POC & EOC Received 4/9/24
Approved 4/19/24
BIC = 4/3/24 per ADJ

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

PRINTED: 04/03/2024
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
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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. Representing the Department of Public Health: Health Facilities Evaluator Nurse (HFEN), 46242 HFEN, 49814 HFEN, 46995 HFEN, 48860 HFEN, 48140 HFEN, 49821 Dietician Consultant, 40830 The facility census was 99. The sample size was 24.	F 000	The preparation and execution of this Plan of Correction do not constitute admission of agreement by the Provider of true facts alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because the provision of the Federal and State law require it. This Plan of Correction constitutes the Facility's credible allegation of compliance.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed 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;	F 803	F 803 I. Corrective Action: The District Manager for Healthcare Services Group and the Regional Dietician initiated re-education on Tray Accuracy and Portion Control to the dietary staff on 3/21/2024. II. Residents who may be affected by the deficient practice: NO ill effect noted on the residents as a result of the observed deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 04/09/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 803	Continued From page 1 §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 that the menu was being followed for the therapeutic diet for lunch on 3/20/24 when: 1. Seven residents (Resident 2, 4, 6, 16, 20, 41, and 408) were on modified texture diets Dysphagia mechanical soft (a diet for people with mild to moderate chewing and/or swallowing difficulty) and Dysphagia advance (a diet for people with mild chewing and/or swallowing difficulty and usually more soft and moist for food tolerance) who received no gravy for the meat entrée instead of receiving gravy as indicated on the menu; 2. Two residents (Resident 403 and 405) on TLC (Therapeutic Lifestyle Change, a diet for people who are trying to reduce blood cholesterol levels and risk of heart disease, diet with limited added sugar, saturated fat, and reduced sodium) diet who received gravy on the pork chop instead of no gravy as indicated on the menu; 3. Three residents (Resident 14, 303, and 553) who were on Renal diet (diet to treat chronic or acute kidney disease) and CCD (control carbohydrate diet - diet to treat diabetes and control blood sugar level)/Renal diet received cake instead of cookie for dessert, and received	F 803	F 803 III. Systemic changes to prevent recurrence: On 3/21/24, the District Manager for Healthcare Services Group and the Regional Dietitian initiated re-education on Tray Accuracy & Portion Control for the dietary staff. The Dietary Manager or designee will tray accuracy audit with the dietary staff at least 3 times a week to review the menus and expectations of how to prepare and serve the meals. (Copy of the In-service attached) IV. Monitoring: The Dietary Manager or designee will conduct tray accuracy audits 3 times a week for 3 months. The results of the audits will be reported to the QAA Committee for 3 months and then reevaluated thereafter. V. Completion Date: 03/29/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 803	Continued From page 2 gravy on the pork chop instead of no gravy, and 4. Two residents (Resident 65 and 402) who were on CCD diet received sweet potato instead of mashed potato per the menu. These failures had the potential to result in compromising the medical and nutrition status of those 14 residents. Findings: During an observation of lunch meal service on 3/20/24 beginning at 12:10 p.m., it was noted as followed: 1. Residents 2, 4, 6, 16, 20, 41, and 408 were on dysphagia mechanical soft and dysphagia advance diets who did not received gravy for the meat entrée. A concurrent review of the undated facility document titled, "2023-2024 Diet Guide Sheet," showed that dysphagia mechanical soft and dysphagia advance diet should receive two ounces (oz.) of gravy for the meat entrée. 2. Residents 403 and 405 were on TLC diet wo received gravy on the pork chop. A concurrent review of the undated facility document titled, "2023-2024 Diet Guide Sheet," showed that TLC diet should not receive gravy for the pork chop. 3. Residents 14, 303, and 553 were on Renal diet and CCD/Renal diets who received cake for dessert. A concurrent review of the undated facility document titled, "2023-2024 Diet Guide Sheet," showed that Renal and CCD/Renal diets should receive cookie as dessert. 