxygen at two liters per minute every shift. During concurrent interview and record review on 1/8/25 at 12:16 p.m. with Licensed Nurse 4 (LN 4), Resident 148's care plan was reviewed. LN 4 confirmed there was no oxygen care plan in the clinical record and stated a care plan was needed so staff would know Resident 148's care needs. During an interview on 1/8/25 at 1:06 p.m. with the Interim Director of Nursing (IDON), IDON stated his expectations were all residents should have care plans; otherwise, there was a potential for nurses not to be able to provide the residents' care needs. A review of the facility's policy titled, "Care Plan Process," revised 12/15/21, indicated, "Each resident will have a care plan that is initiated upon admission ... to assure that the resident's immediate care needs are met and maintained."	F 656		
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 services according to professional standards of quality for one of 22 sampled residents (Resident 198), when Licensed Nurse 1 (LN 1) prepared a medication for Resident 198 taken from another	F 658	**F658 Services Provided Meet Professional Standards** **Resident no longer resides at the facility.** **Any resident has the potential to be affected by the same alleged deficient practice.**	2/9/2025

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F 658	Continued From page 6 resident's medication supply. This failure decreased the facility's potential to safely administer medications to residents. Findings: A review of Resident 198's "Resident Face Sheet" indicated Resident 198 was admitted to the facility in December 2024 with diagnoses including right hip fracture and chronic constipation. A review of Resident 198's "Prescription Order," dated 12/22/2024, indicated an order for polyethylene glycol (medication used to treat constipation) once a day. During a concurrent observation and interview on 1/6/25 at 9:17 a.m. with LN 1, LN 1 was observed preparing polyethylene glycol for Resident 198. LN 1 removed the medication from a plastic bag and the bag's label indicated a different resident's name. LN 1 confirmed she prepared Resident 198's medication after taking it from another resident's bag and stated she should have taken it from the facility's medications stock; otherwise, the medication might have the wrong dose and Resident 198 might have an adverse effect. During an interview on 1/8/25 at 12:38 p.m. with the Interim Director of Nursing (IDON), IDON stated his expectations were nurses should have followed the five rights of medication administration (right patient, right medication, right time, right dose, and right route); otherwise, there was a potential for residents experiencing adverse effects if given medications that did not belong to them.	F 658	1 on 1 in-service was given to LN1 on 1/6/25 by RN- Infection Preventionist on Medication Administration General Guidelines, including the five rights of medication administration. Licensed Nurses given an in-service by Director of Nursing on 1/24/25 regarding Medication Administration General Guidelines, including the 5 rights of medication administration. DON will perform weekly med pass observations with licensed nurses x 1 month, then monthly for 3 months. The pharmacy nursing consultant will perform a med pass observation quarterly with results given to the DON. The results of the audit will be given to the DON/SNF Administrator. Results will be reported at quarterly QAPI for the next 3 months or until 90% compliance is reached.	

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F 658	Continued From page 7 A review of the facility's policy and procedure (P&P) titled, "Medication Administration General Guidelines," dated 1/21, indicated, "Read medication label three times before preparing medication, when pulling medication package from med cart, when dose is prepared and before dose is administered." P&P further indicated, "Medications supplied for one resident are never administered to another resident."	F 658	**F677 ADL Care Provided for Dependent Residents** Resident 248 no longer resides at the facility. The Director of Staff Development completed an audit on other residents and no other deficiencies were found. All residents have the potential to be affected by the alleged deficient practice. The Director of Staff Development performed an in-service for Licensed Nurses and CNA's on 1/14/25 regarding residents shower schedule and reviewed the policy of Necessary Care and Services: Activities of Daily Living. Director of Staff Development will review shower sheets weekly for 3	2/4/25
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate assistance with activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily) for one of 22 sampled residents (Resident 248), when Resident 248 was not offered or given showers as scheduled. This failure had the potential to negatively impact Resident 248's cleanliness, discomfort, and psychosocial well-being. Findings: A review of Resident 248's "Resident Face Sheet" indicated she was admitted to the facility on 12/29/24 with a diagnosis of right femur (the large bone in the upper part of your leg) fracture.	F 677		

