STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. BUILDING _____ B. WING _____	06/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification survey. Representing the Department of Public Health: Health Facilities Evaluator Nurse (HFEN), 40841 HFEN, 44971 HFEN, 45770 HFEN, 48694 HFEN, 48860 HFEN, 49821 HFEN, 50282 HFEN, 50368 Registered Dietician, 40830 Pharmacy Consultant, 41600 The facility census was 38. The sample size was 15. No complaint or facility reported incident was investigated during the Recertification Survey.	F 000	POC Received 6/25/24 POC Approved 7/2/24 BIC = 7/2/24 per TG	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least	F 636		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Darrell Price | Executive Director | 6/24/24

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

MOUNTAIN MANOR SENIOR RESIDENCE makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this plan of correction is an admission otherwise.

MOUNTAIN MANOR SENIOR RESIDENCE is submitting this plan of correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any of allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This plan of correction constitutes MOUNTAIN MANOR SENIOR RESIDENCE's written credible allegation of compliance for the deficiencies noted.

F-636:

It is the facility's policy to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity, using the resident assessment instrument (RAI) specified by CMS, within the required timeframes (F636).

Corrective Action for Affected Residents:

The MDS assessment for Resident 9 was completed on 1/11/24, resident 21 on 1/30/24

Identifying other Residents having the Potential to be Affected:

- On 6/8/24, the MDS Coordinator audited all residents admitted within the past 30 days to ensure comprehensive MDS assessments were completed within 14 days of admission. No other residents were found to be affected.

Measures put into place or Systemic Changes:

- On 6/25/24, the Administrator provided re-education to the MDS Coordinator on the facility's "MDS Completion and Submission Timeframes" policy, emphasizing the requirement to complete admission assessments within 14 days of admission.

Plan to Monitor Performance:

- The DON or designee (Medical Records) will audit 5 resident admissions weekly x4 weeks, then 5 resident admissions monthly x2 months to ensure comprehensive admission assessments are completed within 14 days.

- Medical Records will report monitoring results of the timeliness of the MDS assessments to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.

All corrective action to be completed by 7/4/24.

F-656:

It is the facility's policy to 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.

Corrective Action for Affected Residents:

On 6/4/24, the ADON developed and implemented a comprehensive person-centered care plan for Resident 491 that addressed the resident's dialysis care and interventions. The care plan includes measurable objectives and timeframes related to the resident's dialysis schedule, monitoring, and any special considerations.

Identifying other Residents having the Potential to be Affected:

The ADON and Case Manager conducted a full audit on 6/4/24 of all current residents receiving dialysis to ensure their care plans comprehensively address their dialysis care and interventions. No other residents were receiving dialysis care at the time.

Measures put into place or Systemic Changes:

The DON or designee will provide re-education to all licensed nursing staff and Medical Records staff on the facility's policy for developing and implementing comprehensive person-centered care plans, with emphasis on ensuring care plans address residents' specialized services such as dialysis.

Plan to Monitor Performance:

Beginning 6/25/24, the ADON or designee will conduct random weekly audits of care plans for residents receiving dialysis to verify they comprehensively address the residents' dialysis care, for 4 weeks. If compliance is maintained, the audits will be reduced to monthly for 2 months. Audit results will be reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee for review and recommendations. The QAPI committee will determine the need for continued monitoring based on audit outcomes.

The DON will be responsible for reporting the results of this monitoring to the quarterly QAPI committee. The QAPI committee will monitor the results on an ongoing basis until substantial compliance with the set-forth protocol is achieved.

All corrective action will be completed by 7/4/24.

F658:

It is the facility's policy that the services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality (483.21(b)(3)(i)).

Corrective Action for Affected Residents:

On 6/5/24, the Assistant Director of Nursing (ADON) entered the physician's order for the knee immobilizer into the E.H.R. Prior to the order being entered into the E.H.R. it was care planned and being followed by staff, however, the physician order received from the discharging hospital was not caried out in the facility E.H.R. as it should have at admission.

Identifying other Residents having the Potential to be Affected:

On 6/5/24, the Case Manager, Rehab Director, and ADON conducted an audit of all current residents to identify any other residents using orthopedic devices without a corresponding physician's order. No other residents were identified.

Measures put into place or Systemic Changes:

The DON or designee will re-educated all licensed nursing, therapy, and medical records staff on the facility's "Medication and Treatment Orders" policy, emphasizing that verbal orders, including those for orthopedic devices, must be recorded immediately in the resident's chart.

- Beginning 6/7/24, the DON or designee will audit all new admissions within 24 hours to ensure any orthopedic devices in use have a corresponding physician's order. This will continue until 100% compliance is achieved for 4 consecutive weeks.

Plan to Monitor Performance:

- The DON or designee will conduct random audits of 5 residents per week for 4 weeks, then 5 residents per month for 2 months to ensure any orthopedic devices in use have a corresponding physician's order.

- Audit results will be reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee by the DON.

- The QAPI committee will monitor results and make recommendations for ongoing compliance.

All corrective action will be completed by 7/4/24.

F677:

It is the facility's policy that 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, per 483.24(a)(2).

Corrective Action for Affected Residents:

On 6/5/24, Resident 25 received nail care prior to discharge home. Resident 25's nails were trimmed and cleaned by the Case Manager

Identifying other Residents having the Potential to be Affected:

On 6/5/24, the ADON and Case Manager initiated a 100% audit of all current residents to identify any other residents with deficient nail care. No other residents were identified with deficient nail care.

Measures put into place or Systemic Changes:

A review and revision of the facility's "Care of Fingernails/Toenails" policy and procedure occurred finding revisions were needed. Revisions included specifying the roles and responsibilities of CNAs, Licensed Nurses, and Activities Aides in providing nail care, as well as the process for CNAs to report nail care needs to the appropriate staff. The revised policy was approved by the Quality Assurance Performance Improvement (QAPI) committee on 6/25/24.

The Staff Development Director or designee will provide re-education of all CNAs, Licensed Nurses, and Activities Aides on the revised "Care of Fingernails/Toenails" policy and their roles in the nail care process. This education will be completed by 7/4/24. Any staff not educated by 7/4/24 will not be allowed to work until educated. This education has been added to the orientation process for all new hires.

Plan to Monitor Performance:

- Beginning 7/1/24, the DSD or designees will conduct random weekly audits of 5 residents per unit to ensure nail care is being provided per the "Care of Fingernails/Toenails" policy. This will continue until 100% compliance is achieved for 6 consecutive weeks.

- The DON or designee will report the results of these audits to the monthly QAPI committee for review and recommendation. The QAPI committee will determine the ongoing frequency of audits based on findings.

All corrective action to be completed by 7/4/24.

F684:

It is the facility's policy to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Corrective Action for Affected Residents:

On 6/4/24 the order for floating heals on Resident 2 was discontinued. The order was started when the resident was essentially bed bound, but was not discontinued when the resident no longer needed heels floated. The order is now discontinued.

Identifying other Residents having the Potential to be Affected:

On 6/4/24, the ADON and Clinical Support Specialist Nurse conducted an audit of all current residents' physician orders and care plans to identify any other residents with orders to float heels or similar preventive skin care measures. No other residents were identified as having missed or incorrectly ordered interventions.

Measures put into place or Systemic Changes:

The Staff Development Coordinator or designee will re-educate all licensed nursing and medical records staff on following physician orders, care planning, and the facility's "Medication and Treatment Orders" policy, with emphasis on preventive skin care orders. Education will include the process for notifying the physician and care planning refusals.

- Skin assessments and preventive care orders will be reviewed in daily clinical meetings to ensure implementation.

Plan to Monitor Performance:

- The DON or designee will audit 5 random residents weekly x4 weeks, then 5 residents monthly x2 months to ensure physician orders for preventive skin care are implemented and care planned.

- Audit results will be reviewed by the DON and reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee for review and further recommendations x2 quarters or until substantial compliance is achieved.

All corrective action will be completed by 7/4/24.

