STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555819	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmwood Care Center	2829 Shattuck Avenue Berkeley, CA 94705

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50013 Based on observation and interview, the facility failed to provide a comfortable, temperature-controlled environment for one of six residents (Resident 319) when Resident 319's window was in a fixed open position and found to be non-functional due to a missing crank. This failure prevented Resident 319 from opening or closing the window at the resident's discretion to control the room's temperature. Findings: During a review of Resident 319's Minimum Data Set (MDS - an assessment tool used to guide care) assessment dated [DATE], Section C showed a Brief Interview for Mental Status (BIMS - an assessment tool used to evaluate mental status) score of 12 out of 15, indicating the resident had moderately impaired mental status but could communicate needs. During a concurrent observation and interview on 7/15/2024 at 10:00 am with Resident 319 in her room, the window was missing a crank handle and could not be closed. Resident 319 stated she was unable to close the window adjacent to the foot of the bed resulting in a draft on her feet at night. Resident 319 stated the open window was bothersome because it made her feet cold and it was reported to staff on 7/14/2024. During an interview on 7/17/2024 at 2:30 pm, with Maintenance (MAIN), MAIN stated he was unaware of the broken crank on the window. Main stated staff report items in need of repair to him and if he is unable to repair it a vendor is brought in. MAIN stated he was not familiar with, nor used, a maintenance log to track or report broken items.

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45091 Based on observation, interview, and record review, the facility failed to ensure medication error rate did not exceed five percent. There were four medication errors out of 26 opportunities for errors, which resulted in an error rate of 15.38 percent (%). 1. For Resident 39, Licensed Vocational Nurse (LVN) 2 administered insulin (a medication that helps people control their blood sugar) that was expired for 13 days. 2. For Resident 220, LVN 3 administered Senna (a medication used to relieve constipation) . and Divalproex (a medication used to treat seizures) 2hrs (hours) over their appropriate scheduled timeframe, and Levetiracetam (a drug used to treat seizures) 3hrs over it's appropriate scheduled timeframe. These failures had the potential to jeopardize resident 39 and 220's health due to unsafe medication administration practices not being followed. Findings: 1. A review of Resident 39's Admission Record printed [DATE], indicated Resident 39 was admitted to the facility in 2024 with multiple diagnoses, which included Type 2 Diabetes Mellitus (a long-term disease in which the body cannot regulate the amount of sugar in the blood) with Diabetic Neuropathy, unspecified (a complication of diabetes that causes nerve damage throughout the body). During an observation on [DATE], at 11:58 a.m., with LVN 2, LVN 2 was observed while they administered insulin to Resident 39. Resident 39's insulin medication label indicated, Discard 31 days after opening, and Date open [DATE]. During an interview on [DATE], at 12:55 p.m., with LVN 2, LVN 2 stated, they trashed the insulin. LVN 2 stated a medication's mechanism of action can be decreased if it was given past the expiration date. During an interview on [DATE], at 12:52 p.m., with Director of Nursing (DON), DON stated, their policy for insulin was to document the open date on the insulin bottle and appropriately dispose of the insulin on the manufacture's recommended expiration date, which was usually 28 or 31 days after opening. DON stated it was important to use insulin within the manufacture's recommended timeframe to ensure the medication was most effective. During a review of Resident 39's Doctor's Order, dated [DATE], the order indicated Resident 39 had a doctor's order for Insulin Regular Human Injection Solution 100 Unit/mL (milliliter) (a short-acting insulin) . Inject as per sliding scale . subcutaneously (under the skin) before meals . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Residents 39's SBAR (situation, background, assessment, and recommendation) Communication Form, dated [DATE], the SBAR indicated on [DATE], Resident was given insulin that was past it's 28 use date. The SBAR indicated Recommendations of Primary Clinicians . Continue to monitor for adverse effects r/t (related to) expired insulin such as uncontrolled glucose, N/V (nausea/ vomiting) . During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, revised [DATE], the P&P indicated, Purpose . To provide guidelines for the safe administration of insulin to residents with diabetes. The P&P indicated Steps in the Procedure (Insulin Injections via Syringe) . Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening). During a review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines, dated 2007, the P&P indicated, No expired medication will be administered to a resident. 2. A review of Resident 220's Admission Record printed [DATE], indicated Resident 220 was admitted to the facility in 2024 with multiple diagnoses, which included Cerebral Infarction, Unspecified (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain). During an observation on [DATE], at 11:24 a.m., with LVN 3, LVN 3 was observed while they administered medications to Resident 220. LVN 3 administered Senna, Divalproex, and Levetiracetam, to Resident 220. During an interview on [DATE], at 11:45 a.m., with LVN 3, LVN 3 stated their policy was to give medications up to 1hr (hour) before or after the doctor's ordered time. LVN 3 stated it was important to give medications on time as ordered because it could have disturbed their medication schedule. During an interview on [DATE], at 12:40 p.m. with DON, DON stated their policy was to administer medications up to 1hr before or after their doctor's ordered scheduled time. DON stated it was important to give medications on time to ensure they were effective. During a review of Resident 220's Doctor's Orders, dated [DATE], the orders indicated Resident 220 had a doctor's order, dated [DATE], for Senna Oral Tablet 8.6 MG . Give 2 tablet by mouth two times a day for bowel regularity . The orders indicated Resident 220 had a doctor's order, dated [DATE], for Divalproex Sodium Oral Tablet Delayed Release 500 MG (milligram) . Give 1 tablet by mouth two times a day for epilepsy (a group of brain disorders that causes seizures) The orders indicated Resident 220 had a doctor's order, dated [DATE], for Levetiracetam Oral Tablet 250 MG . Give 1 tablet by mouth two times a day for epilepsy. During a review of Resident 220's Medication Administration Record (MAR), dated [DATE], the MAR indicated resident 220 had Senna Oral Tablet 8.6 MG . scheduled for two times a day . at 0900 and 2100. The MAR indicated Resident 220 had Divalproex Sodium Oral Tablet Delayed Release 500 MG . scheduled for two times a day . at 0900 and 2100. The MAR indicated Resident 220 had Levetiracetam Oral Tablet 250 MG . scheduled for two times a day . at 0800 and 1800. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Residents 220's SBAR Communication Form, dated [DATE], the SBAR indicated on [DATE], Resident received medication late including Divalproex 500 mg and senna 8.6 mg. The SBAR indicated, Inform MD (medical doctor) and RP (responsible party) and continue to monitor for adverse side effects of late administration. During a review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines, dated 2007, the P&P indicated, Medications are administered within 60 minutes of scheduled time .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34975 Based on observation, interview and record review, the facility failed to ensure the menu was followed for 6 residents on Renal diets (diet that promotes kidney health) and Renal Consistent Carbohydrate (CCHO; a diet typically prescribed to control blood sugar) out of 65 residents who received food from the kitchen. This failure had the potential to result in providing residents on a Renal diet and Renal CCHO diets with an inadequate and/or a harmful amount of nutrients, further compromising residents' medical status. Findings: Review of tray tickets for lunch dated 7/15/24 and used for the lunch trayline on 7/15/24, showed 3 residents received a Renal diet and 3 residents received a Renal CCHO diet. During concurrent tray line observation and record review on 7/15/24 at 12:00 p.m., lunch trays were prepared for residents. The trays included desserts which were placed on the tray by Dietary Aide (DA) 1. The trays with a tray ticket that specified the resident was on a Renal diet or Renal CCHO, had a cup of cappuccino chocolate mousse. Review of the cook's spreadsheet titled Summer Menus dated 7/15/24, showed the dessert for Regular diets was cappuccino mousse, the dessert for Renal diets was two small sugar cookies, small-approximately two inches, and the dessert for Renal CCHO was two small diet sugar cookies. During an observation of trayline and concurrent interviews with DA1, [NAME] 2, and the Certified Dietary Manager (CDM) 1 on 7/15/24 starting at 12 p.m., the surveyor asked DA 1 if residents on a Renal diets should receive mousse or cookies according to the menu, DA 1 confirmed cookies. DA 1 confirmed she placed the Cappuccino Mousse on the trays for the Renal diets. DA 1 placed eight cookies in plastic bags but did not switch out the mousse for the cookies on the Renal trays and left the kitchen. When the surveyor asked [NAME] 2, who also placed food on the trays, if the cookies should replace the mousse for the Renal diets, [NAME] 2 said she was not responsible for the desserts. When CDM 1 was asked if eight cookies were appropriate for the Renal diets, he stated he did not know. During an interview on 7/18/24 at 9:56 a.m., CDM 1 stated he did not clarify with the Registered Dietitian (RD) how many cookies the Renal diets should have received for lunch on 7/15/24 and what type of diet cookies the Renal CCHO diets should have received. During a phone interview with RD1 on 7/18/24 at 12:05 p.m., RD1 stated the menu should have been followed for lunch on 7/15/24. In a consecutive phone interview with RD1 on 7/18/24 at 1:45 p.m., RD1 stated regular vanilla wafers were not appropriate for the Renal CCHO diet and she was not sure if the kitchen had diet/low carbohydrate cookies available. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50120

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 34975 Based on observation, interview, and record review the facility failed to provide the appropriate food texture for mechanical soft diets. This deficient practice had the potential to cause difficulty with eating, chewing, and/or swallowing leading to an increased risk of choking for 10 of 10 residents who received prescribed mechanical soft diets. Findings: Review of the Cooks spreadsheet titled Summer Menus dated 7/15/24, showed residents prescribed a Mechanical Soft diet received ground French Dip-Roast Beef moistened with broth, and chopped corn coleslaw. During an observation of trayline food service and concurrent interviews with [NAME] 1 and the Certified Dietary Manager (CDM) 1 on 7/15/24 starting at 12:00 p.m., residents who's tray ticket indicated a physician prescribed Mechanical Soft diet were served dry, shredded roast beef on a bun, with no added au jus (a light broth or gravy usually made with the meat's natural juices). In addition, Mechanical Soft diets were served a bowl of dry coleslaw (shredded cabbage salad). [NAME] 1 confirmed she did not moisten the mechanical beef with the au jus. CDM1 stated confirmed the mechanical meat was dry and it should have the au jus added to the meat. During an observation and interview on 7/15/24 at 1:10 p.m., CDM 1 confirmed the coleslaw served to Mechanical Soft diets was dry and was not mixed with a dressing or any type of moistener. During an interview and facility document review on 7/15/24 at 1:45 p.m., the recipe for the coleslaw was reviewed with CDM 1, and he confirmed the coleslaw recipe included but was not limited to shredded cabbage, lemon juice and mayonnaise, and the ingredients were to be all combined. During interview on 7/17/24 at 2:50 p.m., the Speech Language Pathologist (SLP) stated in general, for residents on a Mechanical Soft diet, moist food, such as cabbage mixed with a sauce, was safer than dry cabbage. Review of the facility'sDiet Manual dated 2020, showed the Mechanical Soft diet is designed for residents who experience chewing or swallowing limitations. Meats are to be ground with meat juices, gravy or sauce. Dry meat is not allowed. 50120

