STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555421	A. Building B. Wing	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrook Healthcare Center	4367 Concord Boulevard Concord, CA 94521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38491 Based on interview and record review, the facility failed to develop Baseline Care Plan (BCP) and provide written summary of the care plan to resident (s) and /or resident's representative for 31 of 31 sampled residents (Residents 9, 22, 28, 31, 43, 73, 74, 77, 281, 431, 180, 280, 430, A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q and R) when: 1. For Resident 9, 22, 28, 31, 34, 73, 74, 77, 281, 431, K, L, M, N, O, P, Q and R's BCP for dietary, therapy and social services were not developed within 48 hours of admission. There was no evidence a copy of the BCP summary was provided to the resident or resident's representative. 2. For Resident 180, 280, 430, A, B, C, D, E, F, H, I and J, there was no evidence that a copy of BCP summary was provided to resident and /or resident's representative These failures had the potential to result in lack of communication, increased risk of adverse events due to inappropriate and inadequate care and services. And potentially had the staff, resident, and resident's family members to be unaware of the treatment and services the residents were receiving prior the completion of the comprehensive assessment and care plan. Findings: 1.During a review of Resident 1's 48- hour BCP, it indicated Resident 1 was admitted on [DATE] with diagnoses including hypotension (low blood pressure), atrial fibrillation (irregular heart rhythm), and dehydration. Resident 1's BCP for dietary, therapy and social services were completed on 6/21/2023. The BCP summary for Resident 1 was blank and had no resident or representative's signature that it was received. During a review of Resident 9's 48- hour BCP, it indicated Resident 9 was admitted on [DATE] with diagnoses including hypertension (high blood pressure), anorexia (an abnormal loss of the appetite for food), and senile degeneration of brain. Resident 9's BCP for dietary, therapy and social services were completed on 6/14/2023. The BCP summary for Resident 9 was blank and had no resident or representative's signature that it was received. (continued on next page)

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.

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 22's 48- hour BCP, it indicated Resident 22 was admitted on [DATE] with diagnoses including end stage renal disease, dependence on renal dialysis, diabetes mellitus (is a condition defined by persistently high levels of sugar (glucose) in the blood), hemiplegia (paralysis of one side of the body), and peripheral vascular disease (is the reduced circulation of blood to a body part other than the brain or heart). Resident 22's BCP for dietary, therapy and social services were completed on 6/21/23. BCP summary for Resident 22 was blank and had no resident or representative's signature that it was received. During a review of Resident 28's 48- hour BCP, it indicated Resident 28 was admitted on [DATE] with diagnoses including hypertension, osteoarthritis (is a degenerative joint disease that can affect the many tissues of the joint), and atrial fibrillation. Resident 28's BCP's for dietary, therapy and social services was completed on 6/13/23. The BCP summary for Resident 28 was blank and had no resident or representative's signature that it was received. During a review of Resident 34's 48- hour BCP, it indicated Resident 34 was admitted on [DATE] with diagnoses including hypertension, chronic kidney disease, dysphagia (difficulty swallowing), unsteadiness on feet and abnormalities of gait and mobility. Resident 34's BCP's for dietary, therapy and social services was completed on 6/14/23. The BCP summary for Resident 34 was blank and had no resident or representative's signature that it was received. During a review of Resident 31's 48- hour BCP, it indicated Resident 31 was admitted on [DATE] with diagnoses including sepsis (is the body's extreme reaction to an infection), bacteremia (is the presence of bacteria in the blood), diabetes mellitus and bipolar disorder (a mental condition characterized by severe and disabling highs (mania) and lows (depression). Resident 31's BCP's for dietary, therapy and social services was completed on 6/13/23. The BCP summary for Resident 31 was blank and had no resident or representative's signature that it was received. During a review of Resident 73's 48- hour BCP, it indicated Resident 73 was admitted on [DATE] with diagnoses including osteomyelitis (bone infection), diabetes mellitus and hypertension. Resident 73's BCP's for dietary, therapy and social services was completed