F-685:

It is the facility's policy to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, and if necessary, assist the resident in making appointments and arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

Corrective Action for Affected Residents:

The social worker followed-up on the vision services for Resident 15. During the follow-up it was discovered the glasses had already been delivered, but the box was mixed up with other supplies. Resident 15 received her glasses on 6/6/24.

Identifying other Residents having the Potential to be Affected:

The Social Services dept. will review all current residents' vision status, MDS assessments, and care plans to identify any other residents needing assistance with making appointments and obtaining vision devices. The SW will facilitate appointments and arrange transportation as needed to ensure all residents have access to proper vision treatment and devices. No other residents were found with missing vision or ancillary service appointments needs not already scheduled.

Measures put into place or Systemic Changes:

The SW will be re-educated by the Administrator on the facility's "Referrals, Social Services" policy and procedure, emphasizing the need to coordinate resident referrals for vision services based on assessed needs in a timely manner. This education will be incorporated into the orientation of new social services staff.

The MDS Coordinator will review MDS assessments upon completion to identify any vision needs and inform the SW to facilitate prompt appointments and obtainment of devices.

Plan to Monitor Performance:

The Director of Nursing or designee will audit 5 random residents' vision status and associated appointments/devices weekly x4 weeks, then monthly x3 months to ensure residents are receiving necessary vision services.

The Administrator will report monitoring results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.

All corrective action will be completed by 7/4/24.

F-732:

It is the facility's policy to post the required nurse staffing data on a daily basis at the beginning of each shift in a clear, readable format and in a prominent place readily accessible to residents and visitors, in accordance with 42 CFR §483.35(g)(1)-(4).

Corrective Action for Affected Residents:

No specific residents were identified as being affected by this deficient practice. However, all residents have the potential to be affected when notices are not posted timely.

Identifying other Residents having the Potential to be Affected:

All residents have the potential to be affected by the deficient practice of not posting daily staffing information in time.

Measures put into place or Systemic Changes:

- The Staffing Coordinator and/or designee will be responsible for posting the daily staffing information at the beginning of each shift, including weekends and holidays, no later than 2 hours after the start of the day shift.

- The weekend receptionist duties have been updated to include posting the daily staffing on weekends and holidays as directed by the staffing coordinator.

- The Administrator or designee will in-service all staff responsible for posting daily staffing, including the Staffing Coordinator and receptionist, on the updated procedures.

Plan to Monitor Performance:

- The Adinistrator or designee will audit the posting of daily staffing information 5x/week for 4 weeks, then 3x/week for 2 months to ensure it is posted at the beginning of each shift, no later than 2 hours after the start of the day shift.

- Audit results will be brought to the monthly QAPI meeting for review for a minimum of 3 months.

The Administrator will report monitoring plan results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.

All corrective Action to be completed by 7/4/24.

F-755:

It is the facility's policy to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, as per 483.45(a).

Corrective Action for Affected Residents:

On 6/3/24, the ADON contacted the pharmacy to replace the accessed E-kits #53 and #49. The E-kits were replaced by the pharmacy on 6/3/24.

Identifying other Residents having the Potential to be Affected:

All residents have the potential to be affected by this practice. On 6/3/24, the ADON audited all E-kits in the facility to ensure none were accessed and awaiting replacement. No other E-kits were found to be awaiting replacement.

Measures put into place or Systemic Changes:

The DON or designee will re-educated all licensed nursing staff on the facility's "Emergency Medications" policy, emphasizing that medications used from the E-kits must be replaced upon the next routine drug order, and to call pharmacy to follow-up if not received.

The DON or designee will audit all E-kits daily x1 week, then weekly x1 month to ensure accessed E-kits are replaced per policy.

Plan to Monitor Performance:

The ADON or designee will conduct random audits of E-kits weekly x3 months to ensure ongoing compliance with the facility's "Emergency Medications" policy. Audit results will be brought to the monthly QAPI meeting for review and discussion. The QAPI committee will monitor the audits until 100% compliance is achieved x3 consecutive months.

The ADON will report monitoring plan results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.

All corrective action to be completed by 7/4/24

F-757:

It is the facility's policy that each resident's drug regimen must be free from unnecessary drugs, including drugs used in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for use, or in the presence of adverse consequences indicating the dose should be reduced or discontinued (F757).

Corrective Action for Affected Residents:

On 6/5/2024, the attending physician reviewed and revised the orders for Resident 2 and Resident 3: Resident 2's medication order for Hydroxyzine hydrochloride was given a stop date. Resident 3's order for Cipro was given an indication as well as a stop date.

Identifying other Residents having the Potential to be Affected:

The ADON and Medical Records audited all current residents' medication orders to identify any other residents on PRN psychotropic medications without stop dates and residents on antibiotics for greater than 7 days without adequate indication. No other non-compliant orders were found in the audit.

Measures put into place or Systemic Changes:

The DON or designee will provide re-education to all licensed nursing and medical records staff on the facility's policies for psychotropic medication use, including the 14-day limit on PRN psychotropic orders, and antibiotic stewardship, including required elements of antibiotic orders such as start/stop dates and duration.

Plan to Monitor Performance:

- The DON or designee will audit all new PRN psychotropic medication orders weekly x4 weeks then monthly x2 months to ensure they include 14-day stop dates.

- The DON or designee will audit all antibiotic orders weekly x4 weeks then monthly x2 months to ensure they include start/stop dates and/or duration and are clinically indicated.

- Medical Records Staff will audit all new PRN psychotropic and antibiotic orders to ensure proper stop dates and indications moving forward.

- Audit results will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee monthly x3 months to evaluate the effectiveness of the plan of correction and make revisions as needed.

The DON will be responsible for reporting the results of this monitoring to the quarterly QAPI committee. The QAPI committee will monitor performance until substantial compliance with the set-forth protocol is achieved.

All corrective action to be completed by 7/4/24.

F-759:

It is the facility's policy to ensure that medication error rates are not 5 percent or greater (F759).

Corrective Action for Affected Residents:

- On 6/3/24, Resident 241 received the correct dose of famotidine 20 mg (two 10 mg tablets) as per physician's orders.

- On 6/3/24, the pharmacy was contacted regarding the missing metoprolol succinate 25 mg for Resident 540. The medication was delivered and administered to the resident on the same day.

Identifying other Residents having the Potential to be Affected:

All residents receiving medications have the potential to be affected by medication errors. the Director of Nursing (DON) or designee will conduct an audit of all residents' medication administration records (MARs) from the past 30 days to identify any other potential medication errors. No other medication errors or missing medications were found.

Measures put into place or Systemic Changes:

The DON or designee will provide re-education to all licensed nurses and Medical Records staff on the facility's policy for medication administration, including verifying the 5 rights (right resident, medication, dose, time, route) and ensuring medications are available as ordered. Education will include follow-up with pharmacy for any delivery errors or missing medications.

Plan to Monitor Performance:

The DON or designee will do Med-Pass audit/following with 2 nurses per week until all nurses have been followed on a med-pass and the medication error rate is 0% for all nurses. Continued med-pass errors will result in additional training to the nurses with errors and/or all nurses if needed.

The DON will report the results of this monitoring plan to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will evaluate the effectiveness of the above systemic changes and make further recommendations as needed to ensure ongoing substantial compliance.

All corrective action to be completed by 7/4/24.

F-761:

It is the facility's policy to label drugs and biologicals in accordance with currently accepted professional principles, including appropriate accessory and cautionary instructions and expiration dates when applicable. The facility must also store all drugs and biologicals in locked compartments under proper temperature controls, permitting only authorized personnel to have access to the keys, in accordance with State and Federal laws.

Corrective Action for Affected Residents:

- On 6/3/24, the ADON removed and properly disposed of the six metered-dose inhalers found with unlabeled open dates in Medication Cart A.

- On 6/3/24, the ADON removed and properly disposed of the two expired insulin vials found in the medication refrigerator.

- On 6/3/24, the ADON removed the prescription medication blister packs that were found lodged in the rear gap of Medication Cart A and returned them to the pharmacy.

- On 6/3/24, the ADON removed and properly disposed of the two expired glucometer control solutions found in Medication Cart A.

