STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555206	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Creek Post Acute	12696 Monte Vista Road Poway, CA 92064

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on interview and record review, the facility failed to send a copy of the transfer/discharge notice to the ombudsman's office when one of three reviewed discharged residents (Resident 139) required immediate transfer to an acute care hospital for urgent needs. This failure resulted in a lack of resident discharge notification to the State Long Term Care (LTC) Ombudsman representative and the potential advocate, to assist the resident with appeal rights. Findings: Resident 139 was admitted to the facility on [DATE] with diagnoses which included a history of atrial fibrillation (irregular and often very rapid heart rhythm), per the Admission Record. On 2/13/25 at 4:09 P.M., a review of Resident 139's clinical record was conducted. Resident 139's progress note indicated Resident 139 was transferred to an acute care hospital on 12/18/24 at 18:15 [6:15 P.M.] for positive norovirus (a contagious virus that causes vomiting and diarrhea). On 2/13/25 at 4:20 P.M., an interview was conducted with the Medical Records Director (MRD). The MRD stated she was not responsible to notify the ombudsman regarding hospital transfers, and further stated that the Case Manager and the Social Services Director (SSD) may be the ones who contacted the ombudsman for hospital transfers. On 2/13/25 at 4:23 P.M., an interview was conducted with the SSD. The SSD stated that he does not contact the ombudsman regarding hospital transfers. The SSD further stated, I would think it's the nurses that would do that. The SSD stated it was important to contact the ombudsman regarding hospital transfers because they were advocates for residents and can help with appeals as needed. On 2/14/25 at 7:40 A.M., an interview and record review with licensed nurse (LN) 1 was conducted, at nursing station three. LN 1 stated she did not think that the nursing staff was responsible for contacting the ombudsman regarding hospital transfers. LN 1 stated Resident 139's clinical record did not indicate if the ombudsman was notified. LN 1 stated that Resident 139's son and physician were the only ones notified during the hospital transfer. LN 1 stated it was important to notify the ombudsman of Resident 139's transfer to the hospital so that the ombudsman would know where Resident 139 was, and to advocate for the resident for any appeals and/or concerns. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 9:18 A.M., an interview and record review was conducted with the Admission's Coordinator (AC), in the AC's office. The AC stated she was unable to find documentation in Resident 139's clinical record that indicated if the ombudsman was notified. The AC stated she was not aware that she had to fax the ombudsman a Transfer/Discharge Notification and stated it was important to notify the ombudsman of Resident 139's hospital transfer in order for the ombudsman to know where Resident 139 was and to help advocate for any concerns and/or appeals. On 2/14/25 at 10:02 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that the case manager was involved with discharges to home. The DON stated that she planned on having the MRD and the AC work together to make sure that the Transfer/Discharge Notification form was faxed to the ombudsman for hospital transfers. The DON further stated it was important for the ombudsman to be notified about hospital transfers to help with concerns and appeals. A review of the facility's undated policy and procedure titled, TRANSFER or DISCHARGE NOTICE, indicated .A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on interview, and record review, the facility failed to ensure one of three reviewed discharged resident's (Resident 139) or his family member received a notice to request a bed hold when the resident was transferred to the acute care hospital. As a result, Resident 139 and/or his family member did not receive a written notice from the facility at the time of transfer, about the option to pay to hold the resident's bed. Findings: A review of Resident 139's Admission Record indicated Resident 139 was admitted to the facility on [DATE] with diagnoses which included a history of atrial fibrillation (irregular and often very rapid heart rhythm). On 2/13/25 at 4:09 P.M., a review of Resident 139's clinical record was conducted. Resident 139's progress note indicated Resident 139 was transferred to an acute care hospital on 12/18/24 at 18:15 PM [6:15 P.M] for positive norovirus (a contagious virus that causes vomiting and diarrhea). On 2/14/25 at 7:40 A.M., an interview and record review with licensed nurse (LN) 1 was conducted, at nursing station three. LN 1 stated Resident 139's clinical record did not indicate if Resident 139 and/or his responsible party (RP) were notified of the facility's bed hold policy. LN 1 further stated that it was important to notify Resident 