POC Received 08/13/2024
POC Approved 8/18/2024
BIC = 8/18/24 per MK

PRINTED: 08/02/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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), 47563 HFEN, 34328 HFEN, 48140 HFEN, 49821 HFEN, 51078 Registered Dietician, 40830 The facility census was 55. The sample size was 15.	F 000	This plan of correction constitutes a credible allegation of compliance for the California Department of Public Health Recertification Survey that was conducted from 7/16/24 to 7/19/24.	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655	F 655 Temporary and Permanent Correction It is the policy of this facility to develop/ implement Comprehensive Person-Centered Care Plans as required in CFR(s): 483.21(a)(1)-(3) This includes but is not limited to: The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamie Jones	Administrator	8/11/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 655	Continued From page 1 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure baseline care plans (instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) were developed, implemented, and signed by the resident or responsible party within 48 hours of admission for two out of 15 sampled residents (Residents 260 and 261). This failure had the potential to cause residents and staff to be unaware of the residents' plan of care. Findings:	F 655	F 655 The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. Immediate Correction: R260's Care Plan was reviewed and updated by Nursing on 7/17/24 to address resident's diagnoses including sepsis and urine retention. Care Plan was delivered to resident and discussed to ensure understanding. R261's Care Plan was reviewed and updated by Nursing on 7/17/24 to address resident's diagnoses of dementia, pneumonia, and use of oxygen. Care Plan was delivered to residents and discussed to ensure understanding.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 655	Continued From page 2 A review of Resident 260's admission record indicated Resident 260 was admitted to the facility on 7/13/24, with diagnoses including sepsis (a life-threatening complication of an infection) and urine retention (difficulty urinating and completely emptying the bladder). During a concurrent observation and interview on 7/16/24 at 9:07 a.m., with Resident 260 in the resident's room, Resident 260 was observed with a urinary catheter. Resident 260 stated, "I was transferred here from the hospital about three days ago. I don't know how long I'm supposed to have the catheter." During an interview on 7/17/24 at 12:45 p.m. with Resident 260, in the resident's room, Resident 260 confirmed, "I didn't get a copy of the baseline care plan, no one specifically spoke to me about my goals or plan of care when I was admitted." A review of Resident 261's admission record indicated Resident 261 was admitted to the facility on 7/15/24 with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) and pneumonia (inflammation and fluid in your lungs caused by a bacterial, viral or fungal infection). During a concurrent observation and interview on 7/17/24 at 9:12 a.m. with Resident 261 in the resident's room, Resident 261 was observed sitting in her wheelchair with the oxygen concentrator running at 4 L (liters, a unit of measurement) per minute through a nasal cannula (a plastic tube that delivers extra oxygen into your nose) which was laying on the bed, out	F 655	F 655 To ensure that this deficient practice does not reoccur and that no future residents are affected by this deficient practice, the Director of Nursing will educate the MDS Coordinator and the Nurse Supervisors with an inservice on 8/9/24 regarding facility policy, "Baseline Care Plan and Comprehensive Care Plan", regarding developing care plans that meet each residents individual needs. Inservice will educate staff that baseline care plans need to be provided to the resident or resident's responsible party within 48 hours by either email, mail or a printed copy. To ensure compliance, Director of Nursing will review all new admissions during daily Interdisciplinary Team Meeting and ensure care plans are delivered within 48 hours of admission to resident and/or responsible party for one month. If 100% compliance, monitoring will be reduced to regular surveillance that is conducted by the DON, documented and reported to the Quality Assurance Committee Quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 655	Continued From page 3 of Resident 261's reach. Resident 261 stated, "I'm not sure if I should be wearing the oxygen or not." Resident 261 confirmed, "I didn't get a copy of the baseline care plan and no one spoke to me about my plan of care here [at the facility]." During a concurrent interview and record review on 7/18/24 at 9:24 a.m., with the DON (Director of Nursing) and the DCO (Director of Clinical Operations) Resident 260 and 261's baseline care plans were reviewed. The DON and DCO confirmed the baseline care plans were not completed within 48 hours of admission for Resident 260 and 261. The DON and DCO confirmed baseline care plans are completed within 48 hours of admission. Staff are required to provide the resident or resident's responsible party a copy of the baseline care plan by either email, mail, or a printed copy. The DON stated when a copy is provided to the resident the delivery method would be documented in a progress note and the baseline care plan would be documented as,"completed." During a review of the facility's policy and procedure (P&P) titled, "Care Plans - Baseline," revised March 2022, the P&P indicated, "A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission ...The resident and/or representative are provided a written summary of the baseline care plan ...Provision of the summary to the resident and/or resident representative is documented in the medical record."	F 655		
F 656 SS=F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 656	Continued From page 4 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the 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	F 656	F 656 Temporary and Permanent Correction It is the policy of this facility to develop/ implement Comprehensive Person-Centered Care Plans as required in CFR(s): 483.21(b)(1)(3) This includes but is not limited to: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 656	Continued From page 5 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 observations, interviews and record reviews the facility failed to develop and implement person-centered comprehensive care plans for four (4) residents (Resident 2, Resident 36, Resident 10, and Resident 56,) of 15 sampled residents when: 1. Resident 2 and Resident 36 did not have a care plan for the use of psychotropic (medication that affects the brain associated with mental processes and behavior) medications; 2. Resident 10 did not have a care plan for the use of a Wander/Elopement Alarm (WEA, a wearable device that alerts when the wearer wanders or elopes out of the building); 3. Nursing staff did not implement Resident 56's care plan when there was no WEA on him. These failures decreased the facility's potential to provide appropriate interventions and person-centered care. Findings: 1. A review of Resident 2's admission record indicated Resident 2 was admitted to the facility in February 2024 with diagnoses which included dysphagia (difficulty swallowing) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe).	F 656	F 656 (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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 656	Continued From page 6 During a review of Resident 2's "Order Summary Report (OSR, physician orders)," the OSR indicated Resident 2 was prescribed sertraline (a psychotropic medication) for depression manifested by feelings of sadness and loneliness. During a review of Resident 2's care plans on 7/17/24, there was no care plan for the use of Resident 2's psychotropic medication, sertraline. A review of Resident 36's admission record indicated Resident 36 was admitted to the facility in March 2024 with diagnoses including chronic kidney disease (a gradual loss of kidney function over time) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 36's OSR, the OSR indicated Resident 36 was prescribed seroquel (a psychotropic medication used to treat schizophrenia, bipolar disorder, and depression). During a review of Resident 36's care plans on 7/17/24, there was no care plan for the use of Resident 36's psychotropic medication, seroquel. 2. A review of Resident 10's admission record indicated Resident 10 was admitted to the facility in February 2024 with diagnoses including dementia without behavioral disturbance or anxiety (a group of thinking and social symptoms that interferes with daily functioning) and recurrent depressive disorders (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Resident 10's OSR, the OSR indicated Resident 10 had an order for a WEA.	F 656	F 656 Immediate Correction: R2's Care Plan was updated by Nursing on 7/17/24 to include the use of psychotropic medication Sertraline. R36's Care Plan was updated by Nursing on 7/17/24 to include the use of psychotropic medication Seroquel. R10's Care Plan was updated by Nursing on 7/17/24 to include a Wander/ Elopement Alarm. R56's Care Plan was updated on 7/17/24 to include the use of a Wander/ Elopement Alarm. To ensure that this deficient practice does not reoccur and that no future residents are affected by this deficient practice, an inservice will be provided by the Director of Nursing or her designee on 8/9/24 regarding facility policy, "Baseline Care Plan and Comprehensive Care Plan", regarding developing care plans that meet each residents individual needs, including the use of psychotropics. To ensure that this deficient practice does not reoccur and that no future residents are affected by this deficient practice, an inservice will be provided by the Director of Nursing or her designee on 8/9/24 regarding facility policy, "Baseline Care Plan and Comprehensive Care Plan", regarding developing care plans that meet each residents individual needs, including the use of wander/ elopement alarms.	8/9/24 8/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 656	Continued From page 7 A review of Resident 10's care plans on 7/17/24, there was no care plan for the use of Resident 10's WEA. During a concurrent interview and record review on 7/18/24 at 8:51 a.m. with the DON (Director of Nursing), Resident 2's and Resident 36's care plans were reviewed. The DON confirmed there were no care plans for Resident 2's and Resident 36's psychotropic medications. Resident 10's care plan was also reviewed, and the DON confirmed there was no care plan for the use of Resident 10's WEA. The DON stated comprehensive person-centered care plans should be completed within 21 days and are reviewed or updated as applicable and they should include specific orders from the physician. 3. Resident 56's admission record was reviewed and indicated the resident was admitted to the facility with diagnoses of disorientation, apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked), history of falling, and dementia. In an observation on 7/16/24 at 8:45 a.m., Resident 56 was in bed asleep and had bruises around the right eye and face. A WEA was wrapped around her right ankle. During an interview with the Licensed Nurse 3 (LN 3) on 7/16/24 at 8:37 a.m. the LN 3 stated Resident 56 fell last week and sustained bruising to her face and right eye. The LN 3 confirmed Resident 56 had a WEA on her right ankle. During a review of Resident 56's care plans indicated there were no comprehensive care	F 656	F 656 To ensure compliance, Director of Nursing will review 5 random resident's care plans who have psychotropic medications weekly for 90 days. If 100% compliance, Monitoring will be maintained through IDT and MDS reviews and care plan updates. To ensure compliance, Director of Nursing will review 5 random resident's care plans who have wander/elopement alarms weekly for 90 days. If 100% compliance, monitoring will be reduced to regular surveillance that is conducted by the DON, documented and reported to the Quality Assurance Committee Quarterly.	9/8/24 9/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 656	Continued From page 8 plans written for the use of a WEA device. During an interview and record review with the DCO on 7/18 at 8:33 a.m., the DCO reviewed Resident 56's care plans and confirmed there were no care plans for the use of use of a WEA. During a review of the facility's policy and procedure (P&P) titled, "Wandering and Elopements," revised March 2019, the P&P stated, "If identified as a risk for wandering, elopement or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety." A review of the facility's policy and procedure (P&P) titled, "Care Plans, Comprehensive Person-Centered," revised December 2016, indicated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and function needs is developed and implemented for each resident."	F 656		
F 658 SS=F	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 observations, interviews, and record review the facility failed to provide care and services in accordance with acceptable professional standards of quality for seven residents (Residents 2, 36, 19, 10, 34, 56, and	F 658	F 658 Temporary and Permanent Correction It is the policy of this facility for the services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet Professional Standards of quality, including but not limited to the rights specified in paragraphs 483.21(b)(3)(i).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 658	Continued From page 9 110) out of 15 sampled residents when: 1. Psychotropic medications (medication that affects the brain associated with mental processes and behavior) were prescribed for Resident 2 and 36 without appropriate indications, manifestations or monitoring of behaviors. 2. Resident 19, 14 and 110 nasal cannulas (a plastic tube that delivers extra oxygen into your nose) and humidifiers (devices used to humidify supplemental oxygen) were not labeled or dated, and oxygen was not provided per the physician order. 3. Resident 10 and Resident 34 had incomplete monitoring orders for a Wander/Elopement Alarm (WEA, a wearable device that alerts when the wearer wanders or elopes out of the building) 4. Resident 56 had a WEA on without a physician's order. These failures decreased the facility's potential to prevent worsening of the residents' clinical condition. Findings: 1. A review of Resident 2's admission record indicated Resident 2 was admitted to the facility in February 2024 with diagnoses which included dysphagia (difficulty swallowing) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe). During a review of Resident 2's Order Summary Report (OSR, physician orders), Resident 2 had an order for sertraline (a psychotropic medication) for depression manifested by feelings of sadness and loneliness. There was not an order for the	F 658	F 658 Immediate Correction: R2 and R36's use of psychotropic medications were clarified with Medical Director and orders updated to include appropriate indications, manifestations and monitoring of behaviors on 7/16/24. R19, R14 and R110's humidifers and nasal cannulas were labeled and dated. Oxygen was provided to residents R19, R14 and R110 per physician's order on 7/16/24. R10 and R34 monitoring orders were updated and completed for their wander/ elopement alarms to monitor placement, functional status and any behaviors on 7/18/24. R56 wander/elopement alarm was clarified with MD and MD order written and placed in chart on 7/18/24. Corrective action/s: All Licensed nurses currently employed at Auburn Ravine terrace will verbalize and demonstrate how to enter Psychotropics medications orders into the MAR system. Potential to be affected: All residents with Psychotropics medication can be affected by the alleged deficient practice. All psychotropic medication orders were reviewed after survey exit on 7/22/24, no discrepancies found.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 658	Continued From page 10 monitoring of Resident 2's feelings of sadness or loneliness noted on the OSR. A review of Resident 36's admission record indicated Resident 36 was admitted to the facility in March 2024 with diagnoses including chronic kidney disease (a gradual loss of kidney function over time) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 36's OSR, the OSR indicated Resident 36 was prescribed quetiapine (a psychotropic medication used to treat schizophrenia, bipolar disorder, and depression) for depression. The OSR for these psychotropic medications did not include indications, manifestations of behaviors for the use of these medications or orders to monitor behaviors identified. During an interview on 7/18/24 at 9:24 a.m. with the Director of Nursing (DON), the DON stated, "Orders for psychotropic medications need to identify the specific indication or behavior for the use of the medication for the resident...there needs to be an order to monitor those behaviors." A review of the facility's policy and procedure (P&P) titled, "Psychotropic Medication Use," dated July 2022, indicated, "Psychotropic medication management includes: indications for use, dose, duration, adequate monitoring for efficacy and adverse consequences, and preventing, identifying and responding to adverse consequences...Consideration of the use of any psychotropic medication is based on comprehensive review of the resident."	F 658	F 658 Systemic changes/corrective Measure: DON educated licensed nurses on 7/16/24 which included Psychotropics medications to be entered correctly into facility electronic medication record with appropriate indications, manifestations, or monitoring of behaviors. DON educated licensed nurses a second time on 8/9/24 which included Psychotropics medications to be entered correctly into facility electronic medication record with appropriate indications, manifestations, or monitoring of behaviors. Any nurse not receiving the education by 7/18/24 will not be allowed to work the shift until completed. New licensed nurses will be educated during orientation. New resident on Psychotropics medication orders will be reviewed How will it be monitored: Starting on 8/10/24, new orders with Psychotropics medications will be audited by DON or designee weekly M-F for 4 weeks. If 100% compliance, monitoring will be reduced to regular surveillance that is conducted by the DON, documented and reported to the Quality Assurance Committee Quarterly. The DON is responsible for the implementation of the plan of correction and the Administrator is responsible for sustained compliance for residents on Psychotropics medication.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 658	Continued From page 11	F 658		