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F 677	Continued From page 8 A review of Resident 248's "Physician Order Report," dated 12/1/24-12/31/24, indicated she had the capacity to understand choices and make health care decisions. The report further indicated Resident 248 should have showered twice a week on Monday and Friday. During a concurrent observation and interview on 1/6/25 at 10:57 a.m. with Resident 248 in her room, Resident 248 was lying in bed and wearing a hospital gown with a large brown area on the upper chest site. Resident 248's hair was unkempt and matted on the back of her head. Resident 248 stated she did not have a shower since her accident and would "love" to have a shower and her hair to be washed. Resident 248 further stated she asked staff on several occasions for a shower and none of them discussed a shower schedule with her. A review of Resident 248's "Care Plan," dated 12/29/24, indicated Resident 248 needed assistance with bathing and personal hygiene and to be showered/bathed two times a week as scheduled. During a concurrent interview and record review on 1/7/25 at 2:28 p.m. with Certified Nursing Assistant 1 (CNA 1), Resident 248's shower sheets and clinical record were reviewed. CNA 1 stated she did not recall offering a shower or bath to Resident 248 during her stay and could not find a documentation in the clinical record that a shower or bath was offered, refused, or given on the shower's scheduled dates 12/30/24, 1/3/25, and 1/6/25. CNA 1 stated it was the CNA's responsibility to check Resident 248's shower schedule, to offer her a shower or bath and assist her as needed.	F 677	months and report findings to DON/SNF Administrator. Results of the audits will be reported at QAPI for the next 3 months or until 90% compliance is reached.	

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F 677	Continued From page 9 During a concurrent interview and record review on 1/7/25 at 2:33 p.m. with Licensed Nurse 1 (LN 1), Resident 248's shower sheets and clinical record were reviewed. LN 1 could not find a documentation in the clinical record that a shower or bath was offered, refused, or given on the shower's scheduled dates 12/30/24, 1/3/25, and 1/6/25. LN 1 stated CNAs should have offered Resident 248 a shower or bath according to the shower calendar and documented on the "Shower Day Skin Inspection Sheet" whether it was given or refused. LN 1 further stated Resident 248 might become depressed or might develop skin issues because of uncleanliness and not been offered a shower. A review of the facility's policy titled, "Necessary Care and Services: Activities of Daily Living," dated 11/2024, indicated, "The facility will ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good ... grooming ... and personal hygiene."	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 689	**F689 Free of Accident Hazards/Supervision/Devices** Resident 15 was assessed and sent to the acute hospital to for a follow up assessment. The sling that broke during the transfer was immediately removed from service. All other slings were inspected by the DON, DSD and maintenance supervisor.	2/14/25

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F 689	Continued From page 10 review, the facility failed to ensure safety measures were in place for one of 22 sampled residents (Resident 15), when Resident 15 fell to the floor during transfer and sustained a blunt head injury (when the head hit a hard object or surface without breaking the skull) and a scalp abrasion (cut of the scalp). This failure decreased the facility's potential to prevent Resident 15's fall and injury. Findings: A review of Resident 15's "Resident Face Sheet" indicated Resident 15 was admitted to the facility in 2019 with a diagnosis of paraplegia (loss of movement and/or sensation, to some degree, of the legs). A review of Resident 15's "Physician Order Report," dated 1/1/25 to 1/31/25, indicated Resident 15 had no capacity to understand choices and make health care decisions due to dementia (a progressive state of decline in mental abilities). Resident 15 had an order to be "up in chair daily as tolerated." A review of Resident 15's "Johns Hopkins Fall Risk Assessment Tool," dated 11/19/24, indicated Resident 15 had moderate fall risk. During an interview on 1/9/25 at 11:56 a.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 confirmed witnessing one of the loops from the head of the sling broke during Resident 15's transfer and as a result, Resident 15 fell to the floor and hit his head. CNA 4 stated there was no written expiration date on the sling during inspection.	F 689	The mechanical lift was also inspected by the maintenance supervisor. No other slings were noted to have a tear, but undated slings were removed from service. New slings were ordered and a start date was placed on all new slings. An inspection log was created on paper and in the EHR system for sling inspection prior to use of a sling. In-service provided by the Director of Staff Development for CNA's on 1/15/25 to staff on the mechanical lift policy and fall prevention policy. Maintenance created a monthly inspection to mechanical devices and slings in use in the TELS maintenance system Director of Staff Development will audit sling sheets daily for 3 months to ensure that all slings have been inspected prior to use. The results of the audits will be given to the DON/SNF administrator. Results will be	