4. Residents 65 and 402 were on CCD diet who	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 803	Continued From page 3 received sweet potato. A concurrent review of the undated facility document titled, "2023-2024 Diet Guide Sheet," show that CCD diet should receive mashed potato. During an interview with the Regional Registered Dietitian (RRD) on 3/20/24, at 1:33 p.m., she acknowledged and the residents who were on therapeutic and/or modified texture diets received the incorrect food items and stated the staff needed to pay attention and the staff needed to follow the menu/spreadsheet when they prepared meals for the residents. During an interview with the Registered Dietitian (RD) on 3/21/24, at 9:10 a.m., she stated the staff should have followed the menu or spreadsheet during preparing meals which may make the meal under- or over- nutrition and affect the nutrition needs for the residents. A review of facility document, titled "Job Description: Cook," showed " ...The Cook prepares and serves food including texture modified and therapeutic diets according to the facility menu ...adhere to menus and portion control stands, including those for special diets when preparing and serving meals ..."	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	F 812	F 812 I. Corrective Action: 1. The ice machine was immediately shut down on 3/19/24 and ice was obtained from the facility's secondary ice machines.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 812	Continued From page 4 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility document review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety when: 1. Ice machine was not clean, 2. The food storage racks were not well maintained in the walk-in refrigerator and walk-in freezer, and 3. The temperature of the freezer sections of the resident's food refrigerators located in nurse station one (1) and two (2) were not monitored. These failures had potential to cause food-borne illness in a highly susceptible population of 97 out of 98 residents who consumed meals or food in the facility. Findings: 1. During an initial kitchen tour on 3/19/24, at 9:30 a.m., a concurrent interview and observation of	F 812	F 812 2. New storage racks were ordered on 03/20/2024. 3. The log for the resident food refrigerators was immediately revised on 3/19/24 to include a column for recording the temperature of the freezer. A thermometer was already in place in each freezer. All frozen items were immediately checked on 3/19/24 and all items were found to be frozen and temperature readings were at zero degrees. II. Residents who may be affected by the deficient practice: 1. Maintenance Director checked all secondary ice machines on 03/20/2024 and no deficiency was noted. 2. New storage racks were delivered on 04/03/2024 and were immediately installed. 3. On 03/19/2024, the DSD checked the refrigerators on both stations and no food items were stored in the freezer. There is no resident affected by the observed deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 812	Continued From page 5 the ice machine was conducted. The Maintenance Supervisor (MS) stated he was responsible for the cleaning and sanitizing the ice machine. He stated he would take the parts out from the machinery part of the ice machine to clean and sanitize weekly. The MS stated he did the deep cleaning monthly and quarterly which included cleaning and sanitizing the machinery parts, running the chemical cycles, and the ice storage bin. Upon the ice machine dissemble, there were significant black and brown stains with scratches observed on the bottom of the evaporator unit (the part where conducts the heat exchange with water and freezes the water into ice cubes). The MS confirmed and he stated he scrubbed the bottom of the evaporator unit every time when he cleaned the machinery part of the ice machine, but the stains did not come off. He stated the scratches were old and the surface was not smooth, and the machinery part of the ice machine was old which might need to replace. During an interview with the Registered Dietitian (RD) on 3/21/24, at 9:10 a.m., she stated the scratches on the bottom of the evaporator unit surface could be easily harbor microorganisms which could contaminate the ice. The RD added the food contact surface should be smooth and could be cleaned easily. A review of departmental policy and procedure, titled, "Equipment," dated 9/2017, it stated, " ...all foodservice equipment will be clean, sanitary, and in proper working order ..." A review of departmental policy and procedure, titled, "Ice," dated 9/2017, it stated, " ...Ice will be prepared and distributed in a safe and sanitary manner ..."	F 812	F 812 III. Systemic changes to prevent recurrence: 1. A revisit of the policy on Ice Machines was done by the Regional Maintenance Director to the Facility's Maintenance Director on 03/20/2024. 2. New storage racks were ordered 03/20/2024 and Registered Dietician revisited the policy on the Equipment and Food Storage with the Certified Dietary Manager on 03/20/2024. 