2. A review of Resident 19's admission record indicated admission to the facility in June 2024 with diagnoses including acute respiratory failure (not enough oxygen in the tissues in your body) and chronic bronchitis (long term inflammation of the airways that carry air to the lungs).

During an observation on 7/16/24 at 8:47 a.m. in Resident 19's room, Resident 19 was observed laying in bed with oxygen running at 2 L (liters, a unit of measurement) per minute through a nasal cannula connected to a concentrator (a machine that takes air from your surroundings, extracts oxygen and filters it into purified oxygen for you to breathe) with a humidifier. The nasal cannula and humidifier were not dated and initialed.

During a concurrent observation, interview and record review on 7/16/24 at 11:11 a.m. with Licensed Nurse 4 (LN 4), in Resident 19's room, the LN 4 confirmed Resident 19's humidifier was not labeled with an open date and time and the nasal cannula was not labeled or dated.

Resident 19's OSR was reviewed, the oxygen order indicated continuous oxygen due to chronic respiratory failure at 1 L per minute through a nasal cannula. The LN 4 confirmed Resident 19's oxygen was running at 2 L per minute instead of 1 L. The LN 4 acknowledged the importance of following physician orders, and the goal was to wean Resident 19 off from the supplemental oxygen.

During a record review of Resident 14's facesheet, indicated Resident 14 was admitted with diagnoses of Idiopathic (relating to or denoting any disease or condition which arises

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 658	Continued From page 12	F 658		

spontaneously or for which the cause is unknown) Sleep Related Non-Obstructive Alveolar
(the the tiny air sacs in the lungs), Asthma (chronic lung disease caused by inflammation and muscle tightening around the airways, which makes it harder to breathe).

During the initial pool tour 7/16/24 at 9:44 a.m., Resident 14 was observed in her room and was receiving oxygen at 2 LPM nasal cannula via an oxygen concentrator machine.

In an During an interview with the LN3 on, 07/16/24 at 9:44 a.m., he confirmed the Resident 14 was on oxygen and the oxygen cannula did not have a date when it was applied. The LN3 stated the facility practice and expectations were all oxygen tubings must be labeled and the oxygen tubing changed once every week on Friday. The LN3 stated the nasal cannula had no date on the tubing and the humidifier that would indicate when it was first used and when it was due to be changed. The LN 3 stated he will label and change the oxygen NC tubing now.

Review of Resident 14's SRO indicated on 1/16/24:"... Supplemental oxygen via NC (Nasal Cannula) or oxymask to keep SpO2 (blood oxygen level above or equal 90%..."

A review of Resident 110's admission record indicated she was admitted to the facility with diagnoses of chronic respiratory failure with hypoxia (Insufficient oxygen level at the tissue level), chronic respiratory failure with hypercapnea (excessive carbon dioxide in the bloodstream, typically caused by inadequate respiration), and unspecified asthma (a long-term

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 658	Continued From page 13	F 658		

condition that affects the airways in the lungs).

During an observation and interview on 7/16/24 at 9:44 a.m. the LN 3 confirmed Resident 110 was receiving oxygen via oxygen concentrator. Further observation by LN3, he stated the oxygen cannula was not dated when it was applied. The LN 3 stated the facility practice was all oxygen tubes must be labeled and per protocol the cannula was changed once every week on Friday. The LN3 stated he will label and change the oxygen cannula now.

During a record review of Resident 110's OSR dated 7/9/24 indicated : "...Change humidifier bottle and O2 (oxygen) tubing q FRI (every Friday) on noc (night shift) and PRN (abbreviation for as necessary) every night shift every Friday..."

During an interview on 7/16/24 at 5:06 p.m. with the Director of Nursing (DON) and the Director of Clinical Operations (DCO), the DON and DCO both stated the oxygen tubing and the humidifier should be labeled with the date and time it was applied. The DCO confirmed the expectations were that all oxygen tubings would be labeled and changed every Friday.

A review of the facility's P&P titled, "Departmental (Respiratory Therapy) - Prevention of Infection," revised November 2011, indicated, "Distilled water used in respiratory therapy must be dated and initialed when opened and discarded after twenty-four (24) hours."

3. A review of Resident 10's admission record indicated admission to the facility with diagnoses including dementia without behavioral disturbance or anxiety (a group of thinking and social

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 658	Continued From page 14	F 658		

symptoms that interferes with daily functioning) and recurrent depressive disorders (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).

During an observation on 7/16/24 at 11:27 a.m. in the dining room, Resident 10 was observed sitting in her wheelchair.

During an observation on 7/17/24 at 9:29 a.m. in the hallway, Resident 10 was observed sitting in her wheelchair.

During concurrent observation and attempted interview on 7/18/24 at 11:57 a.m. in the dining room with Resident 10, Resident 10 was observed wearing a WEA on the left ankle. Resident 10 did not engage in conversation about the WEA.

During a review of Resident 10's OSR, the OSR indicated Resident 10 had an order for a WEA with a start date of 4/10/24. There were no orders to monitor the placement, functional status or behaviors that would warrant the use of a WEA.

A review of Resident 34's admission record, indicated Resident 34 was admitted to the facility in August 2023 with diagnoses that included adjustment disorder (emotional or behavioral reaction to change) with anxiety (worry and fear).

A review of Resident 34's Minimum Data Set (MDS, an assessment tool), dated 4/23/24, indicated Resident 34 has severe memory problems, used a wheelchair independently, and used a WEA.

A review of Resident 34's OSR, dated 7/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 658	Continued From page 15	F 658		

indicated an active order for "[WEA] to R [right] side of wheelchair to alert staff of attempts to leave building unassisted..." with a start date of 3/1/24. The OSR did not indicate any orders for monitoring placement or functional status of the WEA.

During an interview on 7/18/24 at 2:37 p.m., the DON stated, "Prior to the placement of a [WEA] staff would need to contact the physician to discuss if the [WEA] is appropriate and there should be a lot of documented attempts to exit the building.

During an interview on 7/19/24 at 10:10 a.m. with the DON and DCO, the DON and DCO confirmed orders for WEAs should include monitoring the placement and function of the WEA.

During a review of the P&P titled, "Wandering and Elopements," revised March 2019, the P&P stated, "If identified as a risk for wandering, elopement or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety."

A P&P for the use of wander/elopement alarms was requested on 7/19/24 at 10:10 a.m. from the DON and DCO. The facility was unable to provide a P&P for the use of WEAs.

4. Resident 56 facesheet was reviewed and indicated the resident was admitted to the facility with diagnoses of disorientation, apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked), history of falling, and dementia.

Resident 56 was seen on 7/16/24 at 8:45 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 658	Continued From page 16	F 658		

during an initial pool tour of the facility. The Resident was in bed asleep and observed that Resident 56 has bruising around her right eye and face. Resident 56 was observed to have a WEA in place on her right ankle.

During an interview with the LVN 3 on 07/16/24 at 8:37 a.m. he indicated the resident dad a fall last week and sustained bruising on her face and right eye. The LVN 3 confirmed that the resident has a WEA on her right ankle. The LN3 stated the resident was confused and was exit seeking from the building when she fell.

The Resident's bed was observed to be in a low position and a falls mat was in place at the bedside.

Review of Resident 56's nursing notes 7/12/24 indicated the resident fell and sustained bruises and a laceration by the right eye. Neuro checks were on going. Further review of the nursing notes from 7/12/24 through 7/18/24, there were no notation that indicated a WEA was applied to the resident's right ankle.

Further review of Resident 56's OSR dated 7/16/24, there were no physician's orders obtained for the use of a WEA.

During a record review of the resident 56's clinical records indicated there were no care plans in place for the use and monitor of a WEA.