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F 689	Continued From page 11 A review of Resident 15's "Observation Detail List Report," dated 11/17/24, indicated Resident 15 had a fall on the morning of 11/17/24 during a mechanical lift from bed and sustained a bleeding from head. A review of Resident 15's "Resident Progress Notes," dated 11/17/24, indicated, "... [Resident 15] fell during transfer from [mechanical lift's] sling ... The sling from [mechanical lift] malfunctioned and [Resident 15] fell landed on the floor ... hit his head and is bleeding." A review of Resident 15's hospital "Discharge Instructions Document," dated 11/17/24, indicated Resident 15 was in the hospital for fall, scalp abrasion, and blunt head injury. A review of Resident 15's "Care Plan History," dated 11/17/24, indicated Resident 15 had a "witnessed fall with head injury." During an interview on 1/9/25 at 9:59 a.m. with the Director of Staff Development (DSD) and Interim Director of Nursing (IDON), DSD confirmed Resident 15 fell during transfer due to a broken sling. IDON stated the expectations were staff should have inspected Resident 15's sling to make sure it was intact, had no damage, no break, and was not expired. A review of the facility's policy titled, "Mechanical Lift Policy," dated 10/30/22, indicated, "Slings will be maintained in appropriate condition for use with residents. Slings will be documented with a (in use start date) upon initial use by community. Slings will be inspected prior to each use for compromised material including frayed sling	F 689	reported to quarterly QAPI for the next 3 months or until 100% compliance is reached.	

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F 689	Continued From page 12 loops, frayed/loose seams, and weakness in fabric." A review of the facility's policy titled, "Fall Prevention Program," dated 5/25/21, indicated, "Residents will be provided an environment which will reasonably maximize safety while maintaining an optimal level of independence."	F 689		
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 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:	F 761	**F761 Label/Store Drugs & Biologicals** Residents 14, 148 and 149 undated medications was discarded. New medication was delivered for Residents 14,148 and 149. New medications were dated with open and discard dates. Licensed nurses inspected all medication and treatment carts for any undated and expired medications and treatments. No other undated or expired medication or treatments were found.	2/9/2025

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F 761	Continued From page 13 Based on observation, interview, and record review, the facility failed to properly store medications for three residents (Resident 14, Resident 148, and Resident 149) of a census of 33, when three opened inhalers were not dated with open and discard dates. This failure decreased the facility's potential to properly store residents' medications and ensure medication potency. Findings: A review of Resident 14's "Resident Face Sheet" indicated Resident 14 was admitted to the facility in October 2024 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and asthma (chronic disease of the lungs that makes it difficult to breathe). A review of Resident 148's "Resident Face Sheet" indicated Resident 148 was admitted to the facility in December 2024 with a diagnosis of COPD. A review of Resident 149's "Resident Face Sheet" indicated Resident 149 was admitted to the facility in January 2025 with a diagnosis of COPD. During a concurrent observation and interview on 1/7/25 at 1:01 p.m. with Licensed Nurse 4 (LN 4), LN 4 confirmed the following opened medications were stored in medication cart three without open or discard dates: - Resident 14's fluticasone furoate, umeclidinium, and vilanterol inhaler (treats asthma and COPD) indicated to discard six weeks after opening the foil tray;	F 761	Any resident could potentially be affected by this alleged deficient practice. Licensed Nurse 4 was given a 1 on 1 in-service on Medication Administration General Guidelines, included dating when inhalers are opened/put into service and discard dates by RN-Infection Preventionist. Licensed nurses in-serviced by the infection Preventionist RN on 1/7/25 on Medication Administration General Guidelines to included dating when inhalers are opened/put into service and discard dates. Pharmacy nursing consultant will conduct med cart audits quarterly to ensure that medications and treatments are dated and not expired. The results will be presented to the DON. The DON will perform weekly audits on properly dated medications in carts x 1 month,	