3. The log for the resident food refrigerators was immediately amended on 3/19/2024 to include a column for recording the temperature of the freezer. (copies of invoices and revised log attached) IV. Monitoring Process 1. The maintenance Director or designee will inspect the inside of the ice machine for cleanliness on a weekly basis. In addition, the dietitian or dietary manager will perform a monthly check of the ice machine for cleanliness as part of their kitchen sanitation rounds. The results of the audits will be reported to the QAA Committee for 3 months and then reevaluated thereafter or until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 812	Continued From page 6 According to FDA (Food and Drug Administration) Food Code 2022, 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 an observation in the walk-in freezer and walk-in refrigerator on 3/19/24, at 9:12 a.m. and 9:16 a.m., observed there were two food storage metal racks in the walk-in freezer and two racks in walk-in refrigerator with brown substances. A concurrent interview with the Food and Nutrition Service Director (FNSD), she confirmed the brown substance was rust on the food storage metal racks. The FNSD stated she was aware of the rust and was working on the replacements. A review of departmental document, titled "Kitchen Sanitation Checklist," completed on 1/2024 by the Regional Registered Dietitian (RRD), it indicated the RRD commented the walk-in refrigerator food storage metal racks showed signs of rust. A review of departmental policy and procedure,	F 812	F 812 2. The dietitian or designee will conduct monthly kitchen sanitation checks to include inspecting storage racks to ensure they are free from rust or other residue. The results of the audits will be reported to the QA Committee for 3 months and then reevaluated thereafter or until substantial compliance is achieved. 3. The DSD or Designee will conduct an audit at least three days per week for 3 months to ensure that the temperature of the resident refrigerator freezer is logged daily. The results of the audits will be reported to the QA Committee for 3 months and then reevaluated thereafter or until substantial compliance is achieved. V. Completion date: 03/29/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 812	Continued From page 7 titled, "Equipment," dated 9/2017, it showed, " ...all non-food contact equipment will be clean and free of debris ..." According to FDA Food Code 2022, on Section 4-101.19 Nonfood-Contact Surfaces, it showed, " ...Nonfood-Contact Surfaces of equipment ...shall be constructed of a corrosion-resistant, nonabsorbent, and smooth material ..." On Section 4-101.11 Characteristics, " ...Smooth means ...a nonfood-contact surface of equipment having a surface equal to that of commercial grade hot-rolled steel free of visible scale ..." 3. During an observation of the resident's food refrigeration units (unit with combination of refrigerator and freezer) located at nurse station 1 and 2 on 3/19/24, at 12:29 p.m. and 12:42 p.m., there was a concurrent interview with the Assistance Director of Nurses (ADON) regarding the freezers' temperature monitor logs. She stated the refrigerators and freezers usually monitor temperature by the Director of Staff Developer (DSD). The ADON stated they did not have any monitor logs for both freezers when she reviewed the temperature monitor log folders for nurse station 1 and 2. During a follow up interview with the ADON on 3/19/24, at 2:29 p.m., she confirmed and stated she could not locate any records for the freezers' temperature monitor logs. The ADON stated the nurses did not monitor the temperature for both freezers of the resident's food refrigerators in nurse station 1 and 2. During an interview with the DSD on 3/20/24, at 9:45 a.m., she was aware that the policy and procedure said monitor refrigerator and freezer	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 812	Continued From page 8 temperature for the resident's food refrigerator daily. The DSD stated she did not monitor the freezer temperatures and she would start to monitor as of now. A review of facility policy and procedure, titled, "Safe Handling of Foods from Visitor," dated 8/25/21, it indicated, " ...b. have temperature monitored daily for refrigeration ...and freezer ..."	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 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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:	F 880	F 880 I. Corrective Action 1. The identified resident with an indwelling catheter bag on the floor was immediately removed from the floor and a dignity bag was placed; 2. The identified staff was educated on 03/21/2024 by the DSD. II. Resident who may be affected by the deficient practice 1. DSD made rounds with all the residents with an indwelling catheter on 03/19/2024 to check if there is any other resident with indwelling catheter on the floor, NONE identified. 2. Staff assigned to the rooms on EBP/ ESP were observed by the DSD on 03/22/2024 and NO other direct care staff observed with the noted deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 880	Continued From page 9 (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. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880	F 880 III. Systemic changes to prevent recurrence: Nursing staff have been re-educated on the Facility's policy on catheter care by the DSD on 03/20/2024; and on enhanced standard precautions on 03/22/2024. Copies of in-services attached. IV. Monitoring Process Rounds will be completed on all residents with indwelling catheter at varied times/shifts by the IP/DSD/Designee. Findings shall be reported to the QA monthly meeting for 3 months and evaluate if further actions or recommendations are needed. V. Completion Date: 03/29/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 880	Continued From page 10 Based on observation, interview, and record review the facility failed to follow infection control standards of practice for two of 24 sampled residents (Resident 204 and Resident 7) when: 1. Resident 204's indwelling catheter (tube placed into the bladder to collect urine) bag was lying on the floor and, 2. EBP/ESP (Enhanced Barrier Precautions/Enhanced Standard Precautions-infection control interventions designed to reduce transmission of multi drug organism [MDRO] which involve gown and glove use during high contact resident care activities) were not followed for Resident 7. These failures decreased the facility's potential to prevent the spread of infection. Findings: 1. Resident 204 was admitted to the facility early 2024 with diagnoses which included benign prostatic hyperplasia (BPH, enlargement of the prostate gland), and history of urinary tract infections. Minimum Data Set, (MDS, an assessment tool) dated 3/20/24 indicated Resident 204 had an indwelling catheter. During a review of Resident 204's "Order Summary Report [OSR]," dated 3/22/24, the OSR indicated, "[brand name of indwelling catheter] catheter...to drainage bag..." During a review of Resident 204's "Care Plan Detail [CP]," undated, the CP indicated, "Resident requires indwelling catheter...Resident will have no signs and symptoms of urinary tract infection...Keep catheter off floor..."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 880	Continued From page 11 During a concurrent observation and interview on 3/19/24 at 9:23 a.m. with Certified Nursing Assistant (CNA 1) in Resident 204's bedroom, the urinary catheter bag was lying directly on the floor under his bed. CNA 1 confirmed the urinary catheter bag was on the floor and stated, "They are not supposed to be like that, they should be hanging and not on the floor..." During an interview on 3/21/24 at 3:10 p.m. with the Director of Nursing (DON), the DON was shown a picture of the indwelling catheter bag for Resident 204 lying on the floor. DON confirmed the findings and stated,"...catheter bags should never be on the ground and should be on the bed hanging..." The DON stated the catheter bag on the floor increased the risk for infection. During a review of the facility's policy and procedure (P&P) titled, "Catheter Care, Urinary," undated, the P&P indicated, "The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections...Be sure the catheter tubing and drainage bags are kept off the floor..." 2. Resident 7 admitted to the facility mid 2019 with diagnoses which included persistent vegetative state (when a person shows no sign of awareness). MDS, dated 1/30/24, indicated Resident 7 had a feeding tube (tube placed in to the stomach to give nutrition). During a review of Resident 7's OSR dated, 3/22/24, the OSR indicated, "NPO [nothing by mouth]...Enteral Feed Order..." During a concurrent observation and interview on 3/20/24 at 9:54 a.m. of Resident 7's care, two	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 880	Continued From page 12 certified nursing assistants (CNA 2 and CNA 3) entered his room wearing gloves, mask, but no gown. There was a sign outside Resident 7's door, directly above the name plate which indicated, "Enhanced Standard Precautions....ANYONE PARTICIPATING IN ANY OF THESE SIX MOMENTS MUST ALSO: Don gown and gloves...Toileting & changing incontinence briefs..." The CNA's changed the incontinence brief of Resident 7 without wearing gowns. CNA 2's shirt touched the bed during care. CNA 2 exited the room and when shown the sign, confirmed she was not wearing a gown during the brief change, and stated they did not need to wear a gown during care. During an interview on 3/21/24 at 2:42 p.m. with the Assistant Director of Nursing (ADON), when asked the procedure for ESP care, the ADON stated, "If they provide contact...expect they wear gown and gloves." When asked why it was important to wear gown during care of a patient on ESP the ADON stated, "...you want to make sure you protect yourself and the residents...don't want to transmit infection." During a review of the facility's P&P titled, "Enhanced Standard/Barrier Precautions," dated 8/22, the P&P indicated, "Enhanced standard/barrier precautions [ESP/EBPs] are utilized to prevent the spread of multi-drug resistant organisms [MDROs] to residents...ESP/EBP employ targeted gown and glove use during high contact resident care activities...ESP/EBP are indicated... for resident with wounds and/or indwelling medical devices regardless of MDRO colonization..."	F 880		