- On 6/3/24, the ADON removed and properly disposed of the loose pills found in Medication Cart A.

Identifying other Residents having the Potential to be Affected:

The ADON or designee will audit all medication carts and medication rooms to ensure proper labeling of open dates on multi-dose medications, removal of any expired medications, proper storage of medications, and cleanliness of medication storage areas. No other expired medication, loose pills, or improperly stored medications were found.

Measures put into place or Systemic Changes:

The DON will provide re-education to all licensed nurses on the facility's policies for medication labeling, storage, and expiration dates. This training will emphasize writing open dates on multi-dose medications, checking expiration dates before administration, proper storage of medications, and maintaining clean medication storage areas.

Plan to Monitor Performance:

- The DON or designee will audit all medication storage areas weekly x4 weeks, then monthly x2 months using the updated audit tool. The DON will immediately correct any issues identified during the audits.

- The DON will report the results of these audits to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor the audit results on an ongoing basis until substantial compliance of the set-forth protocol is achieved.

All corrective action to be completed by 7/4/24.

F-803:

It is the facility's policy to ensure menus meet the nutritional needs of residents in accordance with established national guidelines, are prepared in advance, are followed, reflect the religious, cultural and ethnic needs of the resident population, are updated periodically, are reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy, and do not limit the resident's right to make personal dietary choices.

Corrective Action for Affected Residents:

On 6/4/2024, the following corrective actions were taken:

- Resident 1, 5, 25, and 491 on CCHO diets were provided with the correct half serving of fruit mix crumble cake for dessert.

- Resident 2 on a small portion diet was provided with the correct half serving of fruit mix crumble cake for dessert.

- Resident 5 on a mechanical soft texture diet was provided with chopped salad without croutons.

Identifying other Residents having the Potential to be Affected:

On 6/4/2024, the Certified Dietary Manager (CDM) reviewed all resident meal tickets and diets to identify any other residents who may have received incorrect portions or food items not in compliance with their prescribed diets. No other residents were found to be affected. All residents have the potential to be affected if menus and diets are not followed correctly.

Measures put into place or Systemic Changes:

The CDM will re-educat all dietary staff on the importance of following menus exactly as written for regular and therapeutic diets, using the diet manual as a reference, and carefully reading meal tickets to ensure diet accuracy. Education included portion sizes for CCHO and small portion diets, and food items to avoid for mechanical soft diets.

Plan to Monitor Performance:

- The CDM or designee will audit meal trays for diet accuracy daily for 4 weeks, then weekly for 8 weeks. Audits will include all therapeutic diets.

- The CDM will report audit results to the Quarterly Quality Assurance and Performance Improvement (QAPI) committee for review and recommendations until substantial compliance is achieved.

- The RD will review meal tickets and observe meal service on routine visits to ensure ongoing compliance with menus and diets.

All corrective action to be completed by 7/4/24.

F-812:

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

Corrective Action for Affected Residents:

1. On 6/4/2024, the ice machine was immediately deep cleaned and sanitized by a Bullseye Mechanical technician.

2. On 6/3/2024, the 11 rotten tomatoes with black and white indented spots were immediately discarded by the Certified Dietary Manager (CDM).

3. On 6/3/2024, the metal pans found stacked wet and with food debris were rewashed, sanitized, and properly air-dried before storing by the dietary staff.

4. On 6/3/2024, the employee's personal belongings were removed from the dry food storage area by the CDM.

5. On 6/3/2024, the juice dispenser vent was thoroughly cleaned to remove the significant dust buildup by a Bullseye Mechanical technician.

Identifying other Residents having the Potential to be Affected:

All residents have the potential to be affected by the deficient practices related to food procurement, storage, preparation, and service. No specific residents were identified, the above corrective action accounts for all residents.

Measures put into place or Systemic Changes:

1. The CDM will revise the ice machine cleaning schedule and protocol to include bi-monthly deep cleanin. The maintenance staff will be re-educated on the revised protocol.

2. The CDM will re-educate all dietary staff on proper inspection of produce upon delivery and daily monitoring for freshness.

3. The CDM will re-educate all dietary staff on proper dishwashing procedures, including allowing adequate air-drying time before stacking and storing. Random audits of cleaned dishes will be conducted daily.

4. The CDM will designate a specific designated area to store personal belongings (such as drinks, etc..). All Dietary staff will be informed of this new designated area.

5. The CDM will add the juice dispenser to the weekly cleaning schedules. The kitchen staff will be re-educated on proper cleaning of the juice dispenser, including the vents.

Plan to Monitor Performance:

1. The maintenance staff will document bi-monthly deep cleaning. The log will be audited monthly by the CDM.

3. The CDM will conduct random audits of cleaned dishes daily, documenting any issues found. Results will be reviewed weekly to identify trends and need for further education.

4. The CDM will conduct weekly rounds to ensure staff are utilizing the designated area for personal belongings and not storing items in dry storage or the kitchen.

5. The CDM will visually inspect the juice dispenser daily and document cleaning on the weekly schedules. Audits will be reviewed weekly by the CDM.

The CDM will report all monitoring results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review trends and provide recommendations for ongoing compliance and improvement.

All corrective action to be completed by 7/4/24.

F-880:

It is the facility's policy to 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, in accordance with 42 CFR §483.80.

Corrective Action for Affected Residents:

On 6/3/24, CNA 3 was immediately re-educated by the Infection Preventionist on the proper use of personal protective equipment (PPE), including the requirement to wear a face shield or goggles when providing care to residents in the COVID-19 unit. No negative outcome was noted for Resident 32.

Identifying other Residents having the Potential to be Affected:

All residents residing in the COVID-19 unit have the potential to be affected by staff not following proper PPE protocols. A visual audit of the COVID unit was performed by the Infection Preventionist and no other staff were found with improper PPE.

Measures put into place or Systemic Changes:

- The Infection Preventionist or designee provided re-education to all nursing, therapy, housekeeping staff on the facility's policy for PPE use when caring for residents with suspected or confirmed COVID-19, with emphasis on the requirement for face shields or goggles.

- PPE compliance audits will be conducted by the Infection Preventionist or designee on all shifts, 5 days per week for 2 weeks, then weekly for 2 additional weeks. Audit results will be reported to the Quality Assurance Performance Improvement (QAPI) committee.

- PPE supplies, including face shields and goggles, will be checked daily by the Infection Preventionist or designee to ensure adequate stock. Any supply issues will be immediately reported to the Administrator for resolution.

Plan to Monitor Performance:

- The Director of Nursing or designee will conduct random observations of staff PPE use in the COVID-19 unit, on all shifts, 5 days per week for 2 weeks, then weekly for 2 additional weeks.

- The Director of Nursing will report the results of these audits to the QAPI committee monthly for review and recommendation.

- The QAPI committee will monitor for continued compliance and determine the need for additional interventions or monitoring based on audit outcomes.

All corrective action to be completed by 7/4/24.

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F 636	Continued From page 1 the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no	F 636		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 2 significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete the Minimum Data Set (MDS, an assessment tool used to guide care) Admission Assessment within 14 calendar days after admission for two in a census of 38 (Resident 9 and Resident 21). This failure had the potential to delay care planning and the delivery of care that would have been identified in the admission assessment. Findings: 1. Resident 9 was admitted to the facility on 12/13/23, with diagnoses including dementia and cognitive communication deficit. Review of Resident 9's MDS Assessment, dated 12/15/23, indicated the comprehensive Admission Assessment was completed on 1/10/24, 28 calendar days after admission. 2. Resident 21 was admitted to the facilty on 1/4/24 with diagnoses including altered mental status. Review of Resident 12's MDS Assessment, dated 1/6/24, indicated the comprehensive admission assessment was completed on 1/29/24, 26 calendar days after admission.	F 636		

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F 636	Continued From page 3 During a concurrent interview and record review of the MDS assessments for Resident 9 and Resident 21 on 6/6/24 at 9:40 a.m. with the Director of Nursing (DON), the DON acknowledged that Resident 9 and Resident 21's Admission Assessments were completed more than 14 days from their admission and were submitted late. A review of the facility's Policy and Procedure (P&P) titled, "MDS Completion and Submission Timeframes," revised 7/2017, stipulated, " ...Facility will conduct and submit resident assessments in accordance with current federal and state submission ... Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual."	F 636		
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	F 656		

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F 656	Continued From page 4 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 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 comprehensive person-centered care plan for one of 15 sampled residents (Resident 491), when the care plan did not address Resident 491's dialysis (a procedure to remove waste products from the blood when the kidneys stop working properly) care and interventions. This failure decreased the facility's potential to	F 656		

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F 656	Continued From page 5	F 656		

address the residents' individualized and specific needs.