139, and his RP of a bed hold policy as an option for Resident 139 to return to the facility (within seven days) without penalty, or to be notified about out-of-pocket payments that could occur. On 2/14/25 at 9:18 A.M., an interview and record review was conducted with the Admission's Coordinator (AC), in the AC's office. The AC stated she was unable to find documentation in Resident 139's clinical record that indicated if the facility's bed hold policy was provided to Resident 139 or Resident 139's family member. The AC further stated that Resident 139 and/or family should have been notified of the bed hold policy within 24 hours in order for Resident 139 and his family to be aware of a reserved bed for him at the facility, along with out-of-pocket expenses that may have been needed after the seven-day bed hold policy. On 2/14/25, a review of Resident 139's bed hold consent form was conducted. The bed hold consent form sections for confirmation of transfer & bed hold provision and the 24 hour notification were not completed. On 2/14/25 at 10:02 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that the case manager was involved with discharges to home. The DON stated that the nurses were responsible to inform the residents on admission, of the facility's seven-day bed hold policy. The DON stated, it was important to give Resident 139 and his family the opportunity that they can come back here and were explained non-coverage expenses. The facility did not provide a bed hold policy and procedure.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to reevaluate two of 30 sampled residents (2, 57) reviewed for mental health services. As a result, residents may have had unmet mental health needs. Findings: 1. Per the facility's Admission Record, Resident 2 was admitted to the facility on [DATE]. Per the Admission Record, Resident 2 was diagnosed with major depressive disorder (a depressed mood impairing daily function) and schizoaffective disorder (a mental disconnection from reality) on 6/25/24. On 2/11/25 a review was conducted of Resident 2's electronic medical record. There was no documentation that a Level II Mental Health Evaluation (an evaluation for additional services for residents with mental illness) was conducted for Resident 2. On 2/13/25 at 1:30 P.M., an interview was conducted with the Minimum Data set (MDS, a federally mandated resident assessment tool) nurse. The MDS nurse stated, Resident 2 should have been reviewed for a Level II Mental Health Evaluation when she was diagnosed with major depressive disorder and schizoaffective disorder. 2. Per the facility's Admission Record, Resident 57 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD, a mental health condition caused by a traumatic event) and bipolar disorder (a mental health condition with significant shifts in mood). Per the Admission Record, Resident 57 had a new diagnosis of major depressive disorder on 2/27/21. On 2/11/25 a review was conducted of Resident 57's electronic medical record. There was no documentation that a Level II Mental Health Evaluation was conducted for Resident 57. On 2/13/25 at 1:30 P.M., an interview was conducted with the MDS nurse. The MDS nurse stated, Resident 57 should have been reviewed for a Level II Mental Health Evaluation when she was diagnosed with major depressive disorder. The facility's undated policy, titled PASRR (Patient Assessment and Resident Review) Completion Policy did not direct staff to reevaluate residents with a new diagnosis of a mental illness.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to notify the physician of a high blood sugar reading for one of 30 sampled residents (23). As a result, Resident 23 had an increased risk of untreated symptoms of high blood sugar. Findings: Per the facility's Admission Record, Resident 23 was admitted to the facility on [DATE] with diagnoses to include, type 2 diabetes mellitus (unstable blood sugars). Per the facility's Medication Administration Record (MAR), dated 1/1/25 through 1/31/25, Resident 23 had an order for the physician to be notified of blood sugar readings greater than 290. Per the MAR, the following blood sugar readings were greater than 290. On 1/5/25 at 11:30 A.M., Resident 23's blood sugar was 322. On 1/8/25 at 4:30 P.M., Resident 23's blood sugar was 293. On 1/10/25 at 11:30 A.M., Resident 23's blood sugar was 337. On 1/11/25 at 11:30 A.M., Resident 23's blood sugar was 313. On 1/11/25 at 4:30 P.M., Resident 23's blood sugar was 294. On 1/19/25 at 11:30 A.M., Resident 23's blood sugar was 305. On 2/13/25, Resident 23's electronic medical record was reviewed. There were no progress notes on 1/5/25, 1/8/25, 1/10/25, 1/11/25, and 1/19/25 that indicated the physician was notified of Resident 23's high blood sugar readings. On 2/14/25 at 8:41 A.