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F 761	Continued From page 14 - Resident 148's fluticasone and salmeterol inhaler (treats asthma and COPD), indicated to discard one month after opening the foil pouch; and - Resident 149's fluticasone furoate inhaler (treats asthma and COPD), indicated to discard six weeks after opening the foil tray. LN 4 stated opened medications might not be effective if given past the discard date and might not treat the respiratory condition. LN 4 further stated open and discard dates should have been written on the medications according to manufacturer's recommendations. During an interview on 1/8/25 at 12:40 p.m. with the Interim Director of Nursing (IDON), IDON stated medications should have open and discard dates to ensure been given for the maximum effect. IDON further stated residents might not get the maximum effect of medications if given past discard date. A review of the facility's policy and procedure titled, "Medication Administration General Guidelines," dated 1/21, indicated, "The nurse shall place a 'date opened' sticker on the medication ... and certain products have specified shortened end-of- use dating, once opened, to ensure medication purity and potency."	F 761	then monthly to ensure that outdated, contaminated, discontinued, undated medicine in medication and treatment carts are removed. Results of the audits will be presented to the administrator and reviewed at quarterly QAPI meetings. 90% compliance for 3 months will achieve substantial compliance.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804	**F804 Nutritive Value/Appear, Palatable/Prefer Temp** No specific resident was identified as having been affected by the alleged deficient practice. Any resident could potentially be affected by the alleged deficient practice.	2/9/2025

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F 804	Continued From page 15 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the nutritive values of food were conserved during preparation for a census of 33 residents, when Cook 1 prepared quiche (an entrée for lunch) without measuring the ingredients and following the recipe. This failure decreased the facility's potential to meet the residents' nutritional needs. Findings: During a concurrent observation and interview on 1/8/25 at 9:45 a.m. with Cook 1 in the main kitchen, Cook 1 was observed mixing the ingredients when cooking quiche. Cook 1 did not follow the recipe and poured unmeasured amounts of liquid eggs and heavy cream in a pot. Cook 1 confirmed she did not follow the recipe to cook quiche and stated she did not need to measure the amounts of liquid eggs and heavy cream. Cook 1 also stated she was unable to tell the exact numbers of servings to be prepared. A review of the facility's recipe titled, "Quiche Du Jour," dated 2024, indicated, one gallon (a unit of measure) plus three and quarter of a quart (a unit of measure) of liquid eggs, and three quarts plus three cups (a unit of measure) of heavy cream should be used to prepare 180 servings of quiche.	F 804	The Registered Dietician and/or Director of Culinary Experience in-service all chefs on 1/10/25 on following recipes, per policies Menus and Recipes and Food Preparation and safety. The Registered Dietician and/or Director of Culinary Experience will monitor food preparation one meal per week for one month and then minimum monthly thereafter to ensure chefs are preparing food according to recipes. Findings of audits will be provided to the administrator for review. The Registered Dietician and/or Director of Culinary Experience will present findings at the quarterly QAPI for follow up as needed. 100% compliance for two quarters will achieve substantial compliance.	

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F 804	Continued From page 16 During an interview on 1/8/25 at 10 a.m. with Executive Chef (EC), EC stated Cook 1 should have followed the quiche recipe with correct measured amounts of both ingredients. EC also stated the unmeasured amounts of ingredients might have altered the nutritive values of food. During an interview on 1/9/25 at 8:29 a.m. with the Administrator (ADM), ADM stated the expectation was Cook 1 should have followed the recipe and measured the amounts of ingredients to maintain the nutritive values of quiche cooked for the residents. ADM further stated foods with altered nutritive values might not meet the residents' nutritional needs. A review of the facility's policy titled, "Menus and Recipes," revised in 2017, indicated, "... Standardized recipes will be used in preparation of the menu ..." A review of the facility's policy titled, "Food Preparation and safety," revised in 2015, indicated, "... Foods are prepared per the recipes which include ... amounts of ingredients ... based on the diet counts which are available from the computerized tray card system ..."	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat	F 806	**F806 Resident Allergies, Preferences and Substitutes** Resident 15's historical food preferences were reviewed with his responsible party and preferences were noted in the tray system. The resident continues to receive food of	2/9/2025