Findings:

A review of an admission record indicated Resident 491 was admitted to the facility in May 2024 with diagnoses including dependence on renal (kidney) dialysis and end stage renal disease.

During a concurrent observation and interview on 6/4/24 at 8:38 a.m. with Resident 491 in her room, Resident 491 had a tube connected to her left abdominal area. Resident 491 stated she had peritoneal dialysis (a treatment for kidney failure that uses the lining of abdomen to filter the blood) tube, went yesterday to dialysis, and was scheduled for dialysis on Monday, Wednesday, and Friday.

A review of Resident 491's Minimum Data Set (MDS; an assessment tool), dated 5/22/24, indicated Brief Interview of Mental Status (BIMS) score was 13 of 15 with good memory. MDS further indicated hemodialysis (a treatment to filter wastes and water from blood) was performed on Resident 491 on admission and peritoneal dialysis was performed while she was residing in the facility.

A review of Resident 491's "Order Summary Report," dated 6/4/24, indicated Resident 491 was scheduled for dialysis every Monday, Wednesday, and Friday.

During a concurrent interview and record review on 6/4/23 at 3:09 p.m. with Licensed Nurse 1 (LN 1), Resident 491's medical record was reviewed.

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F 656	Continued From page 6 LN 1 stated Resident 491 had dialysis and confirmed there was no care plan for dialysis. During an interview on 6/4/24 at 3:14 p.m. with the Assistant Director of Nursing (ADON), ADON confirmed Resident 491 had no care plan for dialysis. ADON stated nurses should have developed a care plan for dialysis; otherwise, the person-centered care plan interventions might not be followed and implemented for this specialized service. A review of the facility's policy titled, "Comprehensive Person-Centered Care Plans," dated 12/16, indicated "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."	F 656		
F 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 which meet professional standards of quality of care for one of 15 sampled residents (Resident 290) when Resident 290 was allowed to wear a left leg/knee immobilizer without a physician's order. This failure resulted in Resident 290's use of a	F 658		

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leg/knee immobilizer without a required physician's order.

Findings:

A review of Resident 290's Admission Record indicated she was admitted 6/24 with diagnoses including left tibial plateau fracture (fracture in the upper part of the shinbone) after a ground level fall.

During an intial tour observation on 6/3/24 at 10:30 a.m., Resident 290 was observed lying in bed wearing a left leg/knee immobilizer.

During a concurrent observation and interview on 6/4/24 at 2:32 p.m. with the Physical Therapist (PT) while doing therapy with Resident 290, the PT stated a leg/knee immobilizer should be worn at all times as ordered from the hospital to prevent the knee from bending or flexing.

During a concurrent interview and record review of the Order Summary Report (OSR) dated 6/2024 for Resident 290 on 6/4/24 at 2:35 p.m. with Licensed Nurse 6 (LN 6), LN 6 verified the OSR did not include an order for the use of a leg/knee immobilizer.

During a concurrent interview and record review of the same OSR on 6/4/24 at 2:39 p.m. with the Director of Rehab (DOR), the DOR confirmed the order for Resident 290's use of a leg/knee immobilizer was not in the physician's order. The DOR also mentioned the admitting nurse should have written a physician order as ordered from the hospital.

During an interview on 6/5/24 at 10:28 a.m. with

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F 658	Continued From page 8 the Assistant Director of Nursing (ADON), the ADON stated she was the nurse who admitted Resident 290, ADON further stated she had forgotten to write the immobilizer order after clarifying it with the doctor at the hospital. The ADON acknowledged she should have recorded the order right away to prevent inaccuracy in the delivery of care to residents. Review of the facility's Policy and Procedure (P&P) titled, "Medication and Treatment Orders," revised 7/2016, the P&P indicated, "Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order."	F 658		
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 maintain nail care for one of 15 sampled residents (Resident 25) when, Resident 25's fingernails on both hands were long and packed with a brownish-black substance. This failure decreased the facility's potential to maintain residents' nail care and prevent infection. Findings: A review of an admission record indicated	F 677		

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F 677	Continued From page 9	F 677		

Resident 25 was admitted to the facility in May 2024 with diagnoses including dementia (impaired ability to remember, think, or make decisions).

During a concurrent observation and interview on 6/3/24 at 12:20 p.m. with Certified Nurse Assistant (CNA) 4 in the Resident 25's room, Resident 25 was observed with long fingernails packed with a brownish-black substance on both hands. The CNA 4 agreed fingernails on both hands were long and dirty. The CNA 4 stated to inform the Licensed Nurse and the Activities Aide (AA) to take care of Resident 25's fingernails.

During an interview on 6/5/24 at 2:20 p.m. with AA, the AA stated she can trim resident's nails as per CNA's request, but she was not aware that Resident 25 had long and dirty fingernails.

During an interview on 6/5/24 at 2:26 p.m. with Licensed Nurse (LN) 4, the LN 4 stated today she took care of Resident 25 and he was discharged to home. LN 4 also stated she was not aware of long and dirty nails.

During an interview on 6/5/24 at 2:29 p.m. with CNA 5, the CNA 5 stated she took care of Resident 25 on 6/5/24 and noticed long and dirty fingernails on both hands. The CNA 5 also stated she forgot to inform the Licensed Nurse.

During a review of undated care plan titled, "Activities of Daily Living (ADL)," indicated Resident 25 was self-care deficient, and facility did not initiate a nail care plan.

During an interview on 6/6/24 at 8:59 a.m. with Assisting Director of Nursing (ADON), the ADON

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F 677	Continued From page 10 stated the CNAs cannot trim nails without consulting LN or AA and the CNAs should have performed daily hand hygiene for Resident 25. She also stated if nails cannot be trimmed as per diagnoses or doctor's orders then CNAs should have cleaned the dirty nails with soapy warm water and wash cloth. She stated dirty nails were source of infection. Review of the facility's policy and procedure (P&P) titled, "Care of Fingernails/Toenails," dated 2010, the P&P indicated, " ...Nail care includes daily cleaning ... soak in the warm soapy water for approximately five (5) minutes... Rinse the hand or foot that was soaked in soapy water with clear, warm water. Dry the hand or foot with towel ..."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 15 sampled residents (Resident 2) received care in accordance with professional standards when Resident 2's physician order to float heels when in bed was not implemented. This failure decreased the facility's potential to	F 684		

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prevent skin breakdown.

Findings:

A review of Resident 2's Admission Record indicated she was admitted on 8/23 with diagnoses including muscle weakness and age-related physical debility.

In a concurrent observation and interview during the inital tour on 6/3/24 at 9:15 a.m., Resident 2 stated she had a good sleep and was ready to get up, was still in bed in her nightgown and feet observed to have edema (swelling).

Review of Resident 2's Order Summary Report (OSR), dated 8/30/23, indicated an order to ensure heels are floated when in bed every shift for skin breakdown prevention.

In a concurrent observation, interview, and record review on 6/4/24 at 7:50 a.m. with Licensed Nurse 4 (LN 4), Resident 2 was observed lying in bed, LN 4 confirmed Resident 2's feet/heels were not floated. LN 4 also acknowledged there was an active order for heels to be floated when in bed to prevent skin breakdown.

In an interview on 6/5/24 at 10:28 a.m. with the Assistant Director of Nursing (ADON), the ADON stated she expected nursing staff to follow the physician's order to properly care for the residents. If the resident refused the order, the doctor should have been informed and educated the resident and the refusals should have been care planned.