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 34975 Based on observation, interview, and facility document review, the facility failed to fortify resident food according to physician orders. This failure had the potential to result in decreased calorie intake for two (Residents 9 and 14) out of seven residents who had physician prescribed fortified diets. Findings: An observation of trayline food service on 7/15/24 at 12 p.m., showed resident diets printed on tray tickets, and fortified was included in seven resident diets. [NAME] 2 called out diets according to the tray ticket to [NAME] 1. Then [NAME] 1 placed hot food on plates according to the diet called out. [NAME] 2 did not call out fortified when she called out diets with fortified printed on the tray ticket. When the surveyor asked how diets were fortified, [NAME] 1 stated residents with fortified diets received margarine on the sweet potato fries. [NAME] 1 informed [NAME] 2, she had to call out fortified when it was printed on the ticket in order for her to know to place margarine on the sweet potato fries. [NAME] 1 confirmed she did not call out fortified printed on the tray tickets for the first food cart delivered which carried Resident 9 and Resident 14's trays. Review of the lunch tray tickets dated July 15, 2024, showed Resident 9 and 14 were to receive a Fortified diet. During an interview on 07/18/24 at 9:56 a.m., Certified Diet Manager (CDM) 1 confirmed fortified diets were physician prescribed. Review of the facility's Diet Manual dated 2020, showed the Fortified Diet is designed for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status. The goal is to increase the calorie density of the foods commonly consumed by the resident. The amount of calorie increase should be approximately 300-400 per day. Examples of adding calories may include extra margarine or butter to food items. 50120 the facility did not ensure physicians orders were followed for fortified diet FACILITY Dining Observation

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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** 34975 45091 Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared in clean environment, within standards for safety when: 1. Floor drains were not maintained clean; 2. Kitchen tile floors were not clean and were not maintained in good repair; 3. Time/Temperature Control for Safety Food (TCS; a food that requires time/temperature control for safety to limit pathogenic microorganism growth or toxin formation) was not cooled safely and there was no cooldown documentation; 4. Meat was not thawed appropriately; 5. The inside of a food storage refrigerator was not clean; 6. An industrial can opener was not maintained and clean; 7. Clean plates were handled with dirty oven mitts; 8. A food service equipment drawer was not clean; 9. The ceiling above a food preparation area was not clean; 10. There was no airgap (a gap between the sink drain and the drain that leads to sewage drain. This gap prevents a back-up of non-potable water and/or bacteria into the sink) in the food preparation sink drain; and 11. Tube feeding formulas were stored past expiration dates and were available for use for three residents (Residents 13, 42, and 60). These failures had the potential to result in contamination of food leading to food borne illness, for 68 residents who resided in the facility. Findings: 1. During observation in the kitchen on [DATE] at 10:10 a.m., a drain cover over the floor drain in the middle of the dish room was not secured and when the drain grate was removed there was thick sludge build-up as well as standing water inside the drain. In addition, there were small flies around the drain when the grate was lifted, and there was a bad odor coming from the drain. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and observation with the Certified Dietary Manager (CDM) 1 on [DATE] at 3 p.m., CDM1 stated the drain appeared to be backed-up, and sludge in drain could harbor bacteria and was a safety hazard. Review of the facility's Policy and Procedure (P&P) titled General Cleaning of Food and Nutrition Services Department dated 2023, showed floor drains must be scheduled for routine cleaning in order to maintained in a functional condition. The Maintenance Department will assist with more thorough cleanings to ensure the viability of the plumbing features. According to the 2022 Federal Food Code Annex, pooling liquid wastes could attract pests such as insects and rodents or contribute to problems with certain pathogens. 2. An observation in the kitchen on [DATE] at 10:10 a.m., showed tiles around the floor drain were loose and not attached. There were additional tiles around the floor that were broken off, had missing grout, and were collecting pools of water. During observation on [DATE] at 3:00 p.m. There was separation from wall and the floor tile, with no grout. The length was approximately 2 feet in length. The gap with no grouting had dark residue particles resembling food crumbs, and small pieces of trash collecting in the area. During a concurrent observation on [DATE] at 3:00 p.m., there were loose wall tiles along area behind the manual warewashing sink, which created a gap between the wall and the tiles. During concurrent interview and observation with CDM1 on [DATE] at 10:10 a.m. CDM1 stated having loose tiles and the pooled water could harbor bacteria and was a safety hazard. CDM1 stated he was aware of the broken tiles and put in a request for maintenance to fix the issue around one month ago. CDM 1 stated he was not aware of the loose tiles. He confirmed the floor was dirty and that the pooling water could harbor bacteria. During an interview on [DATE] at 12:50 p.m., Operations Manager (OM) confirmed the floors in the kitchen were reported on the maintenance log about a month ago and it just slipped through the cracks. According to the 2022 Federal Food Code, floors and floor coverings are to be constructed so they are smooth and easily cleanable. In addition, when cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures are to be coved and closed to no larger than 1 mm (millimeter). If water flush cleaning methods are used, wall junctures are to be coved and sealed. According to the Annex, pooling liquid wastes could attract pests such as insects and rodents or contribute to problems with certain pathogens. 3. An observation in the kitchen and interview on [DATE] at 9:47 a.m., showed cooked roast pork in a metal pan, stored in a reach-in refrigerator. CDM1 stated he cooked the roast pork the evening prior and placed the cooked pork in the reach-in refrigerator but did not enter the cool down temperatures in the cool down log. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview with [NAME] 1 and CDM 1 on [DATE] at 10:35 a.m., [NAME] 1 stated she did not cool food down that needed to be documented on a cooldown log. When [NAME] 1 was asked about a pan of sliced beef located in a reach-in refrigerator, which was covered with plastic, labeled , d+[DATE] Beef Roast, [NAME] 1 stated it was left over from yesterday's lunch trayline. [NAME] 1 stated she did not measure or document cooldown temperatures for the leftover beef roast. CDM 1 confirmed there were no cooldown temperatures documented for the beef. CDM 1 stated, there should be a logbook to document cooldown temperatures, but he had not seen it lately. During an interview on [DATE] at 9:56 a.m., CDM 1 said there should be documentation for cooling food items. Review of the facility's P&P titled Cooling and Reheating of Potentially Hazardous [PHF] or Time/Temperature Control for Safety Food dated 2023, showed TCS food included food of animal origin. When TCS food will not be served right away it must be cooled as quickly as possible. Cool cooked food from 140 degrees Fahrenheit (F) to 70 degrees F within two hours; then cool from 70 degrees F to 41 degrees F or less in an additional four hours for a total cooling time of six hours. When cooling down food, use the Cool Down Log to document proper procedure. Review of the facility's policy and procedure titled Leftover Foods dated 2023, showed leftover foods are those that have been prepared for a meal and not served. As soon as hot food has dropped to 140 degrees F, the proper methods of cooling food must be used and refer to the Cooling and Reheating of PHF/TCS Food Policy. 