on 6/14/23. The BCP summary for Resident 73 was blank and had no resident or representative's signature that it was received. During a review of Resident 74's 48-hour BCP, it indicated Resident 74 was admitted on [DATE] with diagnoses including arthritis, acute cholecystitis (inflammation of the gall bladder) and cirrhosis of the liver (severe scarring of the liver). Resident 74's BCP's for dietary, therapy and social services was completed on 6/14/23. The BCP summary for Resident 74 was blank and had no resident or representative's signature that it was received. During a review of Resident 77's 48- hour BCP, it indicated Resident 77 was admitted on [DATE] with diagnoses including urinary tract infection, severe sepsis, hyperlipidemia (high cholesterol), and gastro esophageal reflux (is a digestive disorder that occurs when acidic stomach juices, or food and fluids back up from the stomach into the esophagus). Resident 77's BCP's for dietary, therapy and social services was completed on 6/13/23. The BCP summary for Resident 77 was blank and had no resident or representative's signature that it was received. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 281's 48-hour BCP, it indicated Resident 74 was admitted on [DATE] with diagnoses including dysphagia, pneumonitis (inflammation of lung tissue), cognitive communication and repeated falls. Resident 281's BCP's for dietary, therapy and social services was completed on 6/25/23. The BCP summary for Resident 281 was blank and had no resident or representative's signature that it was received. During a review of Resident 431's 48-hour BCP, it indicated Resident 431 was admitted on [DATE] with diagnoses including fracture of left femur, chronic kidney disease and hypertension. Resident 431's BCP's for dietary, therapy and social services was completed on 6/25/23. The BCP summary for Resident 431 was blank and had no resident or representative's signature that it was received. During a review of Resident K's 48-hour BCP, it indicated Resident K was admitted on [DATE] with diagnoses including diverticulitis (is the infection or inflammation of pouches that can form in your intestines. These pouches are called diverticula), congestive heart failure (also called heart failure- is a serious condition in which the heart doesn't pump blood as efficiently as it should) and atrial fibrillation. Resident K's BCP's for dietary, therapy and social services was completed on 6/26/23. The BCP summary for Resident K was blank and had no resident or representative's signature that it was received. During a review of Resident L's 48-hour BCP, it indicated Resident L was admitted on [DATE] with diagnoses including enterocolitis (an inflammation that occurs in a person's digestive tract, specifically the inner lining of the small intestine and colon), rheumatoid arthritis (is a type of arthritis where your immune system attacks the tissue lining the joints on both sides of your body) and hypomagnesemia (low level of magnesium in the blood). Resident L's BCP's for dietary, therapy and social services was completed on 6/25/23. The BCP summary for Resident L was blank and had no resident or representative's signature that it was received. During a review of Resident M's 48-hour BCP, it indicated Resident M was admitted on [DATE] with diagnoses including diabetes mellitus, hypertension, and sepsis. Resident M's BCP's for dietary, therapy and social services was completed on 6/25/23. The BCP summary for Resident M was blank and had no resident or representative's signature that it was received. During a review of Resident n's 48-hour BCP, it indicated Resident N was admitted on [DATE] with diagnoses including diabetes mellitus hypothyroidism (a condition when your thyroid gland doesn't make enough thyroid hormones to meet your body's needs) and asthma (is a chronic condition that affects the airways). Resident N's BCP's for dietary, therapy and social services was completed on 6/23/23. The BCP summary for Resident N was blank and had no resident or representative's signature that it was received. During a review of Resident O's 48-hour BCP, it indicated Resident O was admitted on [DATE] with diagnoses including hyperlipidemia, fracture of the right femur, and atrial fibrillation. Resident O's BCP's for dietary, therapy and social services was completed on 6/25/23. The BCP summary for Resident O was blank and had no resident or representative's signature that it was received. During a review of Resident P's 48-hour BCP, it indicated Resident P was admitted on [DATE] with diagnoses including bacteremia, muscle weakness and kidney failure. Resident P's BCP's for dietary, therapy and social services was completed on 6/25/23. The BCP summary for Resident P was blank and had no resident or representative's signature that it was received. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident Q's 48-hour BCP, it indicated Resident Q was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-s a chronic inflammatory lung disease that causes obstructed airflow from the lungs), hypertension, and congestive heart failure. Resident Q's BCP's for dietary, therapy and social services was completed on 6/25/23. The BCP summary for Resident Q was blank and had no resident or representative's signature that it was received. During a review of Resident R's 48-hour BCP, it indicated Resident R was admitted on [DATE] with diagnoses including hypertension, atherosclerosis (is a disease in which plaque builds up inside your arteries), and fracture of the right femur. Resident R's BCP's for dietary, therapy and social services was completed on 6/14/23. The BCP summary for Resident R was blank and had no resident or representative's signature that it was received. 2. During a review of Resident 180's 48-hour BCP, it indicated Resident 180 was admitted on [DATE] with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, and atrial fibrillation. The BCP summary for Resident R was blank and had no resident or representative's signature that it was received. During a review of Resident 280's 48-hour BCP, it indicated Resident 280 was admitted on [DATE] with diagnoses including osteoarthritis, acute respiratory failure, and pneumonia(infection of the lungs). The BCP summary for Resident 280 was blank and had no resident or representative's signature that it was received. During a review of Resident 430's 48-hour BCP, it indicated Resident 430 was admitted on [DATE] with diagnoses including thrombocytopenia (is any disorder in which there is an abnormally low amount of platelets. Platelets are parts of the blood that help blood to clot), chronic pain syndrome and fracture of the left femur. The BCP summary for Resident 430 was blank and had no resident or representative's signature that it was received. During a review of Resident A's 48-hour BCP, it indicated Resident A was admitted on [DATE] with diagnoses including anxiety disorder and depression The BCP summary for Resident A was blank and had no resident or representative's signature that it was received. During a review of Resident B's 48-hour BCP, it indicated Resident B was admitted on [DATE] with diagnoses including hypertension, asthma, and diabetes mellitus The BCP summary for Resident B was blank and had no resident or representative's signature that it was received. During a review of Resident C's 48-hour BCP, it indicated Resident C was admitted on [DATE] with diagnoses including thrombocytopenia and hypertension. The BCP summary for Resident C was blank and had no resident or representative's signature that it was received. During a review of Resident D's 48-hour BCP, it indicated Resident D was admitted on [DATE] with diagnoses including atrial fibrillation, diabetes mellitus. The BCP summary for Resident D was blank and had no resident or representative's signature that it was received. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident E's 48-hour BCP, it indicated Resident E was admitted on [DATE] with diagnoses including Parkinson's disease (is a progressive disorder that is caused by degeneration of nerve cells in the part of the brain), major depressive disorder, and chronic kidney disease The BCP summary for Resident E was blank and had no resident or representative's signature that it was received. During a review of Resident F's 48-hour BCP, it indicated Resident F was admitted on [DATE] with diagnoses including diabetes mellitus, cholelithiasis (also called gallstones- are pebble-like pieces of bile that develop in the gallbladder) and chronic kidney disease. The BCP summary for Resident F was blank and had no resident or representative's signature that it was received. During a review of Resident G's 48-hour BCP, it indicated Resident G was admitted on [DATE] with diagnoses including fracture of left tibia (lower leg) and history of falling The BCP summary for Resident G was blank and had no resident or representative's signature that it was received. During a review of Resident H's 48-hour BCP, it indicated Resident H was admitted on [DATE] with diagnoses including anemia (is a condition in which the body does not have enough healthy red blood cells), atrial fibrillation, and acute kidney failure. The BCP summary for Resident H was blank and had no resident or representative's signature that it was received. During a review of Resident I's 48-hour BCP, it indicated Resident I was admitted on [DATE] with diagnoses including atrial fibrillation and myocardial infarction (also called heart attack- happens when one or more