STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555844	A. Building B. Wing	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Novato Healthcare Center	1565 Hill Road Novato, CA 94947

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on interviews, record reviews, and facility policy review, the facility failed to ensure the resident's code status was accurately documented for 1 (Resident #169) of 34 sampled residents. Findings included: Review of a facility policy titled, Physician Orders for Life-Sustaining Treatment (POLST), with a revision date of [DATE], revealed, VII. Whenever possible, ensure that the Advance Directive and the POLST form are consistent. Review of Resident #169's Admission Record revealed the facility admitted the resident on [DATE] with diagnoses that included delusional disorders, adult failure to thrive, and cognitive communication deficit. Review of Resident #169's Order Review History Report, for the timeframe from [DATE] to [DATE], revealed an order dated [DATE] for cardiopulmonary resuscitation (CPR). Review of Resident #169's Physician Orders for Life-Sustaining Treatment (POLST), signed by Resident #169's responsible party (RP) and dated [DATE], revealed if the resident had no pulse and was not breathing, staff should not attempt resuscitation. During an interview on [DATE] at 10:08 AM, Licensed Vocational Nurse (LVN) #13 stated the POLST form was used to inform staff of a resident's code status. During an interview on [DATE] at 10:12 AM, LVN #14 stated he was not aware of conflicting information in the electronic health record related to Resident #169's code status. During an interview on [DATE] at 10:23 AM, Resident #169's RP stated Resident #169's code status should be do not resuscitate (DNR). During an interview on [DATE] at 3:21 PM, LVN #15 stated she spoke with Resident #169's RP on [DATE]. Per LVN #15, the Resident #161's RP completed the POLST which indicated Resident #169's code status would be DNR. LVN #15 acknowledged she did not update the resident's code status in the resident's electronic health record. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:07 PM, the Director of Nursing (DON) stated the POLST and the physician orders should match regarding the resident's code status. The DON stated there was some miscommunication regarding Resident #169's code status. During an interview on [DATE] at 2:44 PM, the Administrator stated the POLST and the information in the electronic health record should match. The Administrator said his expectation was that staff made sure all the records matched Resident #169's RP wishes regarding Resident #