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F 806	Continued From page 17 food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food preferences were accommodated to one of 22 sampled residents (Resident 15), when Resident 15's meal ticket did not match with lunch's meal tray. This failure had the potential to negatively impact the resident's nutritional status. Findings: A review of Resident 15's "Resident Face Sheet" indicated Resident 15 was admitted to the facility in 2019 with a diagnosis of paraplegia (loss of movement and/or sensation, to some degree, of the legs). A review of Resident 15's "Physician Order Report," dated 1/1/25 to 1/31/25, indicated Resident 15 had no capacity to understand choices and make health care decisions due to dementia (a progressive state of decline in mental abilities). The report further indicated Resident 15 had fortified diet (food that have nutrients added to them), mechanical soft (food that is easy to eat and does require lots of chewing) chopped, and bit size texture. During a concurrent observation and interview on 1/8/25 at 12:38 p.m. with Certified Nursing Assistant 2 (CNA 2) in the dining room, CNA 2 confirmed Resident 15's meal tray had chicken tamales with green sauce, refried beans, extra sauce, orange juice, milk, and water. CNA 2 also	F 806	historical preference and diet orders for medical and nutritional needs. Any resident could potentially be affected by the alleged deficient practice. An in-service was performed by the Food and Nutrition Manager to the dietary staff On 1/29/25 and 1/30/25 on the Nutritional Care, Screening and Assessment policy to include honoring resident's preferences and meeting medical and nutritional needs Food and Nutrition Manager and/or designee will perform daily audits for 2 weeks, then monthly for 2 months to ensure that the diet slip and meal match prior to delivery to a resident. Results of the audit will be given to the SNF Administrator. Results will be reported at QAPI for 3 months or until 100% compliance is reached.	

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F 806	Continued From page 18 confirmed the meal tray had different food choices compared to the meal ticket. A review of Resident 15's lunch meal ticket, dated 1/6/25, indicated the noon meal was potato soup, chicken supreme, herbed quinoa, green peas, garlic bread, coffee, whole milk, orange juice, apple juice, cranberry juice, and margarine with extra gravy sauce. During an interview on 1/9/25 at 2:01 p.m. with the Interim Director of Nursing (IDON), IDON stated the expectation was Resident 15's meal ticket should have reflected the food choices in the meal tray. A review of the facility's policy titled, "Nutritional Care, Screening and Assessment," dated 2/9/2017, indicated, "Food Preference will be maintained in the tray card system."	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(l)(1)(2) §483.60(l) 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	**F812 Food Procurement, Store/Prepare/Serve – Sanitary** No specific resident was identified as having been affected by the alleged deficient practice. Any resident could potentially be affected by the alleged deficient practice. Unlabeled and/or undated food items were discarded	2/9/2025

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F 812	Continued From page 19 §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 stored and prepared in accordance with professional standards for a census of 33 residents, when; 1. Unlabeled, expired, incorrectly dated, and soiled food items were found stored in the ready-to-cook area in the main kitchen; 2. Wet, dirty, and damaged cooking pans were found stored on the ready-to-use rack next to cooking area in the main kitchen; 3. A can-opener was found dirty, ready-to-use, and attached to the kitchen counter in the main kitchen; 4. The interior dispenser of ice machine had black, brown, and white substances on its surfaces in Skilled Nursing Facility (SNF) kitchen; 5. One kitchen staff touched the clean cutting board and knife with soiled gloved hands after touching multiple surfaces in the main kitchen; and 6. Ice buildup was found on the edges and frames of entry doors and on food boxes inside the walk-in freezers in the SNF and main kitchens. These failures decreased the facility's potential to provide sanitary conditions to store and prepare food for its residents. Findings:	F 812	Wet, dirty and damaged cooking pans were removed from service. Can opener was deep cleaned The interior dispenser in the ice machine was deep cleaned by an outside contractor on 1/6/2025. The ice machine was removed from service until after the deep cleaning and new ice was produced. The kitchen staff was in-serviced on Personal-Sanitary and Dress Standards by the Director of Culinary Experience on 1/8/2025. Registered Dietician/Director of Culinary Experience provided in-service to dietary staff on Food Storage, Ware washing, Sanitation and Cleaning, Ice, and Personal-Sanitary and Dress Standards on 1/8 and 1/10/2025. The Registered Dietician and/or Director of Culinary Experience will conduct weekly audits of the kitchen areas to ensure that food	