areas of the heart muscle don't get enough oxygen). The BCP summary for Resident I was blank and had no resident or representative's signature that it was received. During a review of Resident J's 48-hour BCP, it indicated Resident J was admitted on [DATE] with diagnoses including pneumonia, congestive heart failure and muscle weakness. The BCP summary for Resident J was blank and had no resident or representative's signature that it was received. During an interview with Resident 430, on 6/25/19, at 4:16 PM, he stated he was unaware of his treatment plan and had not been provided with a care plan indicating the treatment he was to be provided. Resident 430 stated he did not like the food that was served in the facility. He was not aware that he could ask for a substitute if he did not like the food that was served. During an interview with Resident 34 on 6/27/23 at 3 PM, he stated he did not receive or was provided a care plan / treatment plan from the facility. Resident 34 stated it would be nice to know what his plan of care would be. During an interview with Resident 77 on 6/25/23 at 4:40 PM, Resident 77 stated I don't think I got the paper and not sure if they explained to me my plan of care when I came. During a concurrent interview and record review with the Director of Nursing (DON) on 6/27/23, at 10:30 AM, the baseline care plan of the newly admit residents were reviewed. The DON verified and acknowledged that the 48- hour baseline care plan for the newly admit residents were not completed within forty-eight hour. The DON also acknowledged the baseline care plan were not provided to the residents or resident's representative. The DON stated the facility's system for care planning needed to be changed. The DON stated its important to provide resident's care plan to the resident so they would be aware of the care to be given, and for the residents' to be involved in their care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Director of Social Services (DSS) on 6/28/23, at 10 AM, the DSS stated the baseline care plan were discussed verbally to the residents after their admission. The DSS was unable to provide evidence that the resident's BCP were provided verbally. The DSS acknowledged that it should have been documented if it was presented or given to the resident and or to the residents' representative. Review of the facility's Policy and Procedures titled BASELINE CARE PLAN dated 1/19/23, indicated It is the policy of [facility name] to develop a baseline care plan within 48 hours of admission .The baseline care plan will include the minimum healthcare information necessary to properly care for a resident including but not limited to A.Initial goal based on admission orders B. Physician orders C. Dietary orders D. therapy services E. Social Services F. PASSARR recommendation if applicable. The facility will provide the resident/resident representative, if applicable, with a summary of the baseline care plan that includes but is not limited to . B. A summary of the resident's medication and dietary instructions. C. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. D. Any updated information based on the details of the comprehensive care plan as necessary.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48967 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 56 and Resident 62) received finger nail care. Resident 56 and Resident 62 had long, thick fingernails with black matter underneath in both hands. This failure placed Resident 56 and Resident 62 at risk for infection. Findings: During a review of Resident 56's admission record titled Resident Information dated 6/26/23, the record showed Resident 56 was admitted on [DATE] with primary diagnosis of Alzheimer's Disease (loss of memory). During a review of Resident 56's Minimum Data Set (MDS- an assessment used to plan resident care) dated 4/16/23, the MDS indicated, Resident 56's Brief Interview for Mental Status (BIMS- a cognition status assessment) was three, indicating impaired mental status. Resident 56 required one staff physical assist to maintain her personal hygiene. During a concurrent observation and interview on 6/25/23, at 2:46 p.m., with Certified Nursing Assistant (CNA) 40, in the Resident 56's room, Resident 56 had long and thick fingernails on both hands, with black matter underneath them. CNA 40 stated, the black matter in Resident 56's nails must be the food she ate as she grabs her food when she eats. CNA 40 further stated, Resident 56 also had a habit of digging into her bowels. During an interview on 6/26/23, at 9:59 am, with Licensed Vocational Nurse (LVN) 14, LVN 14 stated, she was not aware of Resident 11's refusal of nail care. During a concurrent interview and record review on 6/26/23, at 12:15 pm., with Minimum Data Set Coordinator (MDSC),MDSC stated, there was no plan of care and no documentation found under progress notes on Resident 56's nail care and/ or refusal of nail care. During the record review of facility's Policy and Procedure (P&P) titled, Policy for Nail Care, dated 1/19/23, the P&P indicated, It is the policy of [facility] to keep residents nail cut and clean. Fingernails and/or toenails are to be cut during ADLs by the certified nursing assistant unless the resident or resident representative is requesting it to be done by a professional or to be done themselves. 