A review of the facility's Policy and Procedure (P&P) titled, "Medication and Treatment Orders,"

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F 684	Continued From page 12 revised 7/2016, the P&P stipulated all orders for medications and treatments will be consistent with the principles of safe and effective order writing and implementation.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 15 sampled residents (Resident 15) had access to vision services when Resident 15 was not assisted in obtaining prescription eyeglasses. This failure resulted in Resident 15 not having eyeglasses to maintain good vision. Findings: A review of an Admission Record for Resident 15 indicated she was admitted in 7/23 with diagnoses including cataracts (cloudy area in the lens of the eye) and syncope (fainting).	F 685		

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F 685	Continued From page 13 In a concurrent observation and interview on 6/3/24 at 9:45 a.m. with Resident 15, observed Resident 15 was lying in bed, squinting while watching television. A magnifying glass was on top of her table; Resident 15 stated she used it for reading. Resident 15 further mentioned the facility was supposed to provide a pair of new eyeglasses to her and she's been waiting for it for a long time. A review of Resident 15's Minimum Data Set (MDS, an assessment tool used to guide care), dated 4/19/24, indicated Resident 15 needed corrective lenses to maintain vision. In an interview on 6/5/24 at 10:10 a.m. with Social Worker (SW), the SW stated Resident 15 loves watching television and acknowledged she needed to use eyeglasses to be able to watch properly. SW confirmed Resident 15 was in need of a new pair of eyeglasses, but she hasn't provided it yet. In an interview on 6/5/24 at 10:28 a.m. with the Assistant Director of Nursing (ADON), the ADON stated part of resident's care was to provide vision services, the SW should have facilitated the resident's referrals for an appointments and provided what the resident needed to be able to function properly. A review of the facility's Policy and Procedure (P&P) titled, "Referrals, Social Services," revised 12/2008, the P&P indicated social services personnel shall coordinate most resident referrals. Referrals for medical services must be based on resident needs.	F 685		
F 732 SS=C	Posted Nurse Staffing Information	F 732		

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F 732	Continued From page 14 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732		

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F 732	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staffing information was posted on a daily basis at the beginning of each shift for a census of 38, when staffing information was not posted on weekend and at the beginning of weekdays' morning shifts. This failure decreased the facility's potential to post staffing information on a daily basis for residents and visitors. Findings: During an observation on 6/3/24 at 7:39 a.m. the facility's "Daily Staffing," dated 5/31/24, was posted beside the main entrance door. During an observation on 6/4/24 at 9:35 a.m. the facility's "Daily Staffing," dated 6/3/24, was posted bedside the main entrance door. During an observation on 6/5/24 at 9:45 a.m. the facility's "Daily Staffing," dated 6/4/24, was posted bedside the main entrance door. During an interview on 6/5/24 at 11:10 a.m. with the Staffing Coordinator (SC), SC confirmed the facility's "Daily Staffing" for 6/1/24 and 6/2/24 were not posted over the weekend and she posted the "Daily Staffing" on 6/3/24, 6/4/24, and 6/5/24 after 9:30 a.m. during weekdays. SC stated the receptionist should have posted the weekend staffing; otherwise, residents and visitors will not be able to find out the number of staff providing care and the census. SC further stated the morning shift started at 6 a.m. and she should have posted staffing within two hours of	F 732		

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F 732	Continued From page 16 the beginning of the day shift. During an interview on 6/5/24 at 1:04 p.m. with the Assistant Director of Nursing (ADON), ADON stated the receptionist should have posted staffing over the weekend and the SC should have posted it early in the morning; otherwise, residents and visitors will not know the staff ratio and number of staff taking care of them. A review of the facility's policy titled, "Posting Direct Care Daily Staffing Numbers," dated 7/16, indicated "Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of the day shift..."	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		

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F 755	Continued From page 17 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure pharmacy services were maintained for a census of 38 when two opened Emergency drug kits found in the medication room had not been replaced by the pharmacy according to the facility policy. This failure had the potential for residents not receiving necessary medications on time or drug diversion. Findings: During an inspection of medication room 1 on 6/3/24 at 11:28 a.m., two e-kits (emergency kit, a box containing emergency medications) were observed to be previously opened and used, but still not replaced by the pharmacy. E-kit #53 was an e-kit containing controlled medications (drugs with higher risk of addiction and high potency) was accessed on 5/29/24 at 9 p.m. E-kit # 49 was an e-kit containing oral medications was first accessed on 5/30/24 followed by 6/1/24, and 6/2/24.	F 755		

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F 755	Continued From page 18 During an interview on 6/3/24 at 11:36 a.m. with Licensed Nurse 1, LN 1 confirmed that both e-kits had been used, but still not replaced by the pharmacy. LN 1 confirmed e-kit #49 was first accessed on 5/30/24. LN 1 confirmed e-kit #53 was first accessed on 5/29/24 and pharmacy was not notified to replace it. During interview on 6/5/24 at 9:03 a.m. with the assistant Director of Nursing (ADON), the ADON confirmed that if e-kits were accessed multiple times before they were replaced, there might not be certain drugs available when needed. ADON also acknowledged that staff should have followed up with the pharmacy to replace the e-kits with the next delivery. ADON stated that the pharmacy delivers medications two times per day so there were many opportunities to replace the e-kits. During a review of the facility's policy and procedure titled "Emergency Medications", dated 4/2007, indicated, "Medications ...used from the emergency medication kit must be replaced upon the next routine drug order."	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		

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F 757	Continued From page 19 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure two of 15 sampled residents (Resident 2 and Resident 3) were free from unnecessary medication when: 1. Resident 2's anti-anxiety medication (a medication used to help reduce symptoms of worry, fear, and panic) was prescribed without a stop date; and, 2. Resident 3's use of an antibiotic medication (medicines that treat bacterial infections in humans) was continued without adequate indication. These failures increased the risk of Resident 2 and Resident 3 to receive unnecessary medications. Findings: 1. A review of Resident 2's Admission Record indicated Resident 2 was admitted in 8/2023 with diagnoses including anxiety disorder.	F 757		

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A review of an Order Summary Report (OSR) of Resident 2, dated 5/2/2024, indicated an order for hydroxyzine hydrochloride (an anti-anxiety medication) 25 milligrams (mg, unit of measurement) every 8 hours as needed (PRN) for anxiety with restlessness, there was no stop date written.

A review of Resident 2's Medication Regimen Review (MRR) for 5/2024 the Pharmacy Consultant (PC) recommended the doctor to add a stop date for the anti-anxiety medication order. There was no documented revision applied to the anti-anxiety medication order.

A review of Resident 2's Medication Administration Report (MAR) indicated for the whole month of 5/2024 Resident 2 received the anti-anxiety medication three times on 5/7, 5/16, and 5/20.

In a concurrent interview and record review on 6/4/2024 at 9:50 a.m. with the Nurse Practitioner (NP) Resident 2's OSR, dated 5/2/2024, was reviewed, the NP confirmed that the order for anti-anxiety medication did not indicate a stop date, she also stated an end date should have been included to the order since it is an as needed order.

In an interview on 6/5/2024 at 10:28 a.m. with the Assistant Director of Nursing (ADON) the ADON stated they were aware of the recommendation from the PC to add a stop date for the anti-anxiety medication order, but she's not sure if the physician was made aware of it. The ADON acknowledged that the as needed anti-anxiety medication should have been ordered for 14 days

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only.

2. A review of an Admission Record for Resident 3 indicated she was admitted in 5/2016 with diagnoses including cerebral infarction (a type of stroke that occurs when blood flow to the brain is disrupted).

A review of Resident 3's OSR dated 6/26/2023 indicated an order for ciprofloxacin hydrochloride (an antibiotic medication used to treat infections in many different parts of the body) oral tablet 250 milligrams (mg, unit of measurement) given one tablet at night as prophylaxis for recurring urinary tract infection (UTI), the duration of treatment was not included.

A review of Resident 3's MRR dated 6/29/2023 the PC noted that he's aware of the new antibiotic medication order without a stop date for recurring UTI. No recommendations were noted.