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F 812	Continued From page 20 1. During a concurrent observation and interview on 1/6/25 at 9:54 a.m. with Executive Chef (EC), foods and spices were observed in the main kitchen's cooking area. A bottle of citrus seasoned dressing and sauce was found partially used but unlabeled for open and expiry dates. A fish sauce bottle was found expired in 2024. A dark chili powder container was found with two labels indicating two different open and expiry dates. A box of kosher salt was found crumbled with moistened salt inside it. EC confirmed there were unlabeled, expired, incorrectly labeled, and soiled food items stored in the ready-to-cook area in the main kitchen. During an interview on 1/9/25 at 8:29 a.m. with Administrator (ADM), ADM stated any unlabeled, expired, incorrectly labeled, and soiled food items stored in the ready-to-cook area were unsafe. ADM also stated unsafe food items might cause food born illnesses and kitchen staff should have labeled all food items correctly once been opened. A review of the facility's policy titled, "Food Storage," dated 10/29/18, indicated, "... Opened packages of dry food which are to be stored will be dated upon opening ..." 2. During a concurrent observation and interview on 1/6/25 at 10:05 a.m. with EC, cooking pans were observed on the ready-to-use rack next to the main kitchen's cooking area. Fifteen hotel pans size six and 20 hotel pans size three were found stored wet. Seven frying pans were found stored dirty with interior surfaces covered with oil and food crumbs. Twenty nonstick frying pans were found stored with eroded interior surfaces. One big cooking pan was found stored with	F 812	storage and sanitation requirements meet professional standards for food service safety. Findings of weekly inspections will be provided to the administrator for review. Maintenance will place ice machine cleaning monthly inspection in TELS and increase contractual cleaning to every 3 months, versus the 6 month manufacturer recommendations. The Registered Dietician, or Director of Culinary Experience will present findings at quarterly QAPI for follow up as needed. 90% compliance for two quarters will achieve substantial compliance.	

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F 812	Continued From page 21 interior surface covered with yellowish-orange colored substance. EC confirmed wet, dirty, and damaged pans were stored on the ready-to-use rack next to the main kitchen's cooking area. During an interview on 1/9/25 at 8:29 a.m. with ADM, ADM stated staff should have not stored wet, dirty, and damaged cooking pans. ADM also stated wet, dirty, and damaged pans might become sources of food contamination and all cooking pans stored on the ready-to-use rack should have been undamaged, clean, and dry. A review of the facility's policy titled, "Ware Washing," dated 7/17/15, indicated, "... pans ... washed ... rinsed ... sanitized ... inverted on drain board. Let air dry ..." 3. During a concurrent observation and interview on 1/6/25 at 9:37 a.m. with EC, a can-opener was observed attached to the kitchen counter and ready to be used in the main kitchen. The can-opener tip and other parts were found covered with brownish-black substance. EC confirmed the can-opener was dirty and needed to be cleaned. During an interview on 1/9/25 at 8:29 a.m. with ADM, ADM stated a dirty can-opener should have not been placed for ready to use. ADM further stated dirty equipment might cause food contamination and food born illnesses among residents and expected all equipment to be kept clean for food safety. A review of the facility's policy titled, "Sanitation and Cleaning," dated 10/29/18, indicated, "... All equipment shall be kept clean ..."	F 812		

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	555555	A. BUILDING _____ B. WING _____	01/09/2025