48616 2. During a review of Resident 62's admission record titled Resident Information dated 6/27/23, the record indicated, Resident 62 was admitted on [DATE] with diagnosis of Right Hemiplegia (complete paralysis) and Dementia (memory loss). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 4/7/23, the MDS indicated, Resident 62's Brief Interview for Mental Status (BIMS- a brief scanner of cognitive) was three, indicating severely impaired cognitive status. The MDS assessment also indicated, Resident 62 required one staff's extensive assist with personal hygiene. During a review of Resident 62's Activities of Daily Living Care Plan, dated 7/7/22, the care plan indicated, Resident 62 required extensive/ dependent assist to maintain personal hygiene. During a concurrent interview and observation on 6/27/23, at 8:11 a.m., with Certified Nursing Assistant (CNA) 8, in Resident 62's room, Resident 62 had a long fingernails about half inch in length on both hands. Resident 62's right hand was on her chest, formed into a fist unable to open. CNA 8 stated, Resident 62 had long fingernails and should be trimmed. CNA 8 also stated, CNAs are responsible in trimming resident's fingernails when applicable. CNA 8 stated, she was unable to determine when Resident 62's fingernails were trimmed. During a review of the facility's Policy and Procedures (P&P) titled, POLICY FOR NAIL CARE dated 1/19/23 , the P&P showed, It is the policy of the facility to keep residents nail cut and clean . Fingernails are to be cut during Activities of Daily Living (ADLs) by the Certified Nursing Assistant (CNA) unless the resident or resident representative is requesting it to be done by the professional or to be done themselves.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48616 Based on observation, interview and record review, the facility failed to trim and clean toenails for one of one sampled resident (Resident 62). Resident 62's both great toenails were dark yellow-brown, thick, curved-in and long about one inch in length. This failure resulted in Resident 62 to not receive toenail care for three months, placed Resident 62 at risk to get toenails yeast infection and dislocate her both great toenails. Findings: During a review of Resident 62's admission record titled Resident Information dated 6/27/23, Resident 62 was admitted on [DATE] with diagnosis of Right Hemiplegia (complete paralysis). During a review of Resident 62's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 4/7/23, showed Resident 62's Brief Interview for Mental Status (BIMS- a mental status exam) was three (3) out of 15, indicating severely impaired mental status. The MDS assessment also indicated, Resident 62 required one staff's extensive assist with personal hygiene. During a concurrent interview and observation on 6/27/23, at 9:30 a.m., with Certified Nursing Assistant (CNA 8), Resident 62's both great toenails were long about one inch in length, dark yellow brown, thick, and curved-in. CNA 8 stated, Resident 62's toenails required trimming and the facility had a Podiatrist (a medical professional that specializes in foot related problems) to provide toenails care to residents every two months. During an interview on 6/27/23, at 9:50 a.m., Licensed Vocational Nurse LVN, LVN stated, she was not aware that Resident 62's great toenails were long and required care. LVN 6 stated, long great toenails placed Resident 62 at risk for toenails dislocation and to develop yeast infection. LVN 6 also stated, Social Worker (SW) was responsible for scheduling podiatry evaluation and treatment as necessary. During a concurrent interview and record review on 6/27/23, at 1:30 p.m., with SW, Resident 62's Electronic Health Record was reviewed. SW stated, she was unable to find any podiatry consult filed. During a review of the facility's Policy and Procedures (P&P) titled, POLICY FOR NAIL CARE reviewed 1/19/23, the P&P showed, It is the policy of the facility to keep residents nail cut and clean . Toenails are to be cut during Activities of Daily Living (ADL) by the Certified Nursing Assistant (CNA) unless the resident or resident representative is requesting it to be done by the professional or to be done themselves.