During an interview with the Director of Clinical Operations (DCO) on 7/18 at 8:33 a.m. The DCO stated after reviewing the clinical record, that Resident 56 wore a WEA and there were no physician's orders nor care plans in place for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 658	Continued From page 17 use of a WEA. The DCO stated the MD must be notified and must order for the use of a WEA. During a record review of the facility policy and procedure Wandering and Elopements revised March 2019 indicated: "...The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents...1. If identified at risk for wandering, elopement, or other safety issues, the resident's care plan will include startegies and interventions to maintain the resident's safety. During a record review of facility policy Goals and Objectives, Care Plans revised April 2009 indicated: "...Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence...1. Care plan goals and objectives are defined as the desired outcome for a specific reisdent problem...3. Care plan goals and objectives are derived fro information contained in the resident's comprehensive assessment and: a. are resident oriented b. are behaviorally stated c. are measurable, and d. contain timetable to meet the resident's needs in accordance with the comprehensive assessment... 5. Goals and objectives are reviewed and/or revised: a. whne there has been a significant change in the resident's condition. b. when the desired outcome has not been achieved c. when the resident has been readmitted to the facility from a hospital/rehabilitatioon stay; and d. at least quarterly..."	F 658		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 758	Continued From page 18 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758	F 758 Temporary and Permanent Correction It is the policy of this facility to ensure residents are free from unnecessary use of psychotropic drugs/PRN use as required in CFR(s): 483.45(c)(3)(e)(1)-(5) Corrective action/s: All Licensed nurses currently employed at Auburn Ravine terrace will verbalize and demonstrate how to enter Psychotropics medications PRN orders with a 14 day stop date into the MAR system. Potential to be affected: Residents with Psychotropics medication orders can be affected by the alleged deficient practice. All psychotropic medication PRN orders were reviewed after survey exit on 7/22/24, no discrepancies found. Audit was conducted by the IDT members on 7/24/24 to ensure all PRN psychotropics medications have a 14 day stop date. Systemic changes/corrective Measure: Licensed nurses education completed by DON which included Psychotropics medications to be entered correctly with a 14 day stop date into facility electronic medication record (MAR) system on 7/16/24 and again on 8/9/24. How will it be monitored: Starting on 8/12/24, new orders For PRN Psychotropics medications will be audited by DON or designee weekly for 4 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 758	Continued From page 19 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure one resident (Resident 10) out of 15 sampled residents was free from unnecessary psychotropic medications when Resident 10 was prescribed an order for lorazepam (a psychotropic medication that affects the brain associated with mental processes and behavior) as needed (PRN) indefinitely. This failure had the potential to cause medication interactions, confusion, and falls. Findings: A review of Resident 10's admission record indicated Resident 10 was admitted to the facility in February 2024 with diagnoses including dementia without behavioral disturbance or anxiety (a group of thinking and social symptoms that interferes with daily functioning) and recurrent depressive disorders (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Resident 10's Order Summary Report (OSR, physician orders), Resident 10 had a physician order for lorazepam, oral tablet 0.5 mg (milligram, a unit of measurement) every 12 hours PRN for anxiety manifested by	F 758	F 758 If 100% compliance, monitoring will be reduced to regular surveillance and reported to the Quality Assurance Committee Quarterly. The DON is responsible for the implementation of the plan of correction and the Administrator is responsible for sustained compliance for residents on PRN Psychotropics medication.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 758	Continued From page 20 restlessness and angry outburst. During a concurrent interview and record review on 7/16/24 at 5:06 p.m. with the DON (Director of Nursing) and DCO (Director of Clinical Operations) Resident 10's OSR for lorazepam was reviewed. The DON and DCO confirmed Resident 10's lorazepam order was ordered PRN and without a stop date. The DON and DCO acknowledged as needed psychotropic medication orders should only be prescribed for 14 days and then reviewed for continued use or discontinuation. A review of the facility's policy and procedure (P&P) titled, "Psychotropic Medication Use," dated July 2022, indicated, "Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days."	F 758		
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 four residents (Residents 1, 18, 28, and 29) of 15 sampled residents when: 1. Resident 1 was administered morphine ER	F 759	F 759 Temporary and Permanent Correction It is the policy of this facility ensure the medication error rate did not exceed 5% as required in CFR(s): 483.45(f)(1)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 759	Continued From page 21 (extended release, narcotic pain medication) 15 mg (milligram, a unit of measurement) and pramipexole (medication used to treat restless leg syndrome) 0.125 mg at 11:13 a.m. when it was scheduled at 8 a.m.; 2. Resident 18 was administered omeprazole (used to treat heartburn) 20 mg and gemfibrozil (medication to help lower high cholesterol and triglyceride levels in the blood) 600 mg at 8:16 a.m. instead of 30 minutes prior to the breakfast meal.; 3. Resident 28 was administered gabapentin (used to treat nerve pain) 300 mg at 10:17 a.m. when it was scheduled at 8 a.m., and a lidocaine patch 5% (pain relieving patch) at 10:17 a.m. when it was scheduled at 7 a.m.; and, 4. Resident 29 was administered cephalexin (an antibiotic) 250 mg and lisinopril (used to treat high blood pressure and heart failure) 5 mg at 10:56 a.m. when it was scheduled at 8 a.m. These failures resulted in seven medication errors being identified out of 31 opportunities during an observation of medication administration which then resulted in the facility having a medication error rate of 22.58%. Findings: 1. During a medication pass observation on 7/17/24 at 11:13 a.m. with Licensed Nurse 4 (LN 4), the LN 4 prepared one tablet of morphine extended release (ER) 15 mg and one tablet of pramipexole 0.125 mg to administer to Resident 1. During a review of Resident 1's Order Summary Report (OSR), the OSR indicated one tablet of morphine ER 15 mg was to be administered twice	F 759	F 759 Immediate Correction: Corrective action/s: Licensed nurses were provided re-training and re-educated on medication administration by DON on 7/17/24. Administration will be observed by the DON or designee. Observation will consist of ensuring medications are being administered timely. This monitoring will be conducted once a week for 4 weeks. Finding will be reported to the QAPI committee for recommendation and modifications until a pattern of compliance is achieved. To ensure that no other residents are affected by this deficient practice, EMAR audit was completed by the Medical Records Director on July 24, 2024 to ensure all medications were administered timely. No others residents were affected by the alleged deficient practice. To ensure that this deficient practice does not reoccur and that no future residents are affected by this deficient practice, All Licensed Nurses will be provided an in-service education by contracted Pharmacy on general guidelines of medication administration on 8/9/24. The Medical Records Director will audit all EMARs weekly for one month. If 100% compliance, EMARs will be maintained monthly through DON or designee and monitoring will be reported to the Quality Assurance Committee Quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 759	Continued From page 22	F 759		

a day and one tablet of pramipexole 0.125 mg was to be administered once a day.

During a concurrent observation and interview on 7/17/24 at 11:13 a.m. with LN 4, the LN 4 confirmed both medications were scheduled to be administered at 8 a.m.

2. During a medication pass observation on 7/18/24 at 8:16 a.m. with LN 5, the LN 5 prepared one capsule of omeprazole 20 mg and one tablet of gemfibrozil 600 mg to administer to Resident 18.

During a review of Resident 18's OSR, the OSR indicated one tablet of gemfibrozil 600 mg one time a day, 30 minutes before breakfast, and one capsule of omeprazole 20 mg were to be administered twice a day.

During a concurrent observation and interview on 7/18/24 at 8:16 a.m. with LN 5, the LN 5 confirmed both medications should be administered 30 minutes before a meal. The LN 4 confirmed Resident 18 had already eaten her breakfast.

3. During a medication pass observation on 7/17/24 at 10:17 a.m. with LN 3, the LN 3 prepared one capsule of gabapentin 300 mg and a lidocaine patch to administer to Resident 28.

During a review of Resident 28's OSR, the OSR indicated one capsule of gabapentin 300 mg to be administered three times a day and one lidocaine patch 5% to be administered in the morning.

During a concurrent observation and interview on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 759	Continued From page 23 7/17/24 at 10:17 a.m. with LN 3, the LN 3 confirmed the gabapentin should have been administered at 8 a.m. and the lidocaine patch was scheduled to be administered at 7 a.m. 4. During a medication pass observation on 7/17/24 at 10:56 a.m. with LN 4, the LN 4 prepared one capsule of cephalexin 250 mg and one tablet of lisinopril 5 mg. During a review of Resident 29's OSR, the OSR indicated one capsule of cephalexin 250 mg and one tablet of lisinopril 5 mg to be administered once a day at 8 a.m. During a concurrent observation and interview on 7/17/24 at 10:56 a.m. with LN 4, the LN 4 confirmed both medications should have been administered at 8 a.m. During an interview on 7/18/24 at 2:45 p.m. with the Director of Nursing (DON), the DON confirmed the LN 3, LN 4 and LN 5 did not follow physician orders when medications were administered late. The DON stated, "It is important to administer medications at their prescribed times, especially antibiotics to ensure their efficacy." During a review of the facility's policy and procedure (P&P) titled, "Medication Administration - General Guidelines," dated March 2018, the P&P indicated, "Medications are administered in accordance with written orders of the attending physician."	F 759		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 801	Continued From page 24 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to	F 801	F 801 Corrective Action for Affected Resident: The deficiency did not identify a specific resident. Identification of Potentially Affected Residents: The deficiency addresses a regulatory requirement; as such, all residents are potentially affected. Measures to Prevent Recurrence: The Dietary Manager (DM) has resigned effective 8/9/24. We are interviewing Certified Dietary Managers and will hire at the earliest opportunity. Until the hiring of a CDM, an appointed DM will be under the supervision of a Registered Dietitian (RD). The RD will maintain a 24 hour per week, on-site, schedule beginning 8/13/24. The RD on-site hours will increase to 35 hrs. per week on 8/18/24. The RD will have a scheduled consultation once per week with the Dietary Manager that includes overseeing food safety, sanitation, food preparation, meal service and food storage. Consult notes will be reported to the Quality Assurance Committee Quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 801	Continued From page 25 November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.	F 801	F 801 The DSD and DM will complete the following in-services: -Meal Distribution and Modified/Pureed Food Texture Accuracy by 8/14/24. -Safe food handling and kitchen cleanliness on 8/9/24. -On proper labeling and dating of food items in the dry storage, walk-in refrigerator, and dry storage room completed on 8/9/24. -Disposal of expired items throughout the kitchen completed on 8/9/24. -Proper covering and storage of food completed on 7/17/24 -Cool down procedures and how to complete the cooling logs to be completed by 8/15/24. -How to check and complete the sanitizer concentrations log accurately completed by 8/15/24 A monthly kitchen audit will be completed by the RD and a report of findings will be given to the DM by 8/16/2024 for follow up. The RD will continue these audits on a weekly basis. The DM will maintain a record of RD documentation, and follow up, with a summary report to the facilityˇs Patient Care Quality Assurance Committee during its quarterly meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 801	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Dietary Supervisor (DS) met the state's education qualification requirements, as required per federal regulation, to be the DS to carry out the functions of the food and nutrition services. In addition, the facility failed to ensure the Registered Dietitian (RD) provided frequently scheduled consultations with the DS to include overseeing food safety and sanitation, food preparation, meal service and food storage. As a result, there were lapses in the delivery of food and nutrition services associated with meal distribution accuracy (cross reference F803), modified food texture accuracy (cross reference F805), and safe food handling and sanitation (cross reference F812), which lacked the benefit of a qualified DS responsible for the day-to-day food service operation for the skilled nursing facility. In addition, the facility lacked the benefit of the expertise of the RD input when there was not sufficient oversight over the food service operations via frequently scheduled consultation to the DS by the RD, when the job description and the contract of the RD was essentially based on clinical nutrition. There was a total of 53 out of 55 residents receiving meals from the facility kitchen. Findings: During the annual recertifications survey from 7/16/24 to 7/19/24, multiple issues surrounding the delivery of dietetic services were identified:	F 801	F 801 On 8/9/24, a master cleaning list will be implemented. Equipment and areas assigned are defined on the list and include those areas specifically noted in the deficiency. Monitoring: The DM will maintain documentation of required ServeSafe training inclusive of annual updates. The DM will meet with RD, at a minimum, on a weekly basis to review kitchen audits and plans of correction to assure safety and sanitation standards are maintained. The DM will submit a summary report during the facility's monthly Quality Assurance meetings, and during the facility's quarterly Patient Care Quality Assurance committee on audit findings and training.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 801	Continued From page 27 1. Meal distribution accuracy - the menu/spreadsheet (a tool helps the kitchen staff to identify food items, portion sizes and utensils (such as scoops, ladles, etc.) for different therapeutic diets) were not followed, and the portion size of food items were not served correctly; 2. Puree food texture was not prepared appropriately to meet residents' needs, and 3. Safe food handling and sanitation: a. Cooked chicken leftovers were found without temperature monitoring before being stored in the refrigerator for the cool down procedure; b .A cook did not practice ambient (room temperature) food cool down procedures when preparing ambient foods (such as tuna salad, egg salad, chicken salad, etc.); c. Bags of bread (English muffins and raisin bread) passed the used-by date were not discarded; d. Several sizes metal pans were found stacked wet, and few metal pans with brown and white substances on the food contact surfaces were stored at the clean and ready-to-use storage areas; e. The interior of the microwave was found dirty with food debris and liquid splashes; f. Several cutting boards were found with deep gouges, black substances and strong rancid odor; g. Employee's personal beverage containers were found at the resident's food/beverage preparation area, and h. The ice machines located in the kitchen and nourishment room (at nurse station) were not clean.	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 801	Continued From page 28	F 801		

During an initial kitchen tour and concurrent interview with the Dietary Supervisor (DS) on 7/16/24, at 9:13 a.m., the DS stated she started the position since in September last year (2023). She stated she was not certified as a Dietary Services Supervisor (DSS) or Certified Dietary Manager (CDM), and she added she was still taking courses to be a CDM. She stated there were two Registered Dietitians (RD) contracted to the facility and they visited the facility around 16 hours per week. The DS stated the RDs were responsible for clinical and monthly kitchen sanitation audit, but no in-services for the kitchen staff. She stated she was responsible for the in-services for the staff, but she only did one so far since she started working in the facility.