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated, when he notified the physician of a high blood sugar reading he documented it in the progress notes. The DSD further stated, he should have documented in the progress notes if he called the physician. On 2/14/25 at 12:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated, the nurses who took the high blood sugar readings should have notified the physician and documented it in the progress notes. Per the facility's undated policy, titled Guidelines for Notifying Physicians of Clinical Problems, .The floor nurse .should contact the attending physician at any time if they feel a clinical situation requires immediate discussion and management .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47956 Based on observation, interview, and record review, the facility failed to provide an environment free from accident hazards for 28 of 28 sampled residents, when screws were observed protruding from handrails inside the facility. This failure had the potential to cause injury to all facility residents. Findings: On 2/13/25 and 2/14/25, observations were made of the handrails inside of the facility. A total of eight handrails were observed to have screws protruding through the interior aspect of the handrail. These screws were found to be at a height where an individual's hand grasping the handrail would contact the sharp end of the screw. During an interview on 2/13/25 at 3:36 P.M. with Certified Nursing Assistant 12 (CNA 12), CNA 12, upon touching the object, stated it was sharp, like a nail or screw. CNA 12 further stated it would definitely hurt someone. It should not be like that. During an interview on 2/13/24 at 3:40 P.M. with the Maintenance Director (MD), the MD stated That is probably a screw. That could hurt somebody. During an interview on 2/13/25 at 3:42 P.M. with the Director of Nursing (DON), the DON stated If a resident grabbed it, it would cut them. It should not be like that. During a review of the facility's policy titled Maintenance Service, the policy indicated .2. Functions of Maintenance personnel include .b. Maintaining the building in good repair and free from hazards .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to implement professional standards of care for a peripherally inserted central catheter (PICC: catheter [flexible plastic tubing] that is inserted into a vein in either arm and extends all the way to a location near the heart, where medication is delivered) dressing for one of seven sampled residents (Resident 340) receiving intravenous (IV: into the vein) medications, according to the facility's policies and procedures. This failure had the potential to expose Resident 340's PICC site to infections and lead to complications that may negatively impact the resident's health and well-being. Findings: A review of Resident 340's Admission Record indicated Resident 340 was admitted to the facility on [DATE] with diagnoses which included a history of osteomyelitis (inflammation of bone or bone marrow, usually due to infection). A record review of Resident 340's minimum data set (MDS - a federally mandated resident assessment tool) dated 2/7/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 340 did not have cognitive (pertaining to memory, judgement and reasoning ability) deficits. A record review of Resident 340's care plan dated 2/6/25 indicated, .IV DRESSING: (RUA [right upper arm]). Observe dressing Q [every] shift. Change dressing and record observations of site . On 2/11/25 at 10:13 A.M., an observation and interview was conducted with Resident 340, in Resident 340's room. Resident 340 had a RUA PICC line that was dated 1/31/25. Resident 340 stated the nursing staff did not perform any PICC line dressing changes since her admission to the facility. Resident 340 stated she was on an IV antibiotic (medications used for infections) due to her middle toe amputation for osteomyelitis. On 2/11/25 at 10:30 A.M., an interview was conducted with licensed nurse (LN) 2. LN 2 stated PICC line dressings should be changed on a weekly basis to prevent infection and PICC line complications. On 2/12/25 at 2:27 P.M., an interview and record review was conducted with LN 1. LN 1 was shown a picture that was taken on 2/11/25 at 10:15 A.M. of Resident 340's PICC dressing that was dated 1/31/25. LN 1 stated that Resident 340 was admitted to the facility on [DATE] and stated that Resident 340's PICC line dressing should have been changed on 2/7/25. LN 1 stated PICC line dressings should have been changed every week to prevent infection and IV complications. LN 1 stated there was no documentation to support that a dressing change to the PICC site was done within the weekly time frame. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 10:10 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that her expectations were for the admission nurses to assess any residents with an IV site to check the dressing, and change the dressing according to the facility's policy's and procedure for IV dressing changes within seven days. The DON stated that it was important to provide IV site care and dressing changes to prevent IV site complications and infection. According to Centers for Disease Control (CDC) https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5110a3.htm .Central venous catheters including peripherally inserted central catheters and hemodialysis catheters . Replace gauze dressings every 2 days and transparent dressings every 7 days on short-term catheters . A review of the facility's policy and procedure titled Peripheral IV Dressing Changes undated, indicated . Change the dressing if it becomes damp, loosened or visibly soiled and at least every 5-7 days .