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48616 Based on observation, interview and record review, the facility failed to provide upper and lower body Range of Motion (ROM) and walking exercises to one of three sampled residents (Resident 65) per plan of care. Resident 65 received walking exercises for four (4) out of 12 scheduled visits and upper/lower body ROM exercises for three (3) out of 12 scheduled visits over a period of one month. This failure had the potential to result in Resident 65 feeling not receiving good care and placed her at risk for further decreased in limitation of (ROM) and walking. Findings: During a review of Resident 65's admission record titled Resident Information dated 6/27/23, Resident 65 was admitted on [DATE] with diagnosis of Repeated Falls. During a concurrent observation and interview on 6/25/23, at 3:36 p.m., Resident 65 was lying in bed. Resident 65 stated, she was not receiving enough therapy/exercises on a regular basis, and it made her feel she was not getting good care at the facility. During a concurrent record review and interview on 6/27/23, at 12:23 PM, with Minimum Data Set Coordinator (MDSC), Resident 65's MDS assessment dated [DATE]. was reviewed. The assessment indicated, Resident 65 had an impairment on one side of upper and lower extremity. The MDSC stated, Resident 65 had an impaired range of motion on left upper extremity (LUE) and was unable to raise and extend her LUE above head. The MDSC stated, Resident 65 had impaired ROM on right lower extremity (RLE) due to history of right hip fracture. The MDSC stated Resident 65 required one staff extensive assist with walking. During a concurrent interview and record review on 6/27/23, at 12:32 p.m., with MDSC, Resident 65's care plan titled Restorative Nursing Program date initiated 5/26/23 was reviewed, The MDSC stated, Resident 65 should receive ROM for both lower and upper extremities for 15 minutes; and should walk in the hallways for 125 to 200 feet with a Restorative Nurse Aide (RNA) three times a week. During a concurrent interview and record review on 6/27/23, at 12:37 PM, with MDSC, Resident 65's electronic health record (EHR) under POC Response History for RNA program from 5/30/23 through 6/27/23 was reviewed. The MDSC stated, Resident 65 received range of motion exercises only three times; and walking with front wheel walker four times over a period of one month. The MDSC stated, the risk of not receiving ROM / walking exercises placed Resident 65's further decline in mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555421	A. Building B. Wing	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrook Healthcare Center	4367 Concord Boulevard Concord, CA 94521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 44771 Based on observation, interview, and record review, the facility failed to ensure kitchen staff were competent in job duties related to 1. Testing the sanitizer liquid in the red sanitization bucket. 2. Using the three compartment sink This failure has the potential for improper cleaning and sanitization which could lead to increase in risk for food-borne illness for 82 out of 82 residents. Findings: 1. During a concurrent observation and interview on 6/26/23 at 12:55 p.m., in the kitchen, [NAME] (CK 1) was observed filling a red sanitization bucket with sanitizer liquid. CK 1 then demonstrated how she filled the buckets and stated she tests the solution with test strip. She was observed testing the sanitizing solution with sanitizer strip by removing a test strip from a quaternary ammonium (a type of sanitizer) from the sanitizer strip container. She held the test strip in the solution for 8 seconds and compared the color of the test strip to the color chart inside the test strip container. CK 1 stated, she should have held the test strip in the solution for 2 seconds. During a review of the manufacturer's instruction insert located inside the quaternary ammonium test strip container, the manufacturer's instruction indicated, Dip paper in quat solution .for 10 seconds. During a review of facility's policy and procedure (P&P) titled Sanitizer Use Concentration for Food Service and Food Production Facilities, dated 2019, the P&P indicated, all surfaces and equipment should be washed with sanitizing solution. Sanitizing buckets must be established with appropriate sanitizing solution concentration and the concentration range is to be tested . 2. During a concurrent observation and interview on 06/26/23 at 12:52 p.m., in the kitchen, CK 1 was observed putting used kitchen equipment (utensils, tray, pots) into three compartment sink. CK 1 stated, items in the three compartment sink are washed in sink number one, rinse in sink number two, and placed in sanitizer solutions in sink number three for 15 minutes. During a review of facility's [NAME] undated job description , the job description indicated, the [NAME] performs a number of kitchen activities including cleaning equipment. During a review of facility's policy and procedure titled, Three Compartment Sink, dated 7/18/22, P&P indicated, .Sanitize pots and pans in third tank by immersing in water with sanitizing agent two minutes .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44771 Based on observation, interview, and record review, facility failed to provide palatable food when food was served bland (lacking flavor). This failure has the potential for 82 out of 82 residents to consume less food resulting in consumption of less calories and nutrients provided by the planned menu. Findings During a review of the Diet Extensions dated Tuesday, Week 3, [NAME] SS 2023 and used for lunch on 6/27/23, the Diet Extension indicated, the regular consistency food included Baked Pork Chop, Cornbread Dressing, and Squash Medley. The Minced and Moist food included minced and moist pork chop, pureed cornbread dressing, and minced and moist squash medley. During a review of the undated recipe titled Pork Chop Baked f/Bnls (Baked Pork Chop), the recipe indicated, the ingredients included pork chop, ground black pepper, paprika, garlic powder, all purpose flour, low sodium chicken base paste, and tap water. During a review of the undated recipe titled Dressing Stuffing Cornbread, the undated recipe indicated, ingredients included corn muffin baking mix, white bread, ground black pepper, rubbed sage, poultry seasoning, yellow onion, fresh celery, margarine solids, low sodium chicken base paste, and tap water. During a review of the undated recipe titled Zucchini and Squash Yellow Sauteed f/Fresh (Squash Medley) indicated the ingredients included margarine solids, yellow onion, fresh zucchini, fresh yellow squash, garlic powder, paprika, and white pepper. During an interview on 6/27/23 at 10:32 a.m., during Resident Council meeting with surveyors, Resident 36 stated, food is not flavored right. Resident 2 stated, food is bland and menu is not executed properly. During an observation on 6/27/23 at 12:52 p.m., test tray was done with surveyors. Surveyors tasted test tray, baked pork chop, meat was dry and hard, no flavor even with sauce on the top, stuffing was soggy, and squash medley was bland (lacks flavor).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 44771 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food safely when 1. Kitchen staff did not follow approved hand hygiene and glove use procedures when changing gloves 2. 7 clear containers of various powders, 18 servings of frozen dessert, and one bag of green lettuce was not dated and labeled. These failures have the potential of placing 82 out of 82 residents at risk for food borne illness. Findings: 1 During a concurrent observation and interview on [DATE] at 12:55 p.m., with [NAME] (CK 1) in the dishwashing area of the kitchen, CK 1 was observed taking off her gloves and putting on new gloves when asked to fill a red sanitization bucket without washing her hands. CK 1 stated, she forgot to wash hands when changing gloves. CK 1 also stated, that it is important to wash hands to lower risk of spreading infection. During a review of facility's policy and procedure titled Handwashing and Glove Use, dated 2022, indicated 2. When gloves are used, hand washing must occur .prior to putting on gloves and whenever gloves are changed . 2 During a concurrent observation and interview on [DATE] at 2:32 p.m., in the kitchen, with Dietary Aide 1 (DA 1) seven clear containers with various powders inside were unlabeled and undated. DA 1 stated that containers were spices and are supposed to have labels. DA 1 further stated that if there were no labels or dates, staff would not know if spices are expired. During an observation on [DATE], at 2:40 p.m., in the kitchen, Freezer 3 had 18 servings of frozen dessert were not covered and without label and date, and two dessert pies which were not labeled, and not dated. In the walk-in refrigerator, one bag of open green lettuce was without open date and stems were noted brown and soft. During an interview on [DATE] at 2:48 p.m., with Certified Dietary Manager (CDM), CDM stated, her expectation is label with name and use by date on all containers and foods. During a review of facility's policy and procedure(P&P) titled Labeling Food Product, dated 2021, the P&P indicated, All prepared foods, leftovers, and open products stored for later use, will be labeled . and 3. All labels will contain: a. the name of the product, b. the date the product was prepared or opened, c. the date the product must be utilized by, .