During an interview with the Regional Operations Director (ROD) on 7/17/24, at 2:14 p.m., he was aware the DS was not qualified for the current position. A concurrent review of the federal regulations with the ROD indicated the qualified personnel for the Dietary Manager position should meet one of the criteria from the state standards, Health and Safety Code 1265.4. The ROD acknowledged the requirements after he reviewed the state standards.

During an interview with the RD on 7/17/24, at 2:45 p.m., she stated she and the other dietitian visited the facility twice per week (around 16 hours per week) per contract. She stated she and the other dietitian were majorly responsible for clinical work (such as nutrition assessments, monitoring resident's weight and attending weight meeting, and consultations) and monthly kitchen sanitation audit. She stated she usually spent one to two hours for the kitchen sanitation audit monthly. She stated she did some meal tray

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 801	Continued From page 29	F 801		

monitoring and in-services for the staff last year but did not do any this year. She stated she spent approximately 80 percent of her visit time for clinical and 20 percent for foodservice operation (kitchen).

During a follow up interview with the RD on 7/18/24, at 10:30 a.m., she stated she was not aware the DS was not qualified for the position and did not meet the state standards. She stated she was aware that the DS still taking the courses to be CDM certified. RD stated she and the other dietitian covered the full-time position due to the previous dietary supervisor not being qualified. She stated the dietitians' hours cut back to part time since the new company took over and the new supervisor, DS, was on board for the position.

A review of the DS's employee file indicated the DS was hired by the facility on 3/22/24 for the full-time position as Dietary Manager. The file indicated DS had three associate degrees with management, business management and recreational management but no indication of any type of professional registration nor certification. The file included ServSafe certification (a certification provided after the completion of training and an examination of the knowledge of safe food handling), but this certification was not one of the requirements of the state standards.

A review of DS's job description (JD) provided by the facility, revised 6/2020, it did not indicate any education and experience requirements for the dietary supervisor position.

A review of the state's qualifying pathways to be a dietary manager as listed in the Health and Safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 801	Continued From page 30 Code (H & SC) 1265.4, "72035. Dietetic Service Supervisor. Dietetic service supervisor means a person who has completed the training requirements specified in section 1265.4(b) of the Health and Safety Code." A review of the RD's JD, revised 11/2017, it indicated the RD majorly was responsible for clinical work for the facility. A review of the facility-RD contract titled, "[Consulting Company Name] - Consulting Agreement," contracted started 4/1/2024, it indicated the scope of the RD's duties as consultant basis and responsible for clinical work for the facility. It also indicated the RD or RDs were contracted to work in the facility and did not exceed a maximum of 20 hours per week. The contract also indicated work days and hours were flexible and allowed the RD or RDs to be complete remotely for documentation and charting through the electronic medical record system 50 percent of the time.	F 801		
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	F 803	F 803 Temporary and Permanent Correction It is the policy of this facility to have Menus that meet the nutritional needs of residents in accordance with established national guidelines as required by CFR(s):483.60(c)(1)-(7) Immediate Correction: 1.The facility was provided the name of Resident 1. The issues specific to resident 1 are included in the correction outlined below for the other residents individually numbered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 31 reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the menu was followed for the therapeutic diets (a modification of a regular diet, tailored to fit the nutritional needs of a particular person - may be part of a treatment or medical condition and usually prescribed by a physician) during the lunch meal on 7/17/2024 when: 1. 44 out of 44 residents with regular portion size received two scoops (eight ounces (oz.) instead of three scoops (12 oz.) of pasta entrée, 2. Five residents (Resident 6, 9, 14, 33, and 49) with pureed texture diets (diet with modified food texture that is smooth and lump-free for people with swallowing and/or chewing difficulties) received pureed garlic bread sticks instead of soaked white dinner rolls, 3. 16 residents (Resident 7, 11, 19, 21, 25, 29, 32, 38, 39, 40, 43, 46, 52, 56, 110, and 261) who were on Level 5 Minced and Moist texture diets	F 803	F 803 Identification of Potentially Affected Residents: The deficiency addresses a regulatory requirement to ensure menu items are consistent to specific residents care needs and preferences. The menus are to be followed in accordance with the residents therapeutic diet. As such, all residents are potentially affected. Measures to Prevent Recurrence: Portion sizes were provided to cooks on 8/9/24. Therapeutic and mechanically altered diet extensions reviewed for accuracy and signed by RD completed by 8/15/24. Reviewed diet extensions printed and posted in kitchen on 8/15/24. Inservice on therapeutic diets provided to dining staff and nursing staff by RD to be completed by 8/16/24. Inservice on mechanically altered diets provided to dining staff and nursing staff by RD to be completed by 8/16/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 32 (modified texture diet for people with swallowing and/or chewing difficulties), Heart Healthy/Cardiac diets (diet with reduced amount of fat, cholesterol, and sodium for people who are at risk of heart diseases or have heart diseases), and/or Renal diets (diet for people with chronic kidney disease) received wheat dinner rolls instead of white dinner rolls, 4. Five residents (Resident 2, 4, 29, 36, and 52) with small portion diets (diet with controlled serving size is smaller for less calories or sometimes for person's preference) were not served with the correct measured serving size because the menu spreadsheet did not include small portions for accurate measurement. These failures had the potential to result in compromising the medical and nutritional status of 50 residents for a census of 55. Findings: 1. During an observation of lunch service on 7/17/24, beginning at 11:30 a.m., it was noted that 44 residents who were on the regular portion size diets received two scoops equaling 8 oz. (2 servings of a 4-oz. scoop equals 1 cup) instead of three scoops equaling 12 oz. (equals 1 ½ cups) of pasta entree. A concurrent review of the facility document entitled, "Diet Extensions: Wednesday, Week 2, Auburn Ravine- Spring/Summer," dated July 2024, it showed, 1 ½ cups (12 oz.) of pasta dish for all regular portion diets, including for Regular, IDDSI (International Dysphagia Diet Standardization Initiative, describes texture modified foods and thickened liquids used in care	F 803	F 803 Inservice on how to use and read diet extensions provided to dining staff and nursing staff by RD 8/16/24. Monitoring: The facility's dietary aide(s) will perform random tray accuracy audits daily of at least 1 tray per cart, per meal, for 60 days. Following the 60-day period, dietary aide(s) will complete a tray accuracy audit of 3 trays per week, to be on-going. A summary of audits will be maintained and reviewed by the RD to ensure compliance and if there are any additional training needs. The DM, RD, or their designee will maintain a record of these tray accuracy audits. Audits will be reviewed at the monthly Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 33	F 803		

settings) Level 5: Minced and Moist, Pureed, Consistent Carbohydrate (diet to control blood sugar level that is intended for people with diabetes), Heart Healthy/Cardiac, and/or Renal diets.

During an interview with the Dietary Supervisor (DS) on 7/17/24, at 12:38 p.m., the DS acknowledged that residents with regular sized portions received two scoops (8 oz.) of the pasta dish for lunch. A concurrent review of the "Diet Extensions" (a spreadsheet with different therapeutic diets residents should receive according to planned food items with specific portion sizes and modified food texture)" with the DS, she stated those residents should have received three scoops (12 oz.) of the pasta dish.

2. During an observation of lunch service on 7/17/24, beginning at 11:30 a.m., it was noted that five residents (Resident 6, 9, 14, 33, and 49) with puree texture diets were served a pureed texture garlic bread stick instead of a soaked white dinner roll (for pureed diets, bread items are sometimes soaked in a liquid such as milk to soften their texture).

A concurrent review of the facility document titled, "Diet Extensions: Wednesday, Week 2, Auburn Ravine- Spring/Summer," dated 7/2024, it indicated residents with pureed texture diets should receive a soaked white dinner roll.

During an interview with the DS on 7/17/24, at 12:38 p.m., the DS acknowledged that residents with pureed texture diets received pureed garlic bread sticks. After reviewing the Diet Extension, she stated those residents should have received the soaked white roll.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 34	F 803		

3. During an observation of lunch service on 7/17/24, beginning at 11:30 a.m., it was noted that 16 residents (Resident 7, 11, 19, 21, 25, 29, 32, 38, 39, 40, 43, 46, 52, 56, 110, and 261) who were on the IDDSI Level 5 Minced and Moist texture diet, Heart Healthy/Cardiac diet, and/or Renal diet received wheat dinner rolls instead of white dinner rolls.

A concurrent review of the facility document titled, "Diet Extensions: Wednesday, Week 2, Auburn Ravine- Spring/Summer," dated 7/2024, it indicated a white dinner roll was to be served for the following diets: IDDSI Level 5 Minced and Moist texture diet, Heart Healthy/Cardiac diet, and/or Renal diet.

During an interview with the DS on 7/17/24, at 12:38 p.m. she acknowledged that those residents with Level 5 Minced and Moist texture diets, Renal diet, and/or Heart Healthy/Cardiac diet received a wheat roll. After reviewing the Diet Extensions, she confirmed they should have received a white roll.

4. During an interview with the DS regarding the small portion on the Diet Extension on 7/16/24, at 9:05 a.m., the DS stated small portion sizes were not listed on the current menu system with the current menu company the facility was using. The previous menu company the facility used did include portion sizes for small meals on their menu/spreadsheets. The DS stated she has instructed the Cook and kitchen staff to give one-half amount of the regular diet for small portions. She confirmed the small portion did not have accurate measurements since the serving sizes and tools were not included on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 35	F 803		

menu/spreadsheet.

During an observation of lunch service on 7/17/24, beginning at 11:30 a.m., it was noted that five residents (Resident 2, 4, 29, 36, and 52) with small portion diets were not served an accurate measured portion because the Diet Extensions did not include precise measurements for small portion size diets.

During a follow up interview with the DS on 7/17/24, at 12:38 p.m., she acknowledged that those residents with small portions received one scoop (4 oz.) of pasta. She again confirmed that no portion measurements had been allotted on today's menu for small portion size diets and the portion amounts were discussed with the Cook and kitchen staff, and the measurement was up to the Cook's discretion.

During an interview with the Registered Dietician (RD) on 7/18/24, at 10:30 a.m., she stated the current menu company did not have the portion size for diets in the menus. She stated this problem needed to be fixed "right away" because it could affect residents who are being monitored for weight loss. She stated they were looking for a new menu company and the menu should include portion sizes with accurate measurements.

A review of facility document titled, "Diet Extensions: Wednesday, Week 2, Auburn Ravine- Spring/Summer," dated 7/2024, it did not indicate serving sizes (such as ounces, cups, etc.) for small portion diets.