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to provide respiratory care according to standards of practice for one of eight reviewed residents (Resident 38) on a nebulizer (a device that turns the liquid medicine into a mist which is then inhaled through a mouthpiece or a mask) treatment. As a result, Resident 38 was not properly monitored before and after nebulizer treatments were provided, and had the potential for ineffective nebulizer administration, respiratory complications, and infections that increased the risk of negative health outcomes. Findings: A review of Resident 38's Admission Record indicated Resident 38 was readmitted to the facility on [DATE] with diagnoses which included a history of chronic obstructive pulmonary disease (COPD; chronic lung disease causing difficulty in breathing). A record review of Resident 38's Minimum data set (MDS; nursing facility assessment tool) dated 12/23/24 indicated that Resident 38 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions. On 2/11/25 at 8:30 A.M., an observation was conducted with Resident 38, in Resident 38's room. Resident 38 was asleep and lying on her bed covered with blankets. Resident 38's side table by the left wall had a nebulizer machine placed on top of the table with a mask and tubes placed on the nebulizer machine. The nebulizer mask had scattered condensation of clear liquid on the mask along with a nebulizer chamber that had a heavy amount of condensation (mist-like moisture) throughout the chamber. On 2/11/25 at 3:36 P.M., an interview and clinical chart review for Resident 38 was conducted with licensed nurse (LN) 1, at nursing station three. LN 1 stated that Respiratory Therapy (RT) provided nebulizer treatments to Resident 38. LN 1 stated the treatment administration record (TAR) did not record a post respiratory vital signs (lung sounds, heart rate, respiratory rate, oxygen saturation [below 90% means low oxygen levels]) and was not certain if the vital signs documented on the TAR at 7 A.M. were taken before or during the respiratory treatment. On 2/12/25 at 2:49 P.M., an interview and clinical chart review for Resident 38 was conducted with RT 1. RT 1 stated that Resident 38 was scheduled to receive DuoNeb (a combined respiratory therapy medication to treat COPD) via nebulizer at 7 A.M. and 7 P.M. On 2/14/25 at 7:56 A.M., an interview and clinical chart review for Resident 38 was conducted with RT 2, outside of Resident 38's room. RT 2 stated she gave Resident 38 a nebulizer treatment at 7 A.M. and stated during nebulizer treatments they [RTs] stay with the residents and the treatments lasted approximately 8-10 minutes. RT 1 stated there was no record of a pre (before) and post (after) documentation. RT 2 stated there is no before and after documentation for respiratory vital signs and further stated we only do it [vital signs] one time during the procedure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 8:26 A.M., an interview and clinical chart review for Resident 38 was conducted with RT 1, at nursing station two. RT 1 stated that it was important to take pre and post respiratory vital signs for nebulizer treatments to know Resident 38's baseline and monitor for effectiveness and/or complications from the nebulizer treatment. RT 1 stated respiratory vital signs should not have been recorded and documented during or in the middle of the nebulizer treatment. On 2/14/24 at 9:51 A.M., an interview was conducted with the Director of Nursing (DON), in the DON's office. The DON stated her expectations were for the RTs to monitor Resident 38's respiratory vital signs before and after performing a nebulizer treatment and not during to get a baseline comparison and to monitor for respiratory complications after the nebulizer treatment. The DON acknowledged that ongoing monitoring for respiratory distress symptoms should have been monitored throughout the nebulizer treatment to prevent respiratory complications. A review of the facility's policy and procedure titled ADMINISTERING MEDICATIONS THROUGH a SMALL VOLUME (HANDHELD) NEBULIZER, indicated .26. Obtain post-treatment, pulse, respiratory rate and lung sounds .