In a concurrent interview and record review on 6/4/2024 at 10 a.m. with the NP Resident 3's OSR was reviewed, and the NP agreed that Resident 3's antibiotic medication had been ordered for too long and should have been reviewed after her discharge from hospice care three months ago.

In an interview on 6/5/2024 at 10:28 a.m. with the ADON stated the antibiotic medication order should have been reviewed accordingly for its long-term use.

In a concurrent interview and record review on 6/5/2024 at 12:50 p.m. with the Infection Preventionist (IP) an Order Listing Report for the use of antibiotics was reviewed, the IP stated

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F 757	Continued From page 22 according to his list the last time Resident 3 had a UTI was in 6/2022, there were no other UTI infections documented after. A review of the facility's Policy and Procedure (P&P) titled "Antibiotic Stewardship" revised 12/2016 the P&P indicated "If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: ...Duration of treatment (1) Start and Stop date; or (2) Number of days therapy ..." A review of the facility's P&P titled "Psychotropic Medication Use" revised 7/2022 it indicated " ...PRN orders for psychotropic medications are limited to 14 days ..."	F 757		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the medication error rate did not exceed 5% for two of 10 sampled residents (Resident 241 and Resident 540) when: 1. For Resident 241, a licensed nurse administered famotidine, a medication used to treat heartburn and stomach acid reflux, not in accordance with Physician Orders. 2. For Resident 540, metoprolol succinate, a	F 759		

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F 759	Continued From page 23	F 759		

medication used to treat high blood pressure, was not available for the resident.

As a result, 2 errors were identified out of 37 opportunities for error during the observation of medication administration; the facility medication error was 5.41%.

Findings:

1. During an observation of medication administration on 6/3/24 at 7:52 a.m., Licensed Nurse (LN) 1 was observed to prepare and administer Resident 241's morning medications which included famotidine 10 mg (milligrams, unit of measure). LN 1 verified and administered a total of 10 pills.

Reconciliation of the observation of medication administration with Resident 241's current Physician Orders indicated an order for famotidine 20 mg give 1 tablet by mouth two times a day for dyspepsia (pain or discomfort in the upper stomach).

During an interview on 6/4/24 at 11:55 a.m. with LN 1, LN 1 stated Resident 241 received 2 famotidine 10 mg pills. LN 1 was unable to answer why the morning medication count was 10 pills instead of 11. LN 1 acknowledged that the morning medication count would have been 11 pills if 2 famotidine 10 mg tablets were included in the morning medication pass.

During an interview on 6/5/24 at 9:03 a.m. with the Assistant Director of Nursing (ADON), the ADON stated, "nurses are expected to double check and double count before giving medications, etc.." The ADON also acknowledged

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this medication error had occurred since the nurse gave only one famotidine 10 mg tablet instead of two tablets totaling the dose of 20 mg as ordered by the physician.

During a review of the facility's policy and procedure titled "Administering Medications", dated 12/2012, indicated, "Medications must be administered in accordance with the orders ...The individual administering the medication must check the label 3 times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."

2. During an observation of medication administration on 6/3/24 at 8:06 a.m., LN 1 was observed to prepare and administer Resident 540's morning medications which did not include metoprolol succinate 25 mg.

During an interview on 6/3/24 at 8:07 a.m. with LN 1, LN 1 stated she would call the pharmacy and follow up to see why the medication was not there.

During an interview on 6/3/24 at 11:54 a.m. with LN 1, LN 1 stated pharmacy was called and apparently, they had forgotten to send the resident's metoprolol the night before. LN1 stated that the medication would be delivered on the next delivery.

During an interview on 6/5/24 at 9:03 a.m. with ADON, the ADON stated medications should be available for medication administration as prescribed by the physician. ADON further stated, "I will do an in-service to let the nurses know how to follow up with pharmacy to ensure medications

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F 759	Continued From page 25 are available for our residents." During an interview 6/5/24 at 9:21 am with the facility's Registered Pharmacist (RPh), the RPh stated that the robot used for packaging the medication in blister packs had gotten stuck unnoticed and the metoprolol succinate prescription was not filled and sent out to facility along with other resident's medications on time. During a review of the facility's policy and procedure titled "Administering Medications", dated 12/2012, indicated, "Medications must be administered in accordance with the orders ...The individual administering the medication must check the label 3 times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."	F 759		
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.	F 761		

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F 761	Continued From page 26 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were stored correctly, when: 1. Six metered-dose inhalers were found with unlabeled open dates in Medication Cart A; 2. Two expired insulin vials were found in the medication refrigerator; 3. Prescription medication blister packs were found lodged in the rear gap of Medication Cart A; 4. Two expired glucometer control solutions were found in Medication Cart A; and, 5. Loose pills were found in Medication Cart A. These failures had the potential for omitting medications, medication misuse, and administering or using ineffective expired pharmaceutical products. Findings: 1. During a combined observation and interview 6/3/24 at 10:17 a.m. with Licensed Nurse (LN) 1, the open dates were not written on six (6)	F 761		

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F 761	Continued From page 27 metered dose inhalers or accompanying boxes in Medication Cart A, as follows: a) Umeclidinium (an inhaled medication to relax the airways) 62.5 mcg (microgram, unit of measure) and vilanterol (an inhaled medication to control symptoms of asthma and improve lung function) 25 mcg, with an expiration date of 11/26/24 if unopened, had been opened without an open date, for two inhalers. When asked LN 1 to provide the product's expiration date, LN 1 indicated that the opened product would expire on 11/26/24. A review of umeclidinium 62.5 mcg / vilanterol 25 mcg product box indicated that the inhaler should be discarded 6 weeks after opening. b) Fluticasone furoate 100 mcg inhalation powder, a medication used to help with breathing, with an expiration date of 11/20/24 if unopened, had been opened without an open date for two inhalers. When asked LN 1 to provide the product's expiration date, LN 1 indicated that the opened product would expire on 11/20/24. A review of fluticasone furoate inhalation powder 100 mcg product box indicated that the inhaler should be discarded 30 days after opening. c) Budesonide 80 mcg and formoterol fumarate dihydrate 4.5 mcg, combination of two medications used to help with breathing, with an expiration date of 11/24/24 if unopened, had been opened without an open date. When asked LN 1 to provide the product's expiration date, LN 1 indicated that the opened product would expire on 11/24/24.	F 761		

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A review of budesonide 80 mcg and formoterol fumarate dihydrate 4.5 mcg product box indicated that the inhaler should be discarded 3 months after opening.

d) Fluticasone furoate 200 mcg and vilanterol 25 mcg, combination of two medications used to help with breathing, with an expiration date of 11/29/24 if unopened, had been opened without an open date. When asked LN 1 to provide the product's expiration date, LN 1 indicated that the opened product would expire on 11/29/24.

A review of fluticasone furoate 200 mcg and vilanterol 25mcg product box indicated that the inhaler should be discarded 6 weeks after opening.

During an interview on 6/3/24 at 9:17 a.m. with LN 1, LN 1 acknowledged that she didn't know about the shorter expiration dates once these products were in use.

During an interview on 6/5/24 at 9:03 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that the inhalers should have had open date labels on them. The staff should have written the open date on each inhaler in order to know the products' true expiration dates to avoid administering expired and ineffective medications to the residents.