A review of facility document titled "Job Description-Cook, Department: Dietary," revised 9/1/23, it showed, " ...Essential Job Functions:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 36 Follow recipes and prepare foods that correspond to menu cycles and recipes prepared by Dietician..." A review of facility document titled, "Dietary Aide-Job Duties and Responsibilities," revised 6/2020, it showed, " ...Food Services: Assist in checking diet trays before distribution ..." A review of facility policy and procedure titled, "Menus," revised 10/2017, it showed, " ...Menus are developed and prepared to meet resident ...needs while following established national guidelines for nutritional adequacy ...Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutritional Board (National Research Council and National Academy of Sciences)..."	F 803		
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: The facility failed to ensure the appropriate food texture for five residents (Resident 6, 9, 14, 33, and 49) who were on a puree texture diet and received pureed ziti with cheese with chunks of pasta and tomato. The total census was 55. This deficient practice had the potential to increase risk to the residents with swallowing and/or chewing difficulties to choke and/or aspirate (a condition in which food, liquids, saliva,	F 805	F 805 Temporary and Permanent Correction It is the policy of this facility to ensure each resident received and the facility provides food prepared in a form designed to meet individual needs as specified in CFR(s): 483.60(d)(3) Immediate Correction:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 805	Continued From page 37 or vomit is breathed into the airway). Findings: A concurrent observation and interview on 7/17/24, at 10:27 a.m. with Cook (C)1 were conducted during puree preparation for the lunch meal. C1 stated the texture for the puree pasta (ziti with cheese) should be smooth, like mashed potatoes. A concurrent observation and interview on 7/17/24, at 12:38 p.m., with the Dietary Supervisor (DS), were conducted during food sampling of the puree pasta for the test meal tray. The texture of the puree pasta and cheese entrée had a bulky, lumpy consistency when sampling. After tasting, the DS stated the pureed pasta texture was lumpy with noticeable chunks of pasta and tomato, and stated the texture was not correct. The DS stated the texture should have been a smooth consistency. She added that residents who have swallowing difficulties might have increased risk for choking on the food chunks. During an interview with the Registered Dietician (RD) on 7/18/24, at 10:30 a.m., she stated, ""I was very disappointed with yesterday's puree. I was very surprised because normally they do a very good with the purees." The RD disclosed she observed the puree pasta ziti with cheese when she performed dining observation on 7/17/24 lunch meal. She acknowledged the puree ziti with cheese had lumps and stated the kitchen staff and the cook needed more training for that issue. A review of the facility's pureed pasta procedure	F 805	F 805 Identification of Potentially Affected Residents: The deficiency addresses a regulatory requirement to ensure menu items are consistent to specific residents care needs and preferences. The menus are to be followed in accordance with the residents therapeutic diet. As such, all residents are potentially affected. Measures to Prevent Recurrence: Education on pureed/texture diets were provided to cooks on 7/17/24. Pureed/texture diets were reviewed for accuracy by RD and will be completed by 8/15/24. Inservice on pureed/texture diets provided to dining staff and nursing staff by RD to be completed by 8/16/24. Monitoring: The facility's dietary aide(s) will perform random tray accuracy audits daily of at least 1 tray per cart, per meal, for 60 days. Following the 60-day period, dietary aide(s) will complete a tray accuracy audit of 3 trays per week, to be on-going. A summary of audits will be maintained and reviewed by the RD to ensure compliance and if there are any additional training needs. The DM, RD, or their designee will maintain a record of these tray accuracy audits. Audits will be reviewed at the monthly Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 805	Continued From page 38 titled "PU4 Pasta Ziti Baked with Cheese [2] (PU4 Baked Ziti with Cheese)," dated 5/2024, it showed, "Blend [in food processor] until smooth ...Final product must not be sticky or gummy." Pureed foods are classified as Level 4 as established by the IDDSI Framework (International Dysphagia Diet Standardization Initiative, describes texture modified foods and thickened liquids for care settings). A review of a facility document titled "[Company name] Menu Solutions: Standards of Professional Practice-Diet Guide," updated 3/19/2021, under the section of "IDDSI Level 4: Pureed Food" indicated, " ...Description - This diet is used in the dietary management of dysphagia with food texture modification described as foods that are smooth and lump-free, not firm or sticky ..."	F 805		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812	F812 Corrective Action for Affected Resident: The deficiency did not identify a specific resident. Identification of Potentially Affected Residents: The deficiency addresses a regulatory requirement to ensure food is prepared, stored, served, and distributed in accordance with professional standards of food service safety; as such all residents are potentially affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 39 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 store, prepare, and distribute food in accordance with professional standards for food service safety when: 1) Cool down process was not performed for meat leftovers (any food that was prepared for service but was not served), 2) Procedure for cooling down method for ambient (room temperature) food was not being followed, 3) Metal serving pans had brown and white substances on the inside surface; serving pans were found stacked wet, 4) Expired bread had not been discarded, 5) Microwave had food debris on upper interior surface, 6) Several cutting boards had gouges, black smudges, and rancid odor, 7) Employees' beverage containers were stored in residents' food and drink preparation area, and 8) Ice machines in kitchen and nourishment rooms were not clean. These failures had the potential to lead to foodborne illness for a total of 53 out of 55 residents who received facility prepared foods. Findings: 1. During an inspection in the walk-in refrigerator on 7/16/24, at 10:28 a.m., a bucket of cooked leftover chicken breasts (cooked on 7/15/24) was found that did not have temperature monitoring and without the cool down process done before	F 812	F 812 Immediate Correction: On 7/16/24, chicken was thrown out and education was provided to dietary staff regarding cool down process for meat leftovers. On 7/17/24, dietary staff were educated regarding cool down method for ambient food. On 7/16/24, metal serving pans were re-washed and dried before being stacked On 7/16/24 all expired food was disposed of immediately. On 7/16/24, microwave was cleaned. On 7/17/24, any cutting boards with gouges, discoloration or odor were disposed of. On 7/16/24, employees' beverage containers were moved to the Dietary Office. Staff was educated about proper areas to store their food and drink. On 7/16/24, Maintenance Supervisor educated dietary staff on adequate cleaning for ice machines in kitchen and nourishment rooms. Ice machines in kitchen and nourishment rooms were cleaned again after training.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 40 being stored in the refrigerator. In a concurrent interview with the Dietary Supervisor (DS), she reviewed the weekly menu for the week and stated the chicken was prepared for the Asian Chicken salad for dinner on 7/15/24. When the DS was asked whether the cook performed a cool down process for the chicken pieces, she reviewed the Food Cooling Log and stated there was no entry for the chicken breasts for 7/15/24. She stated the cook who placed the chicken breasts in the refrigerator would return to work on 7/18/24. During a follow up interview on 7/17/24, at 9:05 a.m. with the DS, she stated Cook (C) 2 was the one who cooked the chicken in the walk-in refrigerator, and he would be in to work that morning at 10:30 a.m. During an interview with C 2 on 7/17/24, at 10:54 a.m., he stated someone else cooked the chicken breasts, but he was the one who put them in the refrigerator that evening (7/15/24) without taking the temperature of the chicken or following the cool down process. He stated, "It was a mistake," and specified that because he didn't perform the cooling down method, he wouldn't know whether the temperature of the food was within safe food parameters. During an interview with the Registered Dietitian (RD) on 7/18/24, at 10:30 a.m., she stated the cook should have done the cool down procedure for the leftovers before storing them in the refrigerator for food safety. She said, "We need to do the in-service, and we need to get a log for the process."	F 812	F 812 To ensure that this deficient practice does not reoccur and that no future residents are affected by this deficient practice, an inservice was provided by DSD/IP on 8/9/24 on Kitchen Cleanliness and Safety. The RD will complete a kitchen audit by 8/15/24 and report findings to the DM and Administrator. Audits will continue and reports forwarded to the DM and Administrator weekly. If 100% compliance, monitoring will be reduced to regular surveillance and reported by DM to the Quality Assurance Committee Quarterly. On 8/9/24, a master cleaning list will be initiated including the areas and equipment noted in the deficiency; examples of those lists are included as attachments. By 8/16/24, the listed ice machines will be inspected and professionally cleaned by a service technician per manufacturer˘s guidelines.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 41	F 812		

A review of facility's "Food Preparation and Service," revised Nov. 2022, it showed, " ...Potentially hazardous food (PHF) including meats, poultry ...Rapid Cooling: PHF are cooled rapidly. This is defined as cooling from 135 degrees Fahrenheit (F) to 70 F within two hours and then to a temperature of 41 F or below within the next 4 hours. The total cooling time between 135 F and 41 F is not to exceed 6 hours..."

A review of facility policy and procedure titled, "Use of Leftovers" (2013), it showed, "Leftovers must be cooled to 70 F within 2 hours and then down to 41 F within another 4 hours..."

2. During a concurrent observation and interview on 7/17/24 at 3:55 p.m., C 2 was preparing chicken salad for the evening meal, chicken salad sandwiches. C 2 stated there was no system for cooling ambient foods, nor was he practicing it. He verbalized the process of ambient food (such as tuna or egg salad) cool down with prompting. He stated he would put the made salads in the refrigerator but not take any temperature nor using the cool down log for monitoring. C 2 also stated he never practiced or had been told to do the ambient food temperature monitoring and cool down process.

During an interview with the DS on 7/18/24, at 2:55 p.m., she stated the kitchen did not have a policy and procedure for ambient foods, and the kitchen staff were not practicing the ambient cool down process.

During a follow up interview with the DS on 7/19/24, at 9:12 a.m., she changed her answer and stated the kitchen had a cool down process for ambient foods. However, she stated the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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	F 812		

were not monitoring the temperature after the cold salads were prepared. She confirmed that the staff should be monitoring the temperature and practicing the ambient food cooling down process.

A review of undated facility's policy and procedure titled, "Addendum to Food Preparation", it showed, "Ambient food being used for cold food preparation will be pulled from the shelf 24 hours in advance and placed in the refrigerator. Once pulled from the refrigerator, and opened, food items will be temped [temperature taken] to assure temperatures are 41 degrees or below. Once the preparation of the food is completed, the item will then be temped again to assure food temperature has not exceeded 41 degrees ...Ambient food prepared using ingredients from room temperature items for cold production must be cooled to 41 degrees within four hours ...Will maintain cooling logs for ambient food."

3. During a concurrent observation and interview on 7/16/24, at 9:53 a.m. and 10:12 a.m., there were several metal pans found having issues stored in the clean and ready-to-use areas as follows:
-9 of 1/3 sheet pans (stacked wet)
-3 of 1/2 sheet pans (stacked wet)
-4 of full sheet pans (stacked wet)
-2 of full sheet pans (had brown and white substances on the inside surfaces)
The Assistant Dietary Supervisor (ADS) stated the pans should be dried. She also stated the pans should be clean and the staff should check them before being stored away.

During an interview with the RD on 7/18/24, at 10:30 a.m., she stated the pans should be fully

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 43	F 812		

dried and clean before being stored away. The RD stated she would talk with the dishwasher about completely air drying the pans.

A review of facility's policy and procedure titled, "Sanitation: Dish Machine Usage and Testing," dated 10/01/2021, it showed, " ...Air dry: Place equipment or utensils onto a clean surface to air dry. Do not dry with a towel or other method ...Return to storage: Once equipment and utensils are completely air dried, they can be returned to storage..."

A review of the facility's policy and procedure titled, "Sanitation," dated 10/2008, it indicated all food contact surfaces and utensils must be washed to remove the soil completely before manual or machine wash, then sanitized.

4. During a concurrent observation and interview on 7/16/24, at 10:18 a.m., there was a tray of four bags of English Muffins with a label written, "Pulled 6/24/24, Use by 7/14/24." There was another tray of three bags of raisin bread with a label written, "Pulled 6/29/24, Use by 7/13/24." The ADS confirmed and stated those breads were past the use by date and should be discarded. She added the breads stored in the freezer are pulled out for thawing at room temperature. She stated it was everybody's responsibility to check the bread.

During an interview on 7/19/24, at 9:05 a.m. with the DS, she stated the bread was received frozen from the supplier and kept in the walk-in freezer. She stated the kitchen followed the dry storage guidelines for the bread, which could keep for five to seven days unopened or opened on the shelf. A concurrent review of facility policy and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 44	F 812		

procedure, "Food Receiving and Storage Policy and Procedure," dated 11/2022, with the DS, under the Refrigerated/Frozen Storage section, which stated that refrigerated foods should be eaten by their 'use by' date, or else need to be frozen or discarded. The DS confirmed that she would follow that section of the guidance for the dry foods which would be discarded if past the use by date.

During an interview with the RD on 7/18/24, at 10:30 a.m., she stated the kitchen staff need more training. She stated she planned to talk to the staff more about putting correct dates on labels. The RD stated, "There's no excuse. They shouldn't have them (expired bread items) there." She stated she had a prior discussion with kitchen staff about doing a daily walkthrough of food items and discarding expired food.

A review of facility's document titled, "Dry Goods Storage Guidelines," dated 2023, it indicated that the bread should be stored, "5-7 days unopened on shelf...5-7 days opened on shelf...This storage length is to be followed unless you have manufacturer's recommendation indicating otherwise."

A review of facility policy and procedure titled, "Food Receiving and Storage," revised Nov. 2022, it showed, " ...Refrigerated/Frozen Storage: Refrigerated foods are labeled, dated and monitored so they are used by their 'use by' date, frozen or discarded..." (The DS stated this guidance also applied to the dry food, which needed to be discarded when past the use-by date.)

5. An observation of the microwave oven

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 45	F 812		

cleanliness and concurrent interview was conducted on 7/16/24, at 10:09 a.m. The interior top portion of the microwave was found with food residue and liquid splash spots. Dietary Aide (DA) 1 confirmed and stated the microwave was dirty and that she cleans the oven every day. She stated the microwave was scheduled to be cleaned daily.