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F 812	Continued From page 22 4. During a concurrent observation and interview on 1/6/25 at 10:21 a.m. with Dietary Manager (DM) and Director of Environmental Services (DES), the interior dispenser of ice machine in SNF kitchen was observed. The surfaces of interior dispenser were found covered with black, brown, and white substances. Both DM and DES confirmed the interior dispenser of ice machine was dirty and ice was exposed to its dirty surfaces. DM stated the interior of ice machine needed immediate cleaning. During an interview on 1/9/25 at 8:29 a.m. with ADM, ADM stated dirty interior of ice machine might cause contamination of the ice. ADM also stated contaminated ice could cause food borne illnesses among residents and expected the interior of ice machine to be maintained clean at all times.. A review of the facility's policy titled, "Ice," dated 10/29/18, indicated, "... Maintenance is responsible for thoroughly cleaning the ice machine ... and will keep a cleaning log ..." 5. During a concurrent observation and interview on 1/08/25 at 8:35 a.m. with Cook 2 and EC in the main kitchen, Cook 2 was observed wearing single use gloves in the cooking area. Cook 2 touched the clean cutting board and knife with soiled gloves after touching multiple surfaces. Cook 2 confirmed he cleaned the kitchen counter, touched his apron and face with same pair of gloves, did not change the soiled gloves and then touched the clean cutting board and knife. Cook 2 stated he was getting ready to use that cutting board and knife to chop the sausage. EC confirmed Cook 2 touched the clean cutting board and knife with soiled gloves and the food	F 812		

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F 812	Continued From page 23 preparation surfaces might have been contaminated. During an interview on 1/9/25 at 8:29 a.m. with ADM, ADM stated Cook 2 should have not touched the food preparation utensils and surfaces with soiled gloves because touching food preparation areas and surfaces might have caused cross contamination to the food cooked in the main kitchen. ADM also stated Cook 2 should have changed his single-use gloves after each task. A review of the facility's policy titled, "Personal-Sanitary and Dress Standards," dated 3/24/24, indicated, "... Gloves are not to be used as a replacement for frequent, proper hand washing and gloves must be changed when going from dirty to clean operations ..." 6. During a concurrent observation and interview on 1/6/25 at 8:45 a.m. with DM in SNF kitchen, the walk-in freezer was observed. Ice built-up was found on the door edges and frame of walk-in freezer. Big chunks of ice were also found on boxes containing food. DM confirmed the door edges and frame of walk-in freezer were covered with ice built-up and ice chunks were found on top of food boxes inside the freezer. During a concurrent observation and interview on 1/6/25 at 3:07 p.m. with EC in main kitchen, the walk-in freezer was observed. The door edges and frame of walk-in freezer were found covered with ice built-up. Ice was also found accumulated on the food boxes inside the freezer. EC confirmed the walk-in freezer door in main kitchen was not closing properly due to ice built-up and ice accumulated on food boxes.	F 812		

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F 812	Continued From page 24 During an interview on 1/9/25 at 8:29 a.m. with ADM, ADM stated no built-up ice should have been on the doors, frames, or food boxes inside the walk-in freezers in the SNF and main kitchens. ADM expected kitchen staff to report this issue to the maintenance staff on a routine basis and stated ice built-up on the edges and frames of walk-in freezer doors interfere with door closing and might affect the quality of food stored inside. A review of the facility's policy titled, "Sanitation and Cleaning," dated 10/29/18, indicated, "All kitchens, kitchen areas ... shall be kept clean, maintained in good repairs ... and freezers to be cleaned monthly ..."	F 812		
F 880 SS=D	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	F 880	**F880 Infection Prevention & Control** Resident 31 has the potential to be affected by the alleged deficient practice. Infections Preventionist provided a 1 on 1 in-service to CNA3 on 1/06/25 on proper use of PPE. All residents assigned to CNA3 have the potential to be affected by this alleged deficient practice.	2/9/2025

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F 880	Continued From page 25 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: (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.	F 880	Infection Preventionist (IP) performed an in-service to licensed nurses and CNA staff Categories of Isolation Precautions and the use of PPE on 1/24/25 IP will perform daily rounds for 2 weeks, weekly thereafter for 2 months to monitor compliance of proper PPE use. Deficient practices observed will be provided immediate re-education and corrective action will occur. Data will be summarized weekly while analyzing for patterns and trends. Results of the audit will be given to the DON/Administrator. Results will be reported at quarterly QAPI for the next 3 months or until 90% compliance is reached.	