During a review of the facility's policy and procedure titled "Storage of Medication" dated 4/2007, indicated, "The nursing staff shall be responsible for maintaining medication storage areas...in a clean, safe...manner ...Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 29 the pharmacy for proper labeling before storing ...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals." During a review of the facility's policy and procedure titled "Administering Medications" dated 12/2012, indicated, "The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container." 2. During an observation on 6/3/24 at 11:26 am in the medication room, two 10 ml (milliliters, unit of measure) vials of insulin glargine and lispro (medications used to treat high blood sugar levels) were observed to be expired. According to pharmacy labels, both vials were filled on 4/24/24 and expired on 5/22/24. During an interview 6/3/24 at 11:26 am with LN 2, LN 2 stated that the insulin vials' expiry dates were listed on the manufacturer's vial wrap; LN 2 stated expiration dates were 10/2025 and 2/2027 for glargine and lispro respectively since the vials were unused. LN 2 stated she was not aware whether the insulin vials were delivered by the pharmacy in a cold box with ice. During an interview with the ADON on 6/5/24 at 9:03, the ADON confirmed the contracted pharmacy did not deliver insulin on ice, meaning that the product's expiration date should have been 28 days after delivery of medication, whether it was kept in the medication refrigerator or room temperature. The ADON acknowledged that both insulin vials were expired and should have been removed from the active medication storage area.	F 761		

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F 761	Continued From page 30 During a review of the facility's policy and procedure titled "Storage of Medication" dated 4/2007, indicated, "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals." During a review of the facility's policy and procedure titled "Administering Medications" dated 12/2012, indicated, "The expiration/beyond use date on the medication label must be checked prior to administering." 3. During observation on 6/3/24 at 10:17 a.m., two (2) glucometer control solutions were found expired in Medication Cart A. Both had been opened on 2/11/24. During an interview with LN 1, LN 1 stated the expiration dates were three months after date of opening. She agreed that the expiration date would be 5/11/24. When asked what the significance of using expired control solutions would be, LN 1 stated that residents' glucometer readings could be inaccurate. During an interview on 6/5/24 at 9:03 a.m. with the ADON, the ADON stated that the glucometer control solution was expired and that this was not acceptable. During a review of the facility's policy and procedure titled, "Storage of Medication" dated 4/2007, indicated, "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals." 4. During an observation on 6/3/24 at 9:13 a.m. blister pack cards (cards that package medication within small plastic bubbles secured by a	F 761		

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F 761	Continued From page 31 paper-backed foil) containing unused prescription medications were found lodged behind medication drawers in Medication Cart A. The medication cards had fallen from the drawers and wedged themselves in the bottom rear gap of the medication cart. During an interview, on 6/3/24 at 9:13 a.m. with LN 1, LN 1 stated she did not know they were there, but confirmed they shouldn't be there. During an interview on 6/5/24 at 9:07 a.m. with the ADON, the ADON acknowledged that residents might miss their medication doses due to missing blister packs; she also acknowledged medications storage areas were supposed to be kept clean. She stated that monthly inspections of the medication carts are done and that she would provide an in-service training to the nurses on checking the back of the drawers for the blister pack cards. During a review of the facility's policy and procedure titled, "Storage of Medication," dated 4/2007, indicated, "Drugs shall be stored in an orderly manner in ...drawers, carts ..." 5. During a combined observation and interview on 6/3/24 at 10:17 a.m. with LN 1, three (3) loose pills were found on the bottom of Medication Cart A's drawer. LN 1 confirmed that there were three loose pills retrieved from the cart. During an interview on 6/5/24 at 9:07 a.m. with the ADON, the ADON acknowledged that there should be no loose pills in the medication cart and medication storage areas were supposed to be kept clean.	F 761		

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F 761	Continued From page 32 During a review of the facility's policy and procedure titled, "Storage of Medication," dated 4/2007, indicated, "Drugs shall be stored in an orderly manner in ...drawers, carts ..." During a review of the facility's policy and procedure titled, "Administering Medications," dated 12/2012, indicated, "The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container."	F 761		
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; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803		

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F 803	Continued From page 33 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the therapeutic diet menu was followed for the census of 38 during the lunch service on 6/4/2024 when: 1. Four residents (Resident 1, 5, 25, and 491) with (CCHO consistent carbohydrate) diet (a diet used in the treatment for diabetes) received one serving of fruit mix crumble cake instead of half serving for dessert; 2. One resident (Resident 2) with small portion diet, received one serving of fruit mix crumble cake instead of half serving for dessert; and, 3. One resident (Resident 5) with mechanical soft texture (a texture-modified diet that restricts foods that are difficult to chew or swallow) diet, received chopped salad with croutons instead of without croutons. These failures had the potential to result in compromising the medical and nutrition status of those five residents. Findings: 1.During an observation on lunch service on 6/4/2024 beginning at 11:45 a.m., it was noted Resident 1, 5, 25, and 491 were on CCHO diet indicated on the meal tickets (a ticket including resident's diet, date, allergies, specific food and beverage items, dislikes, and likes) received one	F 803		

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F 803	Continued From page 34	F 803		

serving of fruit mix crumble cake instead of half serving for dessert. A concurrent review of the facility document titled, "SUMMER MENUS: Week 1 Tuesday," dated 6/04/2024, indicated CCHO diet should receive half serving of fruit mix crumble cake.

During an interview on 6/4/2024, at 1:42 p.m., the Certified Dietary Manager (CDM) acknowledged there were few residents on CCHO diet received one serving of fruit mix crumble cake instead of half serving. The CDM reviewed the menu and stated residents with CCHO diet should receive half serving of fruit mix crumble cake.

2.During an observation of lunch service on 6/24/2024 beginning at 11:45 a.m., it was noted Resident 2 with small portion diet received one serving of fruit mix crumble cake instead of half serving for dessert. A concurrent review of the facility document, titled, "SUMMER MENUS: Week 1 Tuesday," dated 6/04/2024, indicated small portion diet should receive half serving of fruit mix crumble cake.

During an interview on 6/4/2024, at 1:42 p.m., the CDM acknowledged there was a resident on small portion diet received one serving of fruit mix crumble cake instead of half serving. The CDM reviewed the menu and stated resident with small portion diet should receive half serving of fruit mix crumble cake.

3.During an observation of lunch service on 6/4/2024 beginning at 11:45 a.m., it was noted Resident 5 with mechanical soft texture diet received chopped salad with croutons instead of without croutons. A concurrent review of the facility document, titled, "SUMMER MENUS:

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Week 1 Tuesday," dated 6/04/2024, indicated mechanical soft diet should receive no croutons with chop salad.

During an interview on 6/4/2024, at 1:42 p.m., the CDM acknowledged there was a resident on mechanical soft texture diet received chopped salad with croutons instead of without croutons. The CDM reviewed the menu and stated resident with mechanical soft texture diet should receive chopped salad without croutons.

During a follow up interview on 6/4/2024, at 1:42 p.m., the CDM stated that the cooks and dietary aid staff should follow the menu and recipe.

During an interview on 6/5/2024, at 9:28 a.m., the Registered Dietitian (RD) stated CCHO diet was for residents with diabetes (a condition that happens when your blood sugar is too high) and need to consume lower carbohydrate (carbs) (food compounds as main nutrition food to release energy to the body, such as sugar, starch, etc.). She added that receiving extra carbs may potentially affect the residents' blood sugar level.

The RD also stated the small portion diet was for controlling calories (a measurement of energy) intake and it may cause weight gain if not followed through.

The RD stated mechanically soft texture diet was for the residents with chewing and/or swallowing issues as recommended by a speech therapist (works with people who have speech, language, or swallowing disorders). She confirmed the croutons were too hard to chew for residents on mechanical soft texture diet and was unsafe for

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F 803	Continued From page 36 residents with swallowing difficulty. The RD stated her expectation was the kitchen staff to follow the menu during the meal service and check the accuracy of the trays before leaving the kitchen. A review of departmental policy and procedure titled, "Menu Planning", dated 2023, indicated that " ...The menus are planned to meet the nutritional needs of residents ...The facility's diet manual and the diets ordered by the physician should mirror the nutritional care provided by the facility ...Menus are written for regular and therapeutic diets in compliance with the diet manual." A review of department document, titled, "Diet Manual", dated 2023, it stated "Controlled Carbohydrate Diet (CCHO) ...The carbohydrates are controlled through portion control ...Regular Mechanical Soft Diet ...the mechanical soft diet is designed for residents who experience chewing or swallowing limitations ...avoid breads with hard crusts ..." A review of undated facility document titled, "Job Description: Dietary Aide," stated " ...making sure there is desserts for diabetics...Assist with tray line for breakfast and lunch, reading each card CAREFULLY for allergies, dislikes, special requests and diet types and textures. It is your responsibility to ensure trays are accurate and meets each residents individual needs." A review of undated facility document titled, "Job Description: Cook," stated " ...Follow the menu given for the day assigned and consult with Dietary supervisor on any alternatives or changes."	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812	Continued From page 37 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food serve safety when: 1. The ice machine was not clean with black and pink substances at the bottom of the ice evaporator unit (a part where water freezes to produce ice and push out from the unit) and pink slimy substances on the water curtain (a plastic cover rests over the ice evaporator where the ice dispenses); 2. There were 11 out 15 tomatoes with black and white indented spots found in dry storage;	F 812		