F 887 SS=E	COVID-19 Immunization	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 887	Continued From page 13 CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with	F 887	F 887 I. Corrective Action An audit was immediately done to all the residents not receiving the Covid-19 immunization on 03/21/2024 by the Interim Infection Preventionist together with the DON. II. Residents having the potential to be affected by the deficient practice. NO ill effect as a result of the deficient practice was noted. Immunization consent obtained from identified residents. III. Systemic changes to prevent recurrence: A revisit of the regulation, CDC recommendation and Facility Policy was done on 03/22/2024 by the DON to the Interim IP and DSD. Interim IP started with the distribution of the informed consents via in person for the self-responsible, phone call for those that are not self responsible and those that cannot be reached were posted in the PCC communication board for follow up on 03/22/2024. All consents shall be uploaded in the PCC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 887	Continued From page 14 COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and e vaccine related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide documentation for current COVID-19 (a contagious viral disease that can cause severe respiratory distress) immunizations for three of seven sampled residents (Resident 7, Resident 61, and Resident 73) when there was no documentation of the vaccine being offered, given or refused. These failures decreased the facility's potential to prevent prevent or reduce the severity of COVID-19 . Findings: Resident 7 admitted to the facility mid 2019 with diagnoses which included persistent vegetative state (when a person shows no sign of awareness), history of pneumonia, and history of	F 887	F. 887 Endorsement shall be made upon the return of the IP to ensure continuity of the system that was put into place as monitored by the DON and Administrator. IV. Monitoring All Covid-19 immunizations that were administered and or declined from the identified residents shall be reported during the monthly QA meeting for 3 months by the Infection Preventionist. The QA Committee shall make appropriate recommendations and or suggestions as indicated. V. Completion Date: 03/29/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 887	Continued From page 15 COVID-19. During a review of Resident 7's "Immunization Report [IR]," dated 3/2024, the IR indicated, "Covid-19 Vaccination Dose 3...consented...administered 11/09/2021." Resident 61 admitted to the facility mid 2019 with diagnoses which included cerebral infarct (lack of adequate blood supply to the brain). During a review of Resident 61's IR dated 3/2024, the IR indicated, "Covid-19 Vaccination Dose 3...consented...administered 11/16/2021." Resident 73 was initially admitted to the facility late 2020 with diagnoses which included history of COVID-19. During a review of Resident 73's IR, dated 3/2024, the IR indicated, "Covid-19 Vaccination Dose 3...consented...administered 11/16/2021." During a concurrent interview and record review on 3/21/24 at 3:48 p.m. with the Director of Nursing (DON), Resident 7, Resident 61, and Resident 73's, vaccination records were reviewed. The DON confirmed there were no documented current 2023-2024 COVID vaccines, consents, or refusals. When asked the process for offering vaccinations the DON stated, "The previous IP [Infection Preventionist] sent out a mass text to families when vaccines were available for the residents...if they agree they can come in and sign the consents..." When asked if there was any follow up after the text was sent to families, the DON stated, "I don't see any..." When asked the expectations for how COVID -19 vaccinations were tracked, the DON stated, "My	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 887	Continued From page 16 expectation is like any other vaccine. There should be a consent that says yes or no..." During a phone interview on 3/22/24 at 10:19 a.m. with Resident 61's Family Member (FM 1), FM 1 was asked if she had received any messages which offered COVID-19 vaccination and stated she had not received any text or email. During a phone interview on 3/22/24 at 10:29 a.m. with Resident 73's FM 2, FM 2 was asked if she had received any message which offered COVID-19 vaccination and stated, "Not recently, but they did send out a text." During a review of the facility's policy and procedure (P&P) titled, "SNF CLINIC Coronavirus Disease [COVID-19]- Vaccination of Residents," dated 6/22, the P&P indicated, "Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated...Booster vaccine doses are provided in accordance with current CDC guidance...The resident's medical record includes documentation that indicates, at minimum, the following...That the resident or resident representative was provided education...signed consent...Each dose of COVID-19 vaccine that was administered to the resident...If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination or refusal, appropriate documentation is made in the resident's record..." During a review of the cdc.gov website page titled, "Vaccines & Immunizations," the website indicated, "COVID-19 vaccine recommendations have been updated as of February 28, 2024, to	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. BUILDING _____ B. WING _____	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE 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 887	Continued From page 17 recommend adults ages 65 years and over receive an additional updated 2023-2024 COVID-19 vaccine dose..."	F 887		