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to respond to a pharmacist recommendation related to high levels of fat in the blood, for one of 30 sampled residents (23). This failure had the potential to affect Resident 23's health and well-being. Findings: Per the facility's Admission Record, Resident 23 was admitted to the facility on [DATE] with diagnoses of hyperlipidemia (high levels of fat in the blood). On 2/14/25 a review of the facility's Consultant Pharmacist's Medication Regimen Review, dated 12/5/24, was conducted. This record included a recommendation for the facility to provide a lipid panel (check the level of fat in the blood) for Resident 23. There was no documentation that the facility responded to the pharmacists's recommendation. On 2/14/25 a review of Resident 23's electronic medical record was conducted. There was no evidence that a lipid panel was completed for Resident 23. On 2/14/25 at 1:20 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated, the facility should have responded to the pharmacist recommendation. Per the facility's undated policy, titled Pharmacist Monthly Medication Regiment Review Reporting and Responses, .The nursing staff will document in response to the pharmacist's recommendation in the resident's medical record .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation practices in dietary services were maintained with food storage, sanitation, and equipment maintenance according to standards of practice when: 1. One dented large can and two rusted large cans were found in the dry storage pantry. 2. A sink garbage disposal was not functioning and/or maintained in good working condition. 3. A frosting mix with a use by (U/B) date of [DATE] was found in the dry storage pantry. 4. Low-temperature dishwashing machine temperature did not reach sanitary temperature levels. These failures had the potential to cause widespread food borne illness among the 143 residents who received food from the kitchen. Findings: 1. On [DATE] at 7:51 A.M., an initial kitchen tour was conducted with the Dietary Supervisor (DS). In the dry storage pantry area was a shelf of canned goods that displayed a dented, 10 ounce (oz) can of diced peaches stored alongside canned goods that were in good condition. On the back canned shelf area, there were two cans, each containing seven pounds of pie filling, that had scattered rust shown on the upper side of each can's sides, and top area. One of the canned pie fillings had a splash-like calcium deposit white spot on the top of the can. The DS stated that the dented can and rusted cans should not have been displayed on the canned goods shelf and should have been removed to avoid using the product. The DS stated that cans that were expired, dented, broken, or rusted were put in a discard cardboard box to be thrown away. The DS further stated it was important to discard the dented can and the two rusted cans to prevent botulism (an infection caused by improperly canned food) that could have caused food-borne complications. On [DATE] at 10:16 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that her expectation was for the kitchen to be sanitary with clean and working equipment, along with (identified) food items to be discarded, such as cans (of food items) that were expired, dented, or rusted. The DON stated it was important to discard food items that may cause food-borne illnesses by checking to make sure they were safe to consume. Lastly, the DON stated it was important that the kitchen promoted environments with routine cleaning and maintenance along with equipment that were safe and functional for food preparation. A review of the facility's policy and procedure titled FOOD STORAGE-DENTED CANS dated 2023, indicated .All dented cans (defined as side seam, or rim dents) and rusty cans are to be separated from the remaining stock . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Creek Post Acute	12696 Monte Vista Road Poway, CA 92064

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On [DATE] at 8:14 A.M., an observation and interview was conducted with the Dietary Supervisor (DS) and Dietary Aide (DA) 1. Next to the low temperature dishwasher area was a sink with a garbage disposal, with a controller attached under the sink table, which had a missing red stop button, and a missing bolt on the controller. There was no posted sign that indicated that it was a broken garbage disposal. The garbage disposal was directly attached to a sink and was heavily coated with white calcium-deposit-like film and scattered rust on the top side of the garbage disposal cutting chamber. The garbage disposal controller was also covered with white calcium-deposit-like film. The DS stated that they had not used the garbage disposal or maintained it because it had been broken for over a year. DA 1 stated it [garbage disposal] should be cleaned daily to prevent contamination of foods that are prepped in the kitchen. On [DATE] at 10:16 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that her expectation was for the kitchen to be sanitary with clean and working equipment, along with (identified) food items to be discarded, such as cans (of food items) that were expired, dented, or rusted. The DON stated it was important to discard food items that may cause food-borne illnesses by checking to make sure they were safe to consume. Lastly, the DON stated it was important that the kitchen promoted environments with routine cleaning and maintenance along with equipment that were safe and functional for food preparation. A review of the facility's policy and procedure titled SANITATION dated 2023, indicated .equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions . 3. On [DATE] at 8:33 A.M., a kitchen tour was conducted with the Dietary Supervisor (DS). A gallon-sized open bag of dried frosting mix, contained in a clear plastic wrap, was stored on top of a tray labeled with an O for opened and a U/B [DATE]. The DS stated the frosting mix needed to be discarded and should not have been left on the shelf of the dry storage pantry. On [DATE] at 10:36 A.M., an interview was conducted with Dietary Aide (DA) 1, outside of the dry storage pantry. DA 1 stated that the frosting mix should not have been used because they [facility residents] might get sick if an expired ingredient was used. On [DATE] at 10:37 A.M., an interview was conducted with the DS. The DS stated, the frosting mix was expired and can make someone sick. On [DATE] at 10:16 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that her expectation was for the kitchen to be sanitary with clean and working equipment, along with (identified) food items to be discarded, such as cans (of food items) that were expired, dented, or rusted. The DON stated it was important to discard food items that may cause food-borne illnesses by checking to make sure they were safe to consume. Lastly, the DON stated it was important that the kitchen promoted environments with routine cleaning and maintenance along with equipment that were safe and functional for food preparation. A review of the facility's guidelines titled DRY FOOD STORAGE GUIDELINES undated, indicated .The storage length is to be followed .Frosting mix .unopened 6 months opened on shelf 3 months . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On [DATE] at 8:06 A.M., a kitchen tour was conducted with the Dietary Supervisor (DS), by the low-temperature dishwashing machine. The DS demonstrated use of the dishwashing machine with a crate that went through the dishwashing machine. The temperature gauge indicated a temperature of 109 F (degrees Fahrenheit). A sign on the low-temperature dishwashing machine stated, LOW TEMPERATURE DISH MACHINE ,d+[DATE] DEGREES. On [DATE] at 8:10 A.M., an observation and interview was conducted with the DS and Dietary Aide (DA) 1. DA 1 demonstrated use of the dishwashing machine twice with the temperature gauge set at 118 F on both attempts. DA 1 stated the temperature should have been at 120 F because it's needed to kill the germs. The DS stated the low temperature dishwasher had to reach 120 F and agreed with DA 1 that it (120 F) was the temperature to sanitize dishware, utensils, and cookware items used in the kitchen. On [DATE] at 10:16 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that her expectation was for the kitchen to be sanitary with clean and working equipment along with (identified) food items to be discarded such as cans (of food items) that were expired, dented, or rusted. The DON stated it was important to discard food items that may cause food-borne illnesses by checking to make sure they were safe to consume. Lastly, the DON stated it was important that the kitchen promoted environments with routine cleaning and maintenance along with equipment that were safe and functional for food preparation. A review of the facility's policy and procedure titled DISHWASHING undated, indicated .Low-temperature machine .use the machine at a range of 120F to 140F .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 48263 Based on observation, interview, and record review, the facility failed to ensure outdoor facility garbage and refuse (recyclable and non-recyclable trash) was not overflowing, and was secure with the dumpster's lids closed, for two facility dumpsters located outside the loading dock area near the kitchen hall exit. 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: On 2/11/25 at 8:21 A.M., an observation and interview was conducted with the Dietary Supervisor (DS), outside the back kitchen hallway exit. There were two dumpsters outside the loading dock area with overfilled trash containing clear plastic trash bags with miscellaneous items, mixed with brown cardboard/packing boxes, filled to the top with a fully opened lid for both dumpsters. In addition, two wet, clear plastic bags were on the floor by dumpster two. The DS stated that the dumpsters were used for all facility trash that included the kitchen and resident and facility use. The DS stated that the dumpster should not have been overfilled, and that trash should have been contained in the dumpsters with closed lids to prevent pests (unwanted animals, insects, or other organisms that can cause damage, spread disease, harmful to humans) from getting inside the dumpsters, which could have spread germs and contaminated the facility. A review of the facility's pest control service report identified: - 12/18/24 .Reported 11/22/24 .Trash