During an interview with the RD on 7/18/24, at 10:30 a.m., she acknowledged and agreed the microwave should be cleaned daily.

A review of facility's policy and procedure titled, "Sanitization," revised 10/2008, it showed, " ...All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair ..."

6. A concurrent observation of the cleanliness of cutting boards and interview was conducted with the ADS on 7/17/24, at 9:24 a.m. There were seven plastic cutting boards found with deep gouges, dark brownish black splotches on the surfaces, and a rancid odor. The ADS confirmed and stated the cutting boards were in bad condition and agreed they smelled. She also stated she would discard them.

During an interview with the RD on 7/18/24, at 10:30 a.m., she stated she was aware of the issues with the cutting boards. She stated she recommended they do a chorine wash, and she had also instructed the staff to discard marred or stained cutting boards. She stated the cutting boards should have smooth surfaces to be easily cleaned.

A review of the facility's policy and procedure titled, "Sanitization," revised 10/2008, it showed, "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 46 ...All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning ...All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/chemical sanitizing solutions ...Cutting boards (acrylic or hardwood) will be washed and sanitized between uses..." 7. During an initial kitchen tour on 7/16/24, at 9:00 a.m., an observation of the food preparation area and interview was conducted with the ASD. There were personal beverage containers found on the resident's food and drink preparation area. The ASD confirmed the beverage containers belonged to the kitchen staff. She stated there was no designated area for the staff's drink containers. In a follow up interview with the DS at 9:20 a.m., she confirmed that staff's drinks were in the food preparation area and agreed there should be a designated area for staff's belongings. During an interview with the RD on 7/18/24, at 10:30 a.m., she stated staff's personal items and drinks were not allowed in the food/beverage prep area and these items should be in a designated area. A review of the undated facility's policy and procedure titled, "Employee Health and Hygiene: Personal Items, Food and Drink," it showed, " ...Designate area within the facility for associates to store beverages-ideally 3 feet from any food preparation or storage area. Beverages should not be stored in and around cook areas or utility	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 47	F 812		

rooms ...Observe food preparation areas to ensure no food, drink ...are stored outside of their designated area..."

8. During an inspection of the ice machine in the kitchen on 7/16/24, at 11:20 a.m., the Dietary Aide (DA) 2 stated he was responsible for the monthly cleaning and sanitizing for the ice storage bin. He dissembled the top part (machinery part) of the ice machine. DA 2 stated he was also responsible for rinsing the water curtain (a plastic cover rest on the ice making panel of the top machinery component, the function is to prevent ice shooting out and redirect the ice to the ice storage bin) and the water trough (a component that holds the water before it is frozen during the ice making process) with hot water only. He stated he did not touch anything else other than the ice storage bin, water curtain and water trough.

During an interview with the Maintenance Supervisor (MS) on 7/16/24, at 11:40 a.m., he stated that the facility hired outside vendor and sent their technician to the facility and performed the deep clean (clean and sanitize the machinery part (top part) of the machine and the ice storage bin with the chemical solutions) of the ice machine every six months. Upon removing the ice machine's top access panel, the water curtain and the water trough, there were pink and slimy substances found. This was covering some portion outside of the water curtain and inside of the water trough and was easily removed when wiping with paper towel. There were significant black substances found at the bottom of the evaporator unit (a part where the water condenses and makes ice) and was easily wiped off with the paper towel. The MS stated the last deep clean was done on 3/25/24 and the water

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 48	F 812		

filter would be changed every year with the last change on 3/25/24. The MS confirmed the pink and black substances and stated maybe the ice machine was not scrubbed enough.

During an inspection of the ice machine in the nourishment room located at the nurse station on 7/16/24, at 11:43 a.m., the MS stated he was responsible to clean the ice storage bin and rinse the water curtain and water trough with hot water and clean the ice dispenser nostril monthly. When the MS removed the top access of the machinery part of the ice machine, there were pink slimy substances found on the water curtain and inside the water trough, and on the top and bottom rims of the ice making panel. The pink slimy substances were easily wiped off with paper towel. In addition, there were significant black substances found on the bottom of the evaporator unit and the black substances were easily wiped of with paper towel and felt the surface was not smooth when touched. The MS stated the outside vendor was responsible to do deep clean for the ice machine every six months and the last service was done on 3/25/24. The MS confirmed the pink and black substances were found and stated maybe the outside vendor technician did not scrub enough when cleaning the ice machine.

During an interview with the outside vender technician (OVT) on 7/16/24, at 3:35 p.m., he stated the previous technician may not be scrubbing the parts of the ice machine enough and the calcium deposits accumulated for both ice machines (kitchen and nourishment room). He stated the calcium deposits took times to be soften and clean better.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 49	F 812		

During an interview with the Registered Dietitian (RD) on 7/18/24, at 10:30 a.m., she stated the ice machine should be clean. She stated she checked the ice machine monthly during the monthly kitchen sanitation audit, but she did not check the top (machinery) part.

A review of the facility policy and procedure titled, "Sanitization," revised October 2008, indicated, "The food service area shall be maintained in a clean and sanitary manner... ice machine and ice storage containers will be drained, cleaned and sanitizer per manufacturer's instructions..."

A review of the undated kitchen ice machine manual titled, "[Manufacturer's brand] Ice Machines Installation, Operation and Maintenance Manual", indicated, "...You are responsible for maintaining the ice machine in accordance with the instructions in this manual. CLEANING/SANITIZING PROCEDURE This procedure must be performed a minimum of once every six months. The ice machine and bin must be disassembled, cleaned and sanitized... Removes mineral deposits from areas or surfaces that are in direct contact with water. PREVENTATIVE MAINTENANCE CLEANING PROCEDURE ... This procedure cleans all components in the water flow path, and is used to clean the ice machine between the bi-yearly cleaning/sanitizing procedure without removing the ice from the bin/dispenser ..."

A review of the undated nourishment room ice machine manual titled, "[Manufacturer's brand] Dispensers Installation, Use & Care Manual," indicated all removable and disassembled parts of the ice machine should be clean and sanitize with the cleaning and sanitizing solutions monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 50 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). In addition, on Section 4-202.11 Food-Contact Surfaces, it stated, " ...The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food-contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts ..." and " ...Multiuse Food-Contact Surfaces shall be: 1. Smooth; 2. Free of breaks, open seams, cracks, chips, inclusions, pits ..."	F 812		
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 813	F 813 Temporary and Permanent Correction It is the policy of this facility to ensure any food brought to residents by family and other visitors ensures safe and sanitary storage, handling and consumption of food as required in CFR(s): 483.60(i)(3)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 813	Continued From page 51 review the facility failed to ensure safe food handling and storage for food brought in by family for one resident (Resident 2) out of 15 sampled residents. This failure had the potential for Resident 2 to experience foodborne dangers, such as, nausea, vomiting and diarrhea by consuming moldy food. Findings: A review of Resident 2's admission record indicated Resident 2 was admitted to the facility in February 2024 with diagnoses which included dysphagia (difficulty swallowing) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe). During a concurrent observation and interview on 7/16/24 at 9:31 a.m. with Resident 2, in Resident 2's room, a transparent plastic container with a red plastic lid was observed on Resident 2's bedside table. Indistinguishable personal food items with greenish-blue spots and fuzzy growth were observed through the container. Resident 2 stated, "I'm not sure what those are, my family brought me that a while ago." During a concurrent observation and interview on 7/16/24 at 9:36 a.m. with Certified Nursing Assistant 1 (CNA 1) in Resident 2's room, the CNA 1 opened the plastic container and confirmed the contents in the container was, "old food with fuzzy mold." The CNA 1 stated, "[Resident 2] could've been really sick if she had eaten that." The CNA 1 received permission from Resident 2 to discard the food and plastic container.	F 813	F 813 Immediate Correction: CNA1 discarded R2's transparent plastic container with food and educated nursing staff on 7/16/24. No other residents were affected by this deficient practice. To ensure that this deficient practice does not reoccur and that no future residents are affected by this deficient practice Infection Preventionist inserviced staff on Personal Food Policy by 7/17/24. Infection Preventionist will randomly audit 5 rooms weekly for 60 days to ensure Personal Food Policy is being followed.. If 100% compliance, Monitoring will be maintained randomly. Audits will be shared in Monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 813	Continued From page 52 During a concurrent observation and interview on 7/18/24 at 2:33 p.m. with DON (Director of Nursing) a photo of Resident 2's plastic container with personal food items inside was shown to the DON. The DON confirmed the personal food items, "looks moldy." The DON stated, "Personal food items brought in by family should have the resident's name, date, and time on the container. The food item will be refrigerated for 24 hours and then it will get thrown away. Items left out at room temperature should be thrown away after two hours." During a review of the facility's policy and procedure (P&P) titled, "Foods Brought by Family/Visitors," revised March 2022, indicated, "Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the "use by" date...The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates.)	F 813		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a clean environment for the residents and visitors when one of one garbage dumpster, located outside the facility, was not closed securely due to deformed dumpster lids.	F 814	F 814 Temporary and Permanent Correction It is the policy of this facility to dispose garbage and refuse properly as required in CFR(s): 483.60(i)(4) Immediate Correction: Maintenance Supervisor called contracted Refuse Company on 7/23/24 and had new dumpsters with new lids delivered on 7/23/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 814	Continued From page 53 This failure had the potential for an unsafe environment for the residents and visitors due to possible pest infestation and spread of diseases in the facility. Findings: During a concurrent observation and interview on 7/16/24, at 10:52 a.m., it was observed one out of one outside dumpster was covered with its two lids. However, the dumpster lids were bowed away from the midline where they converged, leaving a two-inch gap in between. The deformed lids lacked the integrity to securely cover the bin. The Dietary Supervisor (DS) confirmed the condition of the dumpster lids and agreed that either the lids needed to be fixed or the facility needed a new trash bin. During an interview with the Director of Clinical Operations (DCO) on 7/19/24, at 9:35 a.m., she stated the facility did not have a policy and procedure regarding dumpster conditions. The DCO stated the maintenance department called a waste management company and had to purchase new lids for the dumpsters. According to the Food and Drug Administration (FDA) Food Code 2022, Section 5-501.15 Outside Receptacle, referenced 7/23/24, "(A) Receptacles and waste handling units for refuse ...used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers."	F 814	F 814 This deficiency did not identify a specific residents. The deficiency addresses a regulatory requirement to maintain garbage dumpster lids be closed when not in use; as such, all residents are potentially affected. To ensure that this deficient practice does not reoccur and that no future residents are affected by this deficient practice, the maintenance and dietary supervisor, or their designee, shall inservice all staff who access the dumpster of the requirement to ensure the lids are closed after, and between, uses. The Maintenance Director, or their designee, will visually confirm the dumpster lids are secure. These visual confirmations will begin on 8/9/24. Visual confirmation will occur at random times, on a weekly basis, for one month. A report, logging the findings, will be maintained in the facility's TELS system for review by the facility's monthly Quality Assurance committee. A summary report will be made available to the facility Patient Care Committee during its quarterly meeting.	
F 839 SS=F	Staff Qualifications CFR(s): 483.70(f)(1)(2)	F 839		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 839	Continued From page 54 §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one Certified Nursing Assistant (CNA), CNA 2, of five sampled CNAs had a valid CNA license. This failure had the potential to result in all 55 residents in the facility to receive care from an unqualified person. Findings: During a concurrent interview and record review on 7/19/24 at 11:44 a.m. with the Director of Nursing (DON), the CNA 2's license verification was reviewed. The DON confirmed CNA 2's license verification indicated an expiration date on 7/18/24. The DON stated she expected CNAs who worked at the facility to have a valid CNA license. During a concurrent observation and interview on 7/19/24 at 11:48 a.m. with the Director of Staff Development (DSD) in the facility's dining room, CNA 2 was assisting residents with their lunch meal. The DSD stated she was aware CNA 2's license was getting close to expiration, CNA 2 had not yet submitted an updated CNA license	F 839	F 839 Temporary and Permanent Correction It is the policy of this facility to ensure Staff Qualifications as required in CFR(s): 483.70(f)(1)(2) Immediate Correction: CNA 2 was taken off of patient lineup immediately on 7/19/24. This deficiency did not identify a specific resident. The deficiency addresses a regulatory requirement that professional staff must be licensed, certified, or registered in accordance with applicable State laws; as such all residents are potentially affected. To ensure that this deficient practice does not reoccur and that no future residents are affected , DSD will run a report of all employees coming due for re-licensure and/or recertification on a monthly basis, and following up with individual employees accordingly. Reports will be available to the facility's Quality Assurance Committee for review and/or further action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 839	Continued From page 55 and confirmed CNA 2 was currently working a CNA shift. An interview on 7/19/24 at 11:53 a.m., CNA 2 confirmed she has not received a CNA license renewal yet and her CNA license was expired. A review of the facility's policy and procedure titled "Competency of Nursing Staff" revised May 2019, indicated, "...all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law..." A review of California Health and Safety Code, Division 2. Licensing Provisions, Chapter 2. Health Facilities Article 9, Section 1337.6, effective date 7/12/06, indicated, "...The department shall give written notice to a certificate holder 90 days in advance of the renewal date and, 90 days in advance of the expiration of the fourth year that a renewal application has not been submitted, and shall give written notice informing the certificate holder, in general terms, of the provisions of this article. Nonreceipt of the renewal notice does not relieve the certificate holder of the obligation to make a timely renewal. Failure to make a timely renewal shall result in expiration of the certificate...."	F 839		
F 880 SS=F	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	F 880	F 880 Temporary and Permanent Correction It is the policy of this facility 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 as required by CFR(s): 483.80(a)(1)(2)(4)(e)(f)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 56 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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	F 880	F 880 Immediate Correction Infection Preventionist informed EVS staff on proper hand sanitation when entering and exiting resident's rooms on 7/18/24. Infection Preventionist informed EVS staff on adequate use of Personal Protective Equipment on 7/18/24. Infection Preventionist informed CNA staff on proper hand sanitation when entering and exiting resident's rooms on 7/18/24. Infection Preventionist put PPE Equipment in Laundry Room on 7/19/24. Maintenance Supervisor obtained Laundry Machine Handbooks and educated EVS staff on proper temperatures for washing and drying laundry. To ensure that no other current or future residents are affected by this deficient practice and that this practice not reoccur, the Infection Preventionist provided the following inservices to all staff: Bloodborne Pathogens and Hand Hygiene on 7.24.24. DSD provided Inservice on 8/9/24 regarding Laundry Regulations and proper use of PPE.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 57 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to maintain an infection control program for a census of 55 residents when: 1. Facility staff were observed not performing hand sanitation when entering and exiting resident's rooms; 2. Soiled linens were processed without adequate use of Personal Protective Equipment (PPE, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses); and, 3. The washing machine's water temperature was not monitored. These failures decreased the facility's potential to prevent the spread of disease and infections among residents.	F 880	F 880 To ensure continued compliance, Infection Preventionist will conduct 5 random audits for CNA staff weekly for 30 days to ensure proper hand hygiene. If 100% compliance monitoring will be reduced to regular surveillance that is conducted by the Infection Preventionist, documented and reported to the Infection Control Committee Quarterly. To ensure continued compliance, Infection Preventionist will conduct 5 random audits for EVS staff weekly for 30 days to ensure proper PPE use and monitoring of laundry machine temperatures. If 100% compliance monitoring will be reduced to regular surveillance that is conducted by the Infection Preventionist, documented and reported to the Infection Control and Quality Assurance Committee Quarterly. Infection Control Policies will be reviewed and approved by the Patient Care Policy Committee at least annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 58	F 880		