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F 812	Continued From page 38 3. There were several metal pans found stacked wet and contained food debris when stored at the clean and ready-to-use storage areas; 4. Employee's personal belonging found in the dry food storage area; and, 5. Juice dispenser was not clean with significant dust on the vent where juice dispended. Findings: 1.During an inspection of ice machine in the kitchen on 6/4/2024, at 8:39 a.m., the Outside Vendor Technician (OVT) removed the top access panel to reveal the machinery part of the ice machine. There were pink and slimy substances on the water curtain upon dissembled and could be easily wiped off with a paper towel. There were several black and pink substances found at the bottom of the ice evaporator unit. A concurrent interview with the OVT, and he stated the substances were calcium deposits and the ice machine needed to be wiped and cleaned more. A concurrent interview with the (Certified Dietary Manager) CDM, and he stated, "We might have to increase the frequency of deep clean to bi-monthly." During an interview with the Registered Dietitian (RD) on 6/5/2024, at 9:28 a.m., she stated the ice machine should be clean and well maintained to prevent any bacterial growth. She added, "It could have potential safety concerns for the patients" when not completely maintained or cleaned. The	F 812		

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F 812	Continued From page 39 RD stated, "It appears to be a concern and we will take actions." A review of undated departmental document, titled, "Ice Machine Sanitation Log," it indicated the maintenance technician was responsible to clean and sanitize the ice machine monthly and the last service was completed on 5/2/2024. A review of undated ice machine manual, titled, "[Manufacturer's brand] Installation, Use, & Care Manual," it stated, " ...Removes mineral deposits from areas or surfaces that are in direct contact with water ...use nylon brush or cloth to thoroughly clean the following ice machine areas ...Evaporator plastic parts - including top, bottom, and sides ...Ice machine cleaner is used to remove lime scales and mineral deposits. Ice machine sanitizer disinfects and removes algae and slime." According to 2022 FDA (Food and Drug Administration) Food Code, on section 4-602.11 Equipment Food-Contact Surface and Utensils, it stated equipment like ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms (a living thing that is so small it must be viewed with a microscope, such as bacteria or algae). 2. An observation of the dry storage in the kitchen on 6/3/2024, at 10:05 a.m., and a concurrent interview conducted with the CDM. There were 11 out of 15 tomatoes were found covered with black and white indented spots stored on the shelf of the metal rack. The CDM confirmed and stated, "they were rotten with discoloration and should be	F 812		

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F 812	Continued From page 40 thrown away." During an interview with the RD on 6/5/2024, at 9:28 a.m., she stated the produce in the dry storage should be fresh and not spoiled. The RD acknowledged the tomatoes were not fresh and should be thrown and not to be used for cooking. She stated her expectation with the staff had to make sure the deliveries were fresh and not spoiled, and they should check the produce for freshness daily. A review of department policy and procedure, titled, "Storing Produce" dated 2023, indicated " ...Check boxes of fruit and vegetables for rotten, spoiled, items. One rotten tomato, apple, or potato in a box can cause the rest of the produce to spoil faster. Throw away spoiled items." 3. During an initial kitchen tour observation on 6/3/2024, at 9:16 a.m., there were several metal pans with conditions as followed: -Six of quarter (1/4) sheet and four of one-eighth (1/8) sheet metal pans were stacked wet, and - Three of 1/4 sheet and three of 1/8 sheet metal pans found with food debris after cleaned and sanitized. A concurrent interview with the CDM, he confirmed there were food debris and wetness found on the metal pans stated above. The CDM stated the metal pans should be left to dry on the air-dried rack for two hours or longer before stored away and should not be dirty. During an interview on 6/5/2024, at 9:28 a.m., the RD stated the dishes and pans should be cleaned and completely air-dried before stored away to	F 812		

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avoid bacteria growth. She added pans should not have food debris and kept clean.

A review of departmental policy and procedure, titled, "Dish Washing," dated 2023, it stated, "All dishes will be properly sanitized through the dishwasher ...the dishes should be air dried in racks before stacking and storing ..."

A review of departmental policy and procedure, titled, "Sanitation," dated 2023, it stated, " ...All utensils, counters, shelves, and equipment shall be kept clean ..."

4. During an observation in the dry storage room on 6/3/2024, at 10:05 a.m., there was a disposable cup with liquid located on the lower level of the metal rack where a box of oranges was stored; and a reusable grocery bag was on the box of oranges. A concurrent interview with the CDM, he stated the soda and the grocery bag belonged to the staff and there was no designated area for staff belongings separate from the kitchen food storage.

During an interview on 6/5/2024, at 9:28 a.m., the RD stated it was not appropriate for the staff to store their belongings or food next to the food in the dry storage area.

A review of departmental policy and procedure, titled, "Employee Personal Items," dated 2023, it indicated, "Personal items brought in by staff outside will not be kept in the kitchen."

5. An initial kitchen tour on 6/3/24, at 8:43 a.m., observation of the juice dispenser machine and a concurrent interview with the CDM was conducted. There was significant dust found on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 42 the vent where the juice dispended. The CDM confirmed and stated the juice machine needed to be cleaned and the maintenance was responsible to clean the vent. During an interview on 6/5/2024, at 9:28 a.m., the RD acknowledged and stated the juice dispenser should be clean and well maintained to prevent any bacterial growth. She added, "It could have potential safety concerns for the patients," when not completely maintained or cleaned. She added, "It appears to be a concern and we will take actions." A review of departmental policy and procedure, titled, "Sanitation," dated 2023, it indicated, " ...All utensils, counters, shelves, and equipment shall be kept clean ..."	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,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. BUILDING _____ B. WING _____	06/06/2024

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F 880	Continued From page 43 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: (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.	F 880		

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F 880	Continued From page 44 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow infection control practices for one of 15 sampled residents (Resident 32) when the Certified Nursing Assistant 3 (CNA 3) did not apply a face shield (a device to protect the eyes and face) while assisting Resident 32 with meal in the Coronavirus-19 Disease (COVID-19, an infectious disease caused respiratory illness) unit. This failure had the potential to spread infection in the facility. Findings: Review of Resident 32's "Admission Record," indicated Resident 32 was admitted to the facility in 2024 with diagnoses including COVID-19. During an observation on 6/3/24 at 12:25 p.m. in Resident 32's room with CNA 3, the CNA 3 entered Resident 32's room, a COVID-19 positive room. The CNA 3 put on N-95 mask (a respiratory protective mask to provide efficient filtration of airborne), gown, and gloves. The CNA 3 assisted Resident 32 with meal and did not use any face shield or goggles. There was a visible sign by the wall of the room with instructions to don (put on) face shield and N-95, hand hygiene	F 880		

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F 880	Continued From page 45 before entering room, and don gown and gloves. During an interview on 6/3/24 at 12:32 p.m. with CNA 3 and Licensed Nurse 5, both staff members confirmed the Personal Protective Equipment (PPE) requirement in the COVID-19 unit was N-95 mask, gloves, gown and googles/face shield. During an interview on 6/6/24 at 9:06 a.m. with the Infection Preventionist (IP), the IP stated the PPE requirement in the COVID-19 unit for staff members are N-95 mask, gown, gloves, and google or face shield. Review of the facility's policy titled, "Coronavirus Disease (COVID-19)-Using Personal Protective Equipment," dated 5/2023, indicated, "When caring for a resident with suspected or confirmed SAR-CoV-2 [COVID-19] infection, personnel who enter the room of the resident ... use ...N95 or equivalent or higher-level respirator, gown, gloves, and eye protection [goggle or face shield]."	F 880		