Can or Bin Not properly Covered-Heavy rodent activity observed at night time near dumpsters .Action: Cover, Close, Repair or replace trash can . - 1/27/25 .Reported 11/22/24 .Trash Can or Bin Not properly Covered-Heavy rodent activity observed at night time near dumpsters .Action: Cover, Close, Repair or replace trash can . On 2/14/25 at 10:16 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that her expectation was for the dumpsters and trash bins to be securely closed with a lid to prevent pest infestation. A review of the facility's policy and procedure titled SANITATION dated 2023, indicated .Kitchen wastes which are not disposed of by garbage disposal units shall be kept in leak-proof, non-absorbent and tightly closed containers . A review of the facility's policy and procedure titled PEST CONTROL undated, indicated .Garbage and trash are not permitted to accumulate and are removed from the facility . The facility did not provide a DISPOSAL of GARBAGE and REFUSE policy and procedure.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to accurately document a resident's medications on the weekly summary for one of 30 sampled residents (2). This failure had the potential to miscommunicate Resident 2's status, care, and treatment. Findings: Per the facility's Admission Record, Resident 2 was admitted to the facility on [DATE] with diagnoses to include schizoaffective disorder (a mental disconnection from reality). On 2/14/25 a review of Resident 2's electronic medical record was conducted. Licensed nurse (LN) 21 completed the weekly summary for Resident 2 on 1/12/25, 1/19/25, 1/26/25, and 2/9/25. On all of the listed weekly summaries, LN 21 documented that Resident 2 had not been using antipsychotic (medication to treat a disconnection from reality) medication over the last seven days. Per the facility's Orders, there was an order dated 6/20/24 for Resident 2 to take risperidone (an antipsychotic medication) for schizoaffective disorder. On 2/14/25 at 10:17 A.M., an interview was conducted with LN 21. LN 21 stated, she must have overlooked the risperidone when completing the weekly summaries for Resident 2. On 2/14/25 at 10:56 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that the LN should have checked the (resident's) orders when completing the weekly summaries and acknowledged that the resident's weekly summaries should have been accurately completed. Per the facility's undated policy, titled Charting and Documentation, .Documentation in the medical record will be .complete, and accurate .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to promote infection control practices according to standards of practice for one or 30 sampled residents (Resident 38) to prevent respiratory illnesses and infection. This failure had the potential for Resident 38 to experience respiratory complications and infections from improper maintenance and storage of their nebulizer treatment equipment. Findings: A review of Resident 38's Admission Record indicated Resident 38 was readmitted to the facility on [DATE] with diagnoses which included a history of chronic obstructive pulmonary disease (COPD; chronic lung disease causing difficulty in breathing). A record review of Resident 38's minimum data set (MDS; nursing facility assessment tool) dated 12/23/24 indicated that Resident 38 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions. On 2/11/25 at 8:30 A.M., an observation was conducted with Resident 38, in Resident 38's room. Resident 38 was asleep and lying on her bed covered with blankets. Resident 38's side table by the left wall had a nebulizer machine placed on top of the table with a mask and tubes placed on the nebulizer machine. The nebulizer mask had scattered condensation of clear liquid on the mask, along with a nebulizer chamber that had a heavy amount of condensation (mist-like moisture) throughout the chamber. On 2/12/25 at 2:49 P.M., an interview and clinical chart review for Resident 38 was conducted with respiratory therapist (RT) 1. RT 1 stated that Resident 38 was scheduled to receive DuoNeb (a combined respiratory therapy medication to treat COPD) via nebulizer at 7 A.M. and 7 P.M. RT 1 was shown Resident 38's nebulizer treatment picture, taken on 2/11/25 at 8:32 A.M. RT 1 stated that the mask looked used and not cleaned. RT 1 stated that Resident 38's nebulizer left on the table would be an infection control issue because it was not cleaned properly and placed to air dry on clean paper towels. RT 1 further stated once the nebulizer was clean and dry it should have been stored in a clear plastic bag to prevent contamination and germs. On 2/14/25 at 7:56 A.M., an interview and clinical chart review for Resident 38 was conducted with RT 2, outside of Resident 38's room. RT 2 stated the way she cleaned nebulizer treatment equipment was to rinse it [nebulizer mask, chamber and tubing] with water, air dry, and put back in the bag. RT 2 stated that she used sink water for rinsing and used sani-wipes (sanitizer wipes used to clean) for the