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F 880	Continued From page 26 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 maintain infection control practices for a census of 33 residents, when Certified Nursing Assistant 3 (CNA 3) did not use gown and gloves in an isolation (separation of residents with an infection from residents without an infection) room. This failure had the potential to increase the spread of infection among residents. Findings: A review of Resident 31's "Resident Face Sheet," indicated Resident 31 was admitted to the facility in 2023 with a diagnosis of pneumonia (an infection/inflammation in the lungs). During a concurrent observation and interview on 1/6/25 at 9:30 a.m. with CNA 3, Resident 31's room had a contact isolation sign on the door. The sign indicated staff to use gown and gloves when entering the room. CNA 3 went inside Resident 31's room and collected the meal tray from the bedside without using gown and gloves. CNA 3 confirmed she should have used gown and gloves while providing care in an isolation room. During an interview on 1/8/25 at 10:46 a.m. with	F 880		

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F 880	Continued From page 27 the Infection Preventionist (IP), IP stated the expectation was staff to wear gown and gloves when providing care to residents in isolated precaution rooms. IP further stated there could have been a chance for cross contamination to other residents when not using gown and gloves. During an interview on 1/9/25 at 2:01 p.m. with the Interim Director of Nursing (IDON), IDON stated staff should have used gown, gloves, and/or face shield when providing care to residents in contact isolation rooms. IDON further stated there could have been cross contamination of infection among other residents when staff did not use gown and gloves. A review of the facility's policy titled, "Categories of Isolation Precautions," dated 6/24/2024, indicated, "... All staff must wear appropriate Personal Protective Equipment (PPE) to include glove (clean, nonsterile) when entering the room, regardless of tasks being performed ... Wear a gown (clean, nonsterile) when entering the room ..."	F 880	**F908 Essential Equipment, Safe Operating Condition** No specific resident was identified as having been affected by the alleged deficient practice. Any resident could potentially be affected by the alleged deficient practice. Excess lint was removed and discarded.	2/9/2025
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to safely operate the dryer for a census of 33 residents, when the dryer's lint compartment was not cleaned accordingly.	F 908		

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F 908	Continued From page 28 This failure decreased the facility's potential to prevent a fire hazard. Findings: During a concurrent observation and interview on 1/8/25 at 11:04 a.m. with Laundry Staff (LS) in the laundry room, the three lint compartments of the dryers were inspected. LS opened the lint compartment, rolled up two thick layers of lint, and discarded it. LS confirmed she did not clean the lint compartment at the beginning of her shift. During a concurrent interview and record review on 1/9/25 at 8:41 a.m. with the Housekeeping Supervisor (HS), the lint compartment log was reviewed. HS expected staff to clean the lint compartment every two hours and stated it would have been a fire hazard if staff did not clean the lint compartment frequently. A review of the facility's "Cleaning the Lint Compartments Log" for January 2025, indicated morning and evening laundry staff should have cleaned the lint trap every two hours and documented it. The log further indicated there was missing documentation of removing lint every two hours on seven occasions at evenings during the month of January 2025. A review of the facility's policy titled, "Supplies and Equipment," dated 12/29/16, indicated, "Housekeeping/Laundry/Nursing department supplies, and equipment shall be readily available so that department personnel can perform necessary tasks. Equipment must be ready for use at all times of the day and night to serve the residents' needs. Care should be exercised in the handling and in the use of equipment to prevent	F 908	Housekeeping supervisor performed in-service to laundry staff on the cleaning of the lint trap and completion of the 2 hour logs and policy on Supplies and Equipment on 1/18/25. Housekeeping supervisor will review cleaning logs daily for 2 weeks, then weekly for 2 months to ensure compliance. Results will be given to Administrator. Results will be reported at QAPI for the next 3 months or until 90% compliance is reached.	

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F 908	Continued From page 29 damage or breakage."	F 908		