Findings:

1. During an observation and concurrent interview with Environmental Service 1 (EVS 1) on 7/18/24 10:32 a.m., the EVS 1 was observed entering and exiting resident rooms 24, 25, 12, and 13 without performing hand sanitation. The EVS 1 was observed to push her cart near room 12, entered room 12 with gloved hands without sanitizing her hands. The EVS 1 was observed to exit room 12, removed her gloves, and donned a new pair of disposable gloves without sanitizing her hands with the intention of entering room 13. The EVS 1 confirmed she had been trained in handwashing and hand sanitation practices, but was rushing and trying to save time to complete her work.

During an observation and concurrent interview on 7/18/24 at 11:05 a.m., the EVS 2 was observed to exit room 4 holding towels with ungloved hands. The EVS 2 proceeded to open the lid of the hamper with her bare hands and tossed the dirty towels into the linen hamper. The EVS 2 immediately re-entered room 4 without sanitizing her hands. The EVS 2 then touched the resident's clean blanket and began to rearrange it. The EVS 2 stated the towels were from the patient's bathroom sink in and confirmed the towels were dirty and needed to be placed in the dirty laundry hamper. The EVS 2 she confirmed she should have worn gloves. The EVS 2 stated she was in a hurry. The EVS 2 also confirmed she should have washed her hands before going into the resident's room and tidying up the resident's blanket.

During an observation and concurrent interview on 7/18/24 11:20 a.m., the Certified Nursing Assistant 3 (CNA 3) was observed to enter and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 59	F 880		

exit rooms 4, 8, and 9 without using any of the alcohol-based hand sanitizers located throughout the hallway to sanitize her hands. The CNA 3 confirmed she had not sanitized her hands and should have done so before entering the residents' rooms.

During an observation on 7/18/24 at 11:25 a.m. resident rooms 4, 8, and 9 were observed to have faucets and sinks with soap dispensers available for use to wash hands.

2. During an inspection of the facility laundry department was performed on 7/19/24 at 9:12 a.m. accompanied by the Infection Preventionist (IP). The laundry department was divided into two sections: one room for storage of dirty linens and the other room was for storage of clean linens. The dirty linens section was observed to have one box of disposable gloves but no other PPE equipment was accessible in the dirty linens room.

During an observation of the clean linens section of the laundry room on 7/19/24 at 9:15 a.m. the Linen Room Technician (LRT) was observed folding clothes and linens. In a concurrent interview the LRT stated she was folding the washed and clean linens.

The LRT was asked to demonstrate how she processed the dirty linens to be washed. The LRT entered the dirty linens room and stated she donned disposable gloves. The LRT stated she transported the dirty linen hamper into the laundry room and the dirty linens were placed into the washing machines to be washed. The LRT stated she would then remove the disposable gloves from her hands and would sanitize her hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 60	F 880		

The LRT confirmed she had never worn a cover gown or faceshield when processing dirty linens, she wore only disposable gloves. The LRT further stated she had not been trained to use a gown or face shield when processing dirty linens.

In an interview with the IP on 7/19/24 at 9:30 a.m., the IP confirmed there were no other PPE in the dirty linens room except for the gloves. Concurrent interview the IP, she stated the LRT staff should be wearing gloves, a gown, and face shield when processing and handling dirty linens.

In a further tour of the clean linen section of the laundry department with the IP and LRT on 7/19/24 at 9:45 a.m., the LRT confirmed there were two washing machines and two dryers in the department. The LRT stated she did not know if the washing machines or dryers were high or low temperature machines. The LRT further stated she did not knowwhat the water temperatures should be in the the washing machines, nor what the dryer machine temperatures were supposed to be when drying the clothes. The LRT stated she had not been monitoring temperatures for either the washing or dryer machines. The only log she kept was for cleaning the lint screens of the dryers.

The LRT further indicated the washing machines were supplied from a dedicated hot water line. She pointed to a "tankless" water heater and had a digital readout which indicated 131 degrees Fahrenheit (a unit of measurement that is used to measure temperature). The LRT was not aware of what the minimum temperatures should be when washing the dirty linens.

In an interview with the Maintenance Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61	F 880		

(MS) on 7/19/24 at 9:50 a.m., the dryer temperature was checked with a heat gun and indicated 139 degrees Fahrenheit (F). The MS stated he did not know what the optimal temperature range the dryers and the washing machines were supposed to operate within. The MS confirmed he was in charge of the Laundry Department. The MS stated the hot water supply for the washing machines came from a "tankless" water heater and the temperature reading from a digital thermometer was 131 degrees F. The MS stated he was unaware the temperatures were needed to be monitored on the washing machines and the dryers. There were no other temperature measuring tools to indicate how hot the water temperatures gets with the washing cycles, nor the dryers temperature when in operation.

A review of an electronic mail addressed to the MS by the laundry company dated 7/19/24 at 11:46 a.m. indicated, "...The washer does not have an internal water heater. However water temps [temperatures] on a Hot fill setting should be around 150 degrees F...The dryers are as follows...Low heat temp= 140 degrees, Medium heat temp= 160 degrees, High heat temp= 185-190 degrees..."

A review of the facility policy and procedure titled "Laundry and Bedding soiled" revised September 2022 indicated, "...Soiled laundry/bedding shall be handled, transported and processed according to the best practices for infection prevention and control. Handling...All used laundry is handled as potentially contaminated using standard precautions (e.g. gloves and gowns when sorting...Onsite Laundry Processing...Laundry processed in hot water temperatures is 160

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 62 degrees F for 25 minutes." A review of an undated facility procedure titled "Isolation Laundry Procedures" indicated, "...Procedures...Wear rubber gloves and gown/apron...Set booster water heater according to instructions to highest setting..."	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop, implement, and monitor an infection control program with the use of antibiotics when: 1. The Infection Prevention and Control Program (IPCP) failed to monitor the laboratory indications on the use of antibiotics. 2. There were inadequate tracking tools in use for tracking of residents on antibiotics and the indications for the use of antibiotics 3. There were inadequate infection control inservices for the facility staff on handwashing. These failures had the potential for residents to be exposed and acquire infectious diseases causing illness.	F 881	F 881 Temporary and Permanent Correction It is the policy of this facility to have an Infection prevention and control program that includes elements such as an antibiotics stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use as required in CFR(s): 483.80(a)(3) Immediate Correction: Nurse Consultant educated Infection Preventionist on 7/18/24 on monitoring laboratory indications when residents are on antibiotics. Nurse Consultant provided Infection Preventionist tracking tools on 7/18/24 to be used for tracking residents on antibiotics and the indications for the use of antibiotics. Facility Staff were re-educated on required hand hygiene on 7/19/24 and inserviced on 7.24.24. This deficiency had the potential to affect all residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 881	Continued From page 63 Findings: 1. During an interview with the Infection Preventionist (IP) on 7/18/24 02:35 PM the IP was asked to provide the tracking tool she used to monitor residents who were using antibiotics. The IP was further asked aside from the tracking tool she used what were the clinical indications for the use of the antibiotics. The IP provided a map of the facility which she stated she used to monitor residents that were having Urinary Tract infections (UTI) which were rooms 11, 23, 24, 25, 26. The IP was asked how she verified and confirmed the specific residents in rooms 11, 23, 24, 25, 26 who had a UTI. The IP was not able to answer who were the specific residents in the room that had UTI, nor the confirming laboratory indicators of a urinalysis (a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes), urine culture and sensitivity (C/S A culture is a test to find germs (such as bacteria or a fungus) that can cause an infection and antibiotics that the germs may be resistant). She was not using any other tool to track antibiotic use. The IP was asked who were the current residents she had that were on antibiotic treatment. The IP state for Resident 35 (3 A), the Medical Doctor (MD) prescribed Ciprofloxacin, an antibiotic for the treatment of UTI. The IP was asked what was the laboratory indication for the use of the antibiotic, she stated she had not checked for the urinalysis and the C/S indication. She was asked to check the lab of Resident 35 and the culture result dated 7/18/24 result was "urogenital flora" (normal). Concurrent interview with the Director of Clinical Operations she was was asked to	F 881	F 881 To ensure that this deficient practice does not reoccur and that no other future residents are affected by this deficient practice, Infection Preventionist will monitor antibiotic use of all residents and their laboratory indications. Infection Preventionist will utilize tracking tools for all residents on antibiotics and the indications for the use of antibiotics. The Infection Preventionist will randomly audit 5 patients on antibiotics weekly for 60 days. If 100% compliance, monitoring will be reduced to regular surveillance and reported to the Quality Assurance Committee Quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 881	Continued From page 64	F 881		

verify the laboratory findings, and she stated it was normal and the resident had no indications for use of the antibiotic. The DCO stated she will clarify with the MD if not to discontinue the medication.

Further interview with the IP on 7/18/24 at 2:55 p.m. the IP was asked to verify if Resident 29 in room 4 was on antibiotics. The IP was not aware if resident 29 was on antibiotics. The MD orders were reviewed with the IP and she confirmed that Resident 29 was on antibiotic Cephalexin 250 mg (milligrams, a dosage) by mouth was ordered on 5/31/24. Further interview with the IP she stated the Cephalexin was ordered to be given 1 capsule once a day for Prophylaxis (preventative) related to Urinary Tract infection. The IP was asked to verify if the resident had any urinalysis or culture and sensitivity labs done to indicate the Resident had any UTI. The IP confirmed there were no laboratory examinations ordered. Further interview with the IP the antibiotic Cephalexin was started on 5/31/24 and as of 7/18/24 Resident 29 had been on antibiotics a total of 48 days for the prevention of UTI. Concurrent interview with the DCO she stated the used of Cephalexin antibiotic for UTI prophylaxis was not normal clinical indications for usage. The DCO stated she will clarify with the MD if not discontinue the medication.

2. During an interview with the Infection Preventionist (IP) on 7/18/24 02:35 PM the IP was asked to provide the tracking tool she used to monitor residents who were using antibiotics. The IP was further asked aside from the tracking tool she used what were the clinical indications for the use of the antibiotics. The IP provided a map of the facility which she stated she used to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 881	Continued From page 65	F 881		

monitor residents that were having Urinary Tract infections (UTI). The IP was asked how she verified and confirmed the rooms 11, 23, 24, 25, 26 had UTI. The IP was not able to answer who were the residents in the room that had UTI nor the confirming laboratory indicators of a urinalysis (a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes), urine culture and sensitivity (C/S A culture is a test to find germs (such as bacteria or a fungus) that can cause an infection and antibiotics that the germs may be resistant). She was not using any other tool to track antibiotic use.

Concurrent interview with the DCO she stated there were tracking tools for the IP to use in the Electronic Health Records (EHR). The DCO stated it was still in development and not yet active. The DCO confirmed there were no other tools in used for monitoring infections and for the use of antibiotics.

3. During an interview with the IP on 07/18/24 at 2:42 PM The IP was asked about staff infection control in-services specifically hand washing. The IP was made aware of observations made on staff who were not performing hand hygiene when going in and out of residents rooms. The IP stated in-services were done on handwashing, and she confirmed all employees whether they are clinical or non clinical employees are expected to attend handwashing inservices. The IP was asked to provide the staff in-services attendance sheets on handwashing from January 2024 to current date of 7/18 /24. The IP stated that ALL staff must attend handwashing in-services whether they are clinical or non-clinical employees. The IP stated and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 881	Continued From page 66 verified total number of employees were 82. The breakdown were Fulltime employees were 59, Part time were 15, on call were eight (8). The IP provided the In-service Training attendance on Handwashing and the sign in attendance sheets dated 2/6/24 for in-service times of 6:30 a.m. and 2:10 p.m. total staff who attended were six (6) staff members. The IP confirmed that was all the inservices she had on file. Review of some of the Infection Prevention Nurse job description indicated: "...Plan, develop, organize, implement evaluate, coordinate, and direct our infection control program in accordance with the current rules, regulations, and guidelines that govern such requirement...Interpret infection control policies and procedures as necessary...Assist the supervisor of laundry services in developing infection control procedures for the handling of clean and soiled laundry and linen, equipment cleaning...Ensure that all nursing service personnel follow established isolation precautions ..to include standard/universal precautions..."	F 881		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities.	F 919	F 919 Temporary and Permanent Correction It is the policy of this facility to have a resident call system that is adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside and toilet and bathing facilities as required in CFR(s): 483.90(g)(1)(2)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 919	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a call light (a device used by a resident to signal the need for help) was accessible for one of 15 sampled residents (Resident 11). This failure had the potential to result in unmet resident needs and delayed staff response. Findings: A review of Resident 11's admission record, indicated Resident 11 was admitted to the facility in 2016 with diagnoses that included spastic hemiplegia (uncontrolled muscle movements on one side of the body), contracture (permanent tightening of muscles which causes stiffness and prevents normal movement of a body part), polyarthritis (painful inflammation and stiffness affecting five or more joints at the same time), dementia (a loss of memory and problem-solving abilities which interfere with daily life) and a history of falling. A review of Resident 11's Minimum Data Set (MDS, an assessment tool), dated 5/1/24, indicated Resident 11 had moderate memory problems, impairments to both upper body and lower body, and was dependent on staff for mobility and care related to incontinence (unintentional passing of urine and bowel movements). During a concurrent observation and interview on 7/16/24 at 1:15 p.m. with Resident 11 in Resident's 11 room, Resident 11 was sitting up in a padded chair in her room, leaning and slumped	F 919	F 919 Immediate Correction: R11's call light was immediately placed in reach of resident on 7/16/24. To ensure that no other residents are affected by this deficient practice, Director of Staff Development will review all call lights to ensure proper placement and that it is within reach of patient. To ensure that this deficient practice does not reoccur and that no future residents are affected by this deficient practice, an inservice will be provided by the DSD or her designee on facility policy regarding call lights by 8/16/24. DSD will randomly audit 5 call lights per week for 90 days and keep a log of compliance. Compliance will be shared in Quarterly QA meeting as well as Monthly Safety Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 919	Continued From page 68	F 919		

on her left side, with a strong odor of feces coming from resident. Resident's 11 call light was tied to the resident's bed out of reach of Resident 11. Resident 11 had a grimace on her face and stated she needed staff's help but she could not reach her call light to get staff's attention.

During a concurrent observation and interview on 7/16/24 at 1:19 p.m. with Certified Nurse Assistant 2 (CNA 2) in Resident 11's room, CNA 2 confirmed Resident 11 could not reach the call light that was tied to the bed while she was sitting in the chair in her room. CNA 2 acknowledged the call light is supposed to be left in reach of Resident 11 so she can call for assistance.

During a concurrent observation and interview on 7/19/24 at 1:20 p.m. with Licensed Nurse 4 (LN 4) in Resident 11's room, the LN 4 confirmed Resident 11's call light was out of Resident 11's reach and confirmed staff should ensure call light is in reach of Resident 11 so she could communicate when she needs help.

An interview on 7/19/24 at 8:22 a.m., the Director of Staff Development (DSD) stated she expected staff to ensure call lights are in reach and added, if the call light is not in reach the resident cannot get the attention of nurses for care needs and may try to get up on their own and fall.

An interview on 7/19/24 at 11:44 a.m., the Director of Nursing (DON) stated she expected call lights be left in resident's reach and added, if call lights are not in reach residents may not be able to communicate with staff when they need help and could lead to resident becoming upset.

A review of the facility's policy and procedure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 919	Continued From page 69 titled, "Call System, Residents", dated September 2022, indicated, "Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station...Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor..."	F 919		
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to ensure the required in-service trainings for three of four sampled Contracted Certified Nursing Assistants (CCNA 1, CCNA 2, and CCNA3) and three of five	F 947	F 947 Temporary and Permanent Correction It is the policy of this facility to have required in-service trainings for nurse aides as required in CFR(s): 483.95(g)(1)-(4) Immediate Correction: Administrator followed up with staffing agencies to obtain required training documentation for contracted staff working in the facility on 7/24/24. DSD will provide mandatory trainings will be provided to all staff, including contract personnel by 8.16.24. To ensure that this deficient practice does not reoccur and that no future residents are affected by this deficient practice, DSD will ensure required in-service trainings are complete prior to contract staff working in the facility. To ensure compliance, DSD will review 5 CNA's and 5 contract CNA's to ensure required inservices and required documentation has been completed weekly for 90 days. This information will be shared during monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 947	Continued From page 70	F 947		

sampled facility employed Certified Nursing Assistants (CNA 2, CNA 3, and CNA 4), when the facility was unable to provide documentation to demonstrate the CCNAs and CNAs had no less than 12 hours per year of continuing competencies including dementia (a loss of memory and problem-solving abilities which interfere with daily life) management and abuse prevention.

These failures had the potential to result in CCNAs and CNAs not identifying and reporting abuse nor being able to effectively care for residents with dementia.

Findings:

In an interview on 7/18/24 at 2:59 p.m., the Director of Clinical Operations (DCO) stated the facility used contracted staff through staffing agencies and she expected those staffing agencies to provide CCNAs mandatory training documentation for facility to review before scheduling the CCNAs to perform patient care.

During a concurrent interview and observation on 7/18/24 at 3:04 p.m., the Staffing Coordinator (SC) stated the facility used three staffing agencies for the CCNAs and the staffing agencies send over documentation to demonstrate the CCNAs completed the mandatory annual trainings. The SC logged onto two of the three staffing agency's online portals to look for documentation to demonstrate the CCNAs had completed the abuse prevention and dementia management trainings. The SC confirmed she could not find any documentation to support the CCNAs had completed any of the mandatory annual trainings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 947	Continued From page 71	F 947		

During a concurrent interview and observation on 7/19/24 at 8:22 a.m., the Director of Staff Development (DSD) stated she did not have a specific training plan for the CCNAs, she would encourage them to attend any in-service trainings hosted by the facility if they were present when trainings occurred, and she believed the staffing agencies provided the CCNAs with annual mandatory trainings including abuse prevention and dementia management.

During a concurrent record review and interview on 7/19/24 at 1:53 p.m. with the Regional Operations Director (ROD) and the DCO. All three staffing agency contracts were reviewed. The ROD confirmed two of the contracts indicated the facility was responsible to provide contracted staff with trainings and the third contract did not indicate who was responsible for trainings. The DCO confirmed the facility was responsible to ensure the CCNAs completed annual trainings prior to working in the facility. The ROD stated he would follow up with the staffing agencies to request training documents for contracted staff who have worked in the facility.

A review of CCNA employee records conducted on 7/19/24 indicated the following:
-CCNA 1 worked in the facility on 7/10/24 and 7/13/24. There was no documented evidence to support CCNA 1 completed dementia management training or completed at least 12 hours of training within the last year or prior to working in the facility.
-CCNA 2 worked in the facility 21 times since 6/6/24. There was no documented evidence to support CCNA 2 completed dementia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 947	Continued From page 72	F 947		

management training or completed at least 12 hours of training within the last year or prior to working in the facility.
-CCNA 3 worked in the facility on 7/14/24. There was no documented evidence to support CCNA 3 completed dementia management training or completed at least 12 hours of training within the last year or prior to working in the facility.

In an interview on 7/19/24 at 3:29 p.m., the ROD stated he reviewed the available CCNA training records and confirmed the facility could not show complete mandatory annual training records for CCNAs.

A review of CNA employee records conducted on 7/19/24 indicated no documented evidence to support CNA 2, CNA 3, and CNA 4 completed training for dementia management and abuse prevention, or completed at least 12 hours of training within the last year.

In an interview on 7/19/24 at 3:53 p.m., the ROD stated he reviewed the CNA training documents for CNA 2, CNA 3, and CNA 4 and confirmed the facility did not have documentation to support the CNAs completed mandatory annual trainings as required.

In an interview on 7/19/24 at 4:14 p.m., the DCO stated she reviewed the CNA training documents for CNA 2, CNA 3, and CNA 4 and confirmed the facility did not have the documentation to support the CNAs completed mandatory annual trainings as required.

A review of the facility policy and procedure "Competency of Nursing Staff," revised May 2019, indicated, "...nursing assistants employed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555645	A. BUILDING _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN RAVINE TERRACE	750 AUBURN RAVINE ROAD AUBURN, CA 95603

(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 947	Continued From page 73 (or contracted) by the facility will: participate in facility-specific, competency-based staff development and training program....and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents...The facility assessment includes an evaluation of the staff competencies that are necessary to provide the level and types of care specific to the resident population...The type and amount of this training is based on the facility assessment..." A review of the Facility Assessment Tool, dated 6/25/24, indicated, "...Our resident profile...common diagnosis...Alzheimer's disease (a progressive disease that destroys memory and other important mental functions which interfere with activities of daily living), non-Alzheimer's dementia...staff training/education and competencies...Required in-service training for nurse aides. In-service must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training..."	F 947		