4. During an observation on [DATE] at 10:33 a.m., a 13 pound raw pork roast thawed in a cardboard box on the lower level of refrigerator #2, adjacent to two large cardboard boxes containing small carton of vanilla and chocolate protein shakes. The bottom surface of the cardboard box the pork was stored in, was visibly wet. The pork roast was soft to the touch and was dated [DATE] with a use by date of [DATE]. During an interview on [DATE] at 9:47 a.m., CDM 1 stated he cooked the pork last night with a use-by date of [DATE], and the cooked pork was now stored in the refrigerator. During an interview on [DATE] at 11:30 a.m., CDM 1 confirmed the pork was cooked on the fourth day into the thawing process, and it should not have been cooked and instead discarded. During an interview on [DATE] at 9:56 a.m., CDM 1 stated meat should be thawed in the refrigerator in a plastic tub. CDM 1 confirmed if meat was thawed in a cardboard box, this could result in cross contamination from the juices of the thawed meat to other items in the refrigerator. Review of the facility's P&P titled Thawing of Meats dated 2023, showed thawing meat properly could be done in the refrigerator. Allow 2 to 3 days to defrost, depending on the quantity and total weight of the meat. Label the defrosting meat with pull and use by date. Use a drip pan under food being thawed so drippings do not contaminate other food. 5. An observation in the kitchen on [DATE] at 10:40 a.m., showed Refrigerator #2 stored containers of milk and juices. There was an accumulation of a sticky, white residue, and a sticky, dark residue on the wire, metal shelving inside the refrigerator. The wire shelving surface was rough and bumpy from the residue build-up, and sticky residue wiped off with a paper towel. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on [DATE] on 10:42 a.m. with CDM1, he stated the refrigerator should be on a deep cleaning schedule and that the racks looked dirty. CDM 1 stated the residue build-up might have been from spilled milk and juices. Review of the facility's P&P titles Refrigerator and Freezer dated 2023, showed maintaining a clean refrigerator can improve the safety and quality of foods. Refrigerators should be on a weekly cleaning schedule. Wipe up spills immediately. According to the 2022 Federal Food Code, multi-use food-contact surfaces shall be smooth, and equipment food-contact surfaces are to be clean to sight and touch. Nonfood-contact surfaces of equipment are to be kept free of an accumulation of dust, dirt, food residue, and other debris. 6. An observation in the kitchen on [DATE] at 10:48 a.m. showed a large metal industrial can opener stored in a base (the can opener holder) attached to a metal table. There was accumulated dark matter on the can opener base, as well as the can opener blade. The surface around the blade was sticky to the touch. In addition, the surface of the can opener metal cogwheel (the part that helps turn the can) had dark orange build-up. During a concurrent observation and interview on [DATE] at 10:50 a.m., CDM1 was asked how often the can opener was cleaned. CDM1 stated the can opener was deep cleaned once a week. CDM 1 confirmed there was black residue build-up on the can opener base and the surface around the blade was sticky. CDM1 stated the cogwheel had rust or residue on the surface. CDM 1 stated a dirty can opener could cause foodborne illness or metal contamination from the rust. Review of the facility's P&P titled Can Opener and Base dated 2023, showed proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. The can opener must be thoroughly cleaned each work shift and, when necessary, more frequently. 7. An observation in the kitchen on [DATE] at 11:53 a.m. during trayline food service, [NAME] 2 wore oven mitts and handled the top surface of plates, which were used to plate resident food. The oven mitts had dried residue on the outside surface around the finger and thumb areas. During interview on [DATE] at 11:57 a.m. CDM1 stated the oven mitts should be cleaned when they were used and/or dirty. CDM 1 confirmed the oven mitts used by [NAME] 2 to handle the clean dishes had a film on the outside and pointed to the dried residue on the outside of the mitts. CDM1 said the oven mitts should not be used to handle clean plates. CDM 1 stated it was inappropriate to use dirty objects to handle clean plates as this could result in cross-contamination. According to the 2022 Federal Food Code, cleaned and sanitized utensils shall be handled so that contamination of food-contact surfaces is prevented. 8. An observation in the kitchen on [DATE] at 10:05 a.m., showed a drawer used to store serving scoops had particles resembling food crumbs on base of drawer with various size scoops resting on top. There was also a sticky substances around the rim of the drawer. During interview on [DATE] at 10:05 a.m. CDM1 confirmed the scoop drawer was not cleaned and stated having these substances in and on the drawer could result in cross-contamination of the serving scoops, as well as possibly resulting in foodborne illness. (continued on next page)

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	555819	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 Federal Food Code, equipment food-contact surfaces are to be clean to sight and touch. Nonfood-contact surfaces of equipment are to be kept free of an accumulation of dust, dirt, food residue, and other debris. 9. During observation in the kitchen on [DATE] at 10:40 a.m., four ceiling tiles had visible accumulated, gray, fuzzy matter on the surface. These ceiling tiles were located above the food preparation area. During interview on [DATE] at 10:40 a.m. CDM1 stated maintenance was responsible for cleaning ceiling tiles in the kitchen. During interview on [DATE] at 3:00 p.m., Maintenance (Main) stated kitchen staff were responsible for cleaning ceiling tiles. Review of the facility's policy and procedure tiled Walls, Ceilings, and Light Fixtures dated 2023, showed ceilings must be washed twice a year and must be cleaned more often as necessary. According to the 2022 Federal Food Code, physical facilities shall be cleaned as often as necessary to keep the clean. 10. An observation in the kitchen on [DATE] at 11:20 a.m. showed the food preparation sink drain was plumbed directly into the wall. During interview and observation with the Operations Manager (OM) on [DATE] at 3:30 p.m., OM confirmed there was no visible gap in the food preparation sink drain. According to the 2022 Federal Food Code, a direct connection may not exist between the sewage system and the drain originating from equipment in which food, portable equipment, or utensils are placed. 11. A review of Resident 13's Admission Record printed [DATE], indicated Resident 13 was admitted to the facility in 2023 with multiple diagnoses, which included an admission diagnosis of Chronic Obstructive Pulmonary Disease (COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems, including emphysema and chronic bronchitis). A review of Resident 42's Admission Record printed [DATE], indicated Resident 42 was admitted to the facility in 2023 with multiple diagnoses, which included an admission diagnosis of Cerebral Infarction . (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain). A review of Resident 60's Admission Record printed [DATE], indicated Resident 60 was admitted to the facility in 2024 with multiple diagnoses, which included an admission diagnosis of Nontraumatic Intracerebral Hemorrhage . (a type of stroke that occurs when bleeding happens in the brain without trauma or surgery). During a concurrent observation and interview on [DATE], at 3:54 p.m., with Director of Nursing (DON), the medication room was observed. Three 1500 milliliter nutritional tube feeding formulas with a use by date of [DATE] were stored and available for resident use. DON stated the formula was expired and they would throw it in the trash. DON stated, I wouldn't give that to a resident. DON stated, they didn't want to give residents anything expired to protect their safety. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 13's Doctor's Order, dated [DATE], the Order indicated Resident 13 had a doctor's order for provide 1700mL . formula . During a review of Resident 42's Doctor's Order, dated [DATE], the Order indicated Resident 42 had a doctor's order for every shift . T/F (tube feeding) formula . During a review of Resident 60's Doctor's Order, dated [DATE], the order indicated Resident 60 had a doctor's order for T/F Formula . 1500mL. During a review of the facility's policy and procedure (P&P) titled, Enteral feedings - Safety Precautions, Revised [DATE], the P&P indicated, Maintain inventory controls and discard any formula past the expiration date. 50120

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 34975 Based on observation, interview, and facility document review, the facility failed to ensure: 1. Residents had a location to safely store perishable food brought into the facility by family/visitors; and 2. A policy described the safe storage of food brought in by family members. This failure had the potential to result in foodborne illness from unsafe food storage, decreased food intake, and did not create a homelike environment for 65 residents who took food by mouth out of a census of 68. Findings: During an interview on 7/16/24 at 2:40 p.m., Certified Nursing Assistant (CNA) 1 stated sometimes food brought in by family/visitors was stored for residents in the staff refrigerator. CNA 1 stated she thought perishable food could be stored up to 24 hours in the staff refrigerator. During an interview on 7/16/24 at 2:48 p.m., CNA 2 stated sometimes family and visitors brought in food for residents, but the facility did not store residents' perishable food because there was not a refrigerator for this purpose. CNA 2 stated if milk was at a resident's bedside during her shift, she would discard it the next day when she was back for her next shift. CNA 2 was asked what the procedures were if a family member brought in a food item such as meat lasagna for a resident. CNA 2 stated if the meat lasagna was brought in during her shift in the afternoon, she would leave it at the resident's bedside in case the resident wanted to eat it for dinner. CNA 2 stated if the meat lasagna was still at the resident's bedside the next day, then she would discard it. An observation on 7/17/24 at 11:05 a.m., showed a refrigerator in the staff breakroom. There was not an internal thermometer inside the refrigerator. During an interview on 7/17/24 at 11:10 a.m., the Restorative Nursing Assistant (RNA) stated she cleaned the staff refrigerator, and she was not aware of a thermometer or a temperature log for the staff refrigerator. RNA stated there was not a refrigerator to store residents' personal perishable food. During an interview on 7/17/24 at 12:42 p.m., the Director of Nursing (DON) stated she was under the impression residents were allowed to keep perishable food for the day. DON stated if a perishable food was brought in for a resident at 8 a.m., the food could be stored in the resident's room until midnight. DON stated she did not know how long perishable food could be stored without refrigeration. DON stated there was not a specific place to store residents' personal perishable food. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy and procedure titled Food Brought by Family/Visitors, revised 2014, showed family members should inform nursing staff of their desire to bring food into the facility. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled including the use-by-date. It was noted this policy did not describe how many hours/days perishable food could be stored for the resident. According to the 2022 Federal Food Code, except during preparation, cooking, or cooling, or when time is used as the public health control, Time/Temperature Control for Safety (TCS) food is to be maintained at or above 130 degrees, or at or below 41 degrees F. In addition, if time without temperature control is used as the public health control there can be up to a maximum of 6 hours with an initial temperature of 41 degrees or less. The food may not exceed 70 degrees F within a maximum time period of 6 hours. 50120

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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. 45091 Based on observation, interview, and record review, the facility failed to follow infection control practices for two of two sampled residents (Residents 5 and 39), when the following was observed: 1. Licensed Vocational Nurse 3 (LVN) did not clean and sanitize the glucose monitor (a device for measuring the concentration of glucose in the blood) in between finger stick blood sugar tests (a test that measures blood glucose levels by pricking a fingertip with a lancet and applying a drop of blood to a test strip in a glucose monitor) for resident 5 and 39. 2. LVN 3 disposed Resident 5 and 39's contaminated blood sugar lancets in residents 5 and 39's trash cans. 3. LVN 3 did not perform hand hygiene in between resident 5 and 39's finger stick blood sugar tests. These failures placed Residents 5 and 39 at risk for injury, cross contamination, and infection. Findings: A review of Resident 5's Admission Record printed 7/17/24, indicated Resident 5 was admitted to the facility in 2021 with multiple diagnoses, which included Unspecified Sequelae (an aftereffect of a disease) of Unspecified Cerebrovascular Disease (a disorder that results from inadequate blood flow in the brain's blood vessels). A review of Resident 39's Admission Record printed 7/17/24, indicated Resident 39 was admitted to the facility in 2024 with multiple diagnoses, which included Type 2 Diabetes Mellitus (a long-term (chronic) disease in which the body cannot regulate the amount of sugar in the blood) with Diabetic Neuropathy, unspecified (a complication of diabetes that causes nerve damage throughout the body). During an observation on 7/15/24, at 11:58 a.m., LVN 3 was observed while they did a fingerstick blood sugar test on Residents 5 and 39. LVN 3 took Resident 5's fingerstick blood sugar test and disposed the contaminated lancet in the resident's trash can. Then LVN 3 took Resident 39's fingerstick blood sugar test. LVN 3 did not clean, disinfect, or sanitize the blood glucose monitor in between resident tests. LVN 3 did not perform appropriate hand hygiene in between resident tests. LVN 3 disposed Resident 39's contaminated lancet in the resident's trash can. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/24, at 12:55 p.m., with Director of Nursing (DON), DON stated their policy was to dispose contaminated lancets in the sharps container (A specialized waste container designed to safely dispose of sharp medical instruments and other items, such as needles, scalpels, and lancets. Sharps containers are typically made of rigid, puncture-resistant plastic or metal with leak-resistant sides and bottom, and a tight-fitting lid that allows sharps to be deposited but is too small for a hand to fit through). DON stated contaminated lancets disposed in resident trash cans placed residents at risk for injury and infection. DON stated their policy was to clean and sanitize blood glucose monitors in between each resident use. DON stated performing fingerstick blood sugar tests with blood glucose monitors that were not cleaned and sanitized in between each resident use, placed residents at risk for cross contamination and infection. DON stated their policy was to perform appropriate hand hygiene when performing fingerstick blood sugar tests in between each resident. DON stated residents were placed at risk for cross contamination and infection when appropriate hand hygiene was not done in between each resident fingerstick blood sugar tests. During a review of Resident 5's Doctor's Order, dated 4/25/23, the Order indicated Resident 5 had a doctor's order for FBS . (fasting blood sugar, a blood test that measures the level of sugar in blood after a person has not eaten or consumed anything but water for 8-12 hours, by pricking the fingertip with a lancet to produce a drop of blood). During a review of Resident 39's Doctor's Order, dated of 4/12/24, the Order indicated Resident 39 had a doctor's order, for Finger stick blood glucose .(also known as finger stick blood sugar test). During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised July 2014, the P&P indicated, Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufactures' instructions. During a review of the facility's policy and procedure (P&P) titled, Sharps Disposal, revised January 2012, the P&P indicated, This facility shall discard contaminated sharps into designated containers. The P&P indicated Contaminated sharps will be discarded into containers that are: a. closable; b. puncture resistant; c. leakproof on sides and bottom; d. labeled or color-coded in accordance with our established labeling system; and e. impermeable and capable of maintaining impermeability through final waste disposal. During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, revised September 2014, the P&P indicated, Purpose . To provide guidelines for the safe administration of insulin to residents with diabetes. The P&P indicated Steps in the Procedure (Insulin Injections via Syringe) 1. Wash hands 2. Check blood glucose per physician order or facility protocol. 50013

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 49498 Based on observation and interview, the facility had 34 resident (Rt) rooms (100, 102, 104, 106, 107, 108, 109, 110, 111, 112, 113, 114, 116, 118, 200, 202, 204, 208, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, and 225) with multiple beds that provided less than 80 square feet per (sq.ft) resident who occupied these rooms. This failure had the potential to result in inadequate space for the delivery of care to each of the residents in each room, or for storage of the residents' belongings. Findings: During observations between 7/15/24-7/18/24, the following resident rooms and corresponding square footage were identified: Room Sq ft Sq ft/resident 100 232.55 77.52 102 150.54 75.27 104 149.41 74.71 106 149.41 74.71 107 151.47 75.73 108 150.33 75.16 109 151.62 76.62 110 154.54 75.27 111 151.25 75.62 112 149.19 74.59 113 142.37 71.18 114 154.4 76.2 115 233.18 77.73 116 150.33 75.18 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	118 149.19 74.59 200 149.19 74.59 202 150.33 75.16 204 149.42 74.71 206 232.55 77.52 208 149.19 74.59 210 149.42 74.71 211 233.18 77.73 212 149.42 74.71 213 155.62 77.81 214 149.19 74.59 215 152.4 76.2 216 151.47 75.73 217 151.25 75.62 218 150.33 75.16 219 150.1 75.05 220 15.47 75.73 221 237.18 79.06 222 150.33 75.16 223 149.41 74.7 224 151.47 75.73 225 149.42 74.7 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During random observations of care and services from 7/15/24-7/18/24, there was sufficient space for the provision of care for the residents in all rooms. There was no heavy equipment kept in the rooms that might interfere with resident care and each resident had adequate personal space and privacy. There were no complaints from residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/or safety concerns in the 34 rooms. Recommend granting room size waiver.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40968 Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by a patient to signal his or her needs for assistance) was functioning for 13 of 68 sampled residents (Resident 32, 168, 40, 174, 26, 51, 20, 31, 41, 2, 4, 5, and 53). This deficient practice had the potential to result in the delay of care and services. Findings: 1. a. During a review of Resident 32's Admission Record, dated 7/17/24, indicated Resident 32 was admitted to the facility on [DATE] with multiple diagnoses that included Parkinson's Disease (a progressive disorder that affects nervous system and parts of the body controlled by the nerves), absence of right and left legs below knees. During a review of Resident 32's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 4/21/24, indicated Resident 32 had a Brief Interview for Mental Status (BIMS - a tool used to assess mental function) score of 14. Meaning Resident 32 was able to understand and understood others. The MDS also indicated Resident 32 was always incontinent of both bladder and bowel. b. During a review of Resident 168's Admission Record, dated 7/17/24, indicated Resident 168 was admitted to the facility on [DATE] with multiple diagnoses that included weakness, migraine (severe headache) and urinary tract infection. c. During a review of Resident 40's Admission Record, dated 7/17/24, indicated Resident 40 was admitted to the facility on [DATE] with multiple diagnoses that included urinary tract infection. During a review of Resident 40's MDS, dated [DATE], indicated Resident 40 had a BIMS score of 13. Meaning Resident 40 was able to understand and understood others. The MDS also indicated Resident 40 required partial/moderate assistance with toileting hygiene and toilet transfer. d. During a review of Resident 174's admission record, dated 7/17/24, indicated Resident 174 was admitted to the facility on [DATE] with multiple diagnoses that included unspecified injury. During a review of Resident 174's MDS, dated [DATE], the MDS indicated, Resident 174 had a BIMS score of 09. Meaning, Resident 174's cognition was moderately impaired. The MDS also indicated, Resident 174 was occasionally incontinent of bladder and bowel. e. During a review of Resident 26's Admission Record, dated 7/17/24, indicated Resident 26 was originally admitted to the facility on [DATE] and was readmitted on [DATE] ,with multiple diagnoses that included obesity, spinal stenosis (a condition that causes pressure on the spinal cord), polyneuropathy (malfunction of many peripheral nerves), neuromuscular dysfunction of bladder (lack of bladder control due to brain, spinal cord and nerve problem) and weakness. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 26's MDS, dated [DATE] indicated Resident 26 had a BIMS score of 13. The MDS also showed, Resident 26 was occasionally incontinent of urine and always incontinent of bowel. f. During a review of Resident 51's Admission Record, dated 7/17/24, Resident 51 was admitted to the facility on [DATE] with multiple diagnoses that included, unspecified injury, neuromuscular dysfunction of bladder, chronic pain syndrome and unspecified nondisplaced fracture. During a review of Resident 51's MDS, dated [DATE], indicated Resident 51 had a BIMS score of 12. Meaning Resident 51's cognition was moderately impaired. The MDS also indicated Resident 51 was always incontinent of bowel. During a concurrent observation and interview on 7/15/24 at 9:54 a.m. with Resident 32, call bell was on the overbed table. Resident 32 stated, she had been using call bell for help, call light has been broken months. During a concurrent observation and interview on 7/15/24 at 10:05 a.m. with Resident 168, Resident 168 stated, call bell was inadequate. Resident 168 further added, last night, she waited for one hour after ringing call bell for her pain medication. Resident 168 also stated call bell was not effective in getting help. During a concurrent observation and interview on 7/15/24 at 10:22 a.m. with Resident 26 in the presence of Certified Nurse Assistant (CNA) 4, Resident 26 stated, call light was broken for weeks now. Resident 26 also stated, the hand bell did not work, when you ring the bell, it takes forever for the staff to come. During a concurrent observation and interview on 7/15/24 at 10:22 a.m. with Resident 51 in the presence of CNA 4, Resident 51 stated, call light did not work. Resident 51 further added, you can ring it (hand bell), they don't come right away. CNA 4 was observed to check the call lights attached to the walls and confirmed Resident 51 and Resident 26's call lights did not work. CNA 4 stated, it has been two weeks since call lights were broken. During a concurrent observation and interview on 7/15/24 at 10:37 a.m., with Resident 40, Resident 40 stated, it was hard to get help from staff because call light did not work. During an interview on 7/15/24 at 10:57 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, the were issues with call lights. LVN 1 also stated, quality of care was impacted when resident's call lights do not function. During an interview on 7/16/24, at 10:08 a.m., with CNA 3, CNA 3 stated, the call light problem (being broken) has existed since she began her employment one month ago. CNA 3 further stated, the hand bell given to residents with call light issues were not effective as CNAs had to check which room the hand bell was coming from. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/16/24 at 10:36 a.m. with Resident 174, Resident 174 stated, call light has not worked in over a week, no one comes when you ring hand bell. Resident 174 further added, he had to wait for staff to walk by and call for help. During a concurrent observation and interview on 7/16/24 at 12:23 p.m. with Maintenance (MAIN), MAIN was observed checking resident call lights and confirmed the call lights for Resident 32, 168, 40, 174, 26, 51 were broken. MAIN also stated, he was designated to fix call lights but was not successful even after changing call light fixtures. MAIN further added, he notified Operations Manager (OM) regarding broken call lights one week ago. During an interview on 7/16/24, at 12:43 p.m., with OM, OM stated he was aware of the call light not functioning properly in multiple resident rooms. OM also stated, the facility made attempts to fix the call light but was not successful. 45091 2. A review of Resident 20's Admission Record printed 7/17/24, indicated Resident 20 was admitted to the facility in 2022 with multiple diagnoses, which included an admission diagnosis of Other Specified Disorders of the Brain (a medical classification under the range of Diseases of the nervous system) During a concurrent observation and interview on 7/16/24, at 9:54 a.m., with Resident 20, Resident 20's call did not work. Resident 20 stated their call light has been broken for a week and staff were aware. Resident 20 stated it made them upset. During a review of Resident 20's Minimum Data Set (MDS, an assessment tool used to guide care), dated 5/10/24, the MDS indicated Resident 20 had a Brief Interview for Mental Status (BIMS, a screening tool used to assess cognition) score of 13, meaning intact cognition. The MDS indicted Resident 20 was, always incontinent, for urine and bowel (unable to control keeping urine or feces in the body). The MDS indicated Resident 20 needed Partial/moderate assistance, for toileting hygiene, roll left and right, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. A review of Resident 31's Admission Record printed 7/17/24, indicated Resident 31 was admitted to the facility in 2022 with multiple diagnoses, which included an admission diagnosis of Cerebral Infraction (death of an area of brain tissue when a blocked blood vessel prevents delivery of an adequate blood and oxygen supply to the brain). During a concurrent observation and interview on 7/16/24, at 9:48 a.m. Resident 31's call did not work. Resident 31 stated their call light has been broken for a week and staff were aware. Resident 31 stated it made them upset. During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 31 had a BIMS score of 13, meaning intact cognition. The MDS indicated Resident 31 needed Supervision or touching assistance, for lying to sitting on side of bed, Sit to stand, Chair/bed-to-chair transfer, and toilet transfer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555819	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmwood Care Center	2829 Shattuck Avenue Berkeley, CA 94705

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 41's Admission Record printed 7/17/24, indicated Resident 41 was admitted to the facility in 2023 with multiple diagnoses, which included an admission diagnosis of Parkinson's Disease (A brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination. Symptoms usually begin gradually and worsen over time. As the disease progresses, people may have difficulty walking and talking. They may also have mental and behavioral changes, sleep problems, depression, memory difficulties, and fatigue.). During a concurrent observation and interview on 7/15/24, at 1:33 p.m., with CNA 4, CNA 4 confirmed Resident 41's call light did not work. During a review of Resident 41's MDS dated [DATE], the MDS indicated Resident 41's cognitive skills for daily decision making, was moderately impaired. The MDS indicated Resident 41 was, always incontinent, for urine. The MDS indicated Resident 41 needed Substantial/maximal assistance, for toilet transfer. The MDS indicated Resident 41 needed partial/moderate assistance, for toileting hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. 49498 3. a. During the resident council interview on 7/17/24 at 10:33 a.m. with Resident 2, Resident 2 stated the call light glitches, sometimes it worked, sometimes it did not, and had been like that for a week. During a record review of Resident 2's MDS dated [DATE], indicated Resident 2's score was 14 out of 15, indicating intact mental status. The MDS indicated Resident 2 required partial/moderate assistance from staff for toileting hygiene, shower/bathing, lower body dressing, lying to sitting on side of bed, sit to stand, chair to bed transfer and toilet transfer. b. During a concurrent observation and interview on 7/15/24 at 11:06 a.m. in Resident 4's room, Resident 4 pressed the call button. Resident 4 stated he needed to be changed. During an observation on 7/15/24 at 11:07 a.m. outside Resident 4's room, the call system light above the door had no light to alert the staff. During a concurrent observation and interview on 7/18/24 at 11:43 a.m. with Certified Nurse Assistant (CNA) 5 in Resident 4's room, CNA 5 pressed Resident 4's call button then went out of the room to check the call system light above the door. CNA 5 stated Resident 4's call light did not turn on. During a concurrent observation and interview on 7/18/24 at 11:55 a.m. in Resident 4's room, CNA 5 removed Resident 4's call system cord plug from the port then plugged in new one. CNA 5 pressed the call button then went out of the room to check the call system light above the door. CNA 5 stated Resident 4's call light did not turn on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555819	A. Building B. Wing	07/18/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's undated Admission Record, indicated Resident 4 was admitted to the facility in 7/24/23 with multiple diagnoses, which included an admission diagnosis of Vascular Dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior). During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had a BIMS score of 08 out of 15, meaning moderate cognitive impairment. The MDS indicted Resident 4 was always incontinent of bowel function (unable to control keeping feces in the body). The MDS indicated Resident 4 was dependent from staff for toileting hygiene and required partial/moderate assistance for mobility to roll left and right and lying to sitting on side of bed. c. During an observation on 7/15/24 at 10:14 a.m. in Resident 5's room, Resident 5's white call system cord was on the floor and was separated from the plug attached to the call system port located at the wall. During a concurrent observation and interview on 7/18/24 at 11:47 a.m. with Certified Nursing Assistant (CNA) 5 in Resident 5's room, Resident 5's white call system cord was on the floor and was separated from the plug attached to the call system port located at the wall. CNA 5 stated the call cord plug and the cord was separated. CNA 5 stated the call cord separated from the plug when the head of the resident's bed was elevated and was pulled from the wall. During an interview on 7/18/24 on 11:49 a.m. with Resident 5, Resident 5 stated, she asked her roommate, Resident 39, with working call system, to press her call button to call the staff for her. During a review of Resident 5's undated Admission Record, indicated Resident 5 was admitted to the facility on [DATE] with multiple diagnoses, which included an admission diagnosis of Personal history of Transient Ischemic Attack (TIA- a short period of symptoms like those of a stroke. It's caused by a brief blockage of blood flow to the brain.), During a review of Resident 5's Minimum Data Set (MDS, an assessment tool used to guide care) dated 5/20/24, the MDS indicated Resident 5 had a Brief Interview for Mental Status (BIMS, a screening tool used to assess cognition) score of 11 out of 15, meaning moderate cognitive impairment. The MDS indicted Resident 5 was occasionally incontinent of urine and bowel function (unable to control keeping urine and feces in the body). The MDS indicated Resident 5 required substantial/maximal assistance from staff for toileting hygiene and required partial/moderate assistance for mobility to roll left and right and sit to lying on bed. d. During the resident council interview on 7/17/24 at 10:35 a.m. with Resident 53, Resident 53 stated the call light in her bathroom was not working. During a record review of Resident 53's MDS dated [DATE], indicated Resident 53's BIMS score was 13 out of 15, indicating intact mental status. The MDS indicted Resident 53 was always incontinent of urine and bowel function (unable to control keeping urine and feces in the body). The MDS indicated Resident 53 required partial/moderate assistance from staff for toileting hygiene, shower/bathing, lower body dressing, lying to sitting on side of bed, sit to stand, chair to bed transfer and toilet transfer.