masks. On 2/14/25 at 8:26 A.M., an interview and clinical chart review for Resident 38 was conducted with RT 1, at nursing station two. RT 1 stated it was important to use sterile water (water is free from bacteria and minerals) with nebulizers during the cleaning process to prevent contamination and infection in the lungs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/24 at 9:51 A.M., an interview was conducted with the Director of Nursing (DON), in the DON's office. The DON stated it was important to follow cleaning procedures by using sterile water to clean nebulizers according to the facility's policies and procedures to prevent contamination and respiratory illnesses and infections. A review of the facility's policy and procedure titled CLEANING and DISINFECTION of RESIDENT-CARE ITEMS and EQUIPMENT, indicated .Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g. respiratory therapy equipment). Such devices should be free from all microorganisms .

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. 47956 Based on observation, interview, and record review, the facility failed to ensure handrails were appropriately secured. This failure had the potential to cause injury to all facility residents. Findings: On 2/13/25 and 2/14/25, observations were made of the handrails inside of the facility. One loose handrail was observed. The ends of the handrail moved in both directions from level. During an interview on 2/13/25 at 9:38 A.M. with certified nursing assistant (CNA) 11, CNA 11 stated the handrails should not move like that. CNA 11 further stated a resident could get really hurt if it tilted while they were holding it. During an interview on 2/14/25 at 9:40 A.M. with licensed nurse (LN) 11, LN 11 stated that the residents used the handrails for support. LN 11 further stated, not being secured could cause a major injury. During a review of the facility's policy titled Maintenance Service, the policy indicated .2. Functions of Maintenance personnel include .b. Maintaining the building in good repair and free from hazards .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48263 Based on observation, interview, and record review, the facility failed to maintain an effective pest control environment when the kitchen floor drain with food particles was observed infested with ants. This failure had the potential for ants to contaminate food and spread food-borne illnesses to all residents receiving food from the kitchen. The facility census was 143. Findings: According to the 2019 Centers for Disease Control, PEST CONTROL https://www.cdc.gov/infection-control/media/pdfs/Guideline-Environmental-H.pdf, stated .Cockroaches, flies and maggots, ants, mosquitoes, spiders, mites, midges [small fly-like insects], and mice are among the typical arthropod [insects with hard bodies like a shell] and vertebrate [back bones] pest populations found in health-care facilities. Insects can serve as agents for the mechanical transmission of microorganisms [tiny living organisms that are harmful to humans such as bacteria, germs, or virus], or as active participants in the disease transmission process by serving as a vector [living organisms that can transmit infectious disease] . Ants will often find their way into sterile packs of items as they forage in a warm, moist environment . On 2/11/25 at 8:08 A.M., an initial kitchen tour was conducted with the Dietary Supervisor (DS). The kitchen floor drain by the low-temperature dishwashing machine had a black polyvinyl chloride (PVC: made of plastic) pipe with no air gap space that lead into the floor drain. The floor drain surface sides were surrounded by a brownish/black, mud-like substance with mixed food particles on the bottom strainer, and was infested by ants. The DS stated there were ants around the drainage pipes because of the food accumulation coming out from the drainage pipes that attracted the ants. On 2/12/25 at 7:58 A.M., an observation and interview was conducted with the DS. The DS stated that the floor drains and drainage outlets should have been cleaned on a daily basis. The DS stated, if it's not clean this could attract ants and other pests. The DS stated that the ants could contaminate the food in the kitchen with germs that could potentially spread food-borne illnesses. The DS stated that the floor drains were supposed to be cleaned routinely during the evening shift. On 2/14/25 at 10:16 A.M., an interview with the Director of Nursing (DON) was conducted, in the DON's office. The DON stated that her expectation was for the floor drains to be cleaned daily to prevent the attraction of pests and to prevent infestations that could contaminate foods and food-borne illness from spreading. A review of the kitchen's routine cleaning titled [Facility name] CLEANING SCHEDULES from December 2024 thru February 2025, indicated no record of routine cleaning for floor drains. A review of the facility's policy and procedure titled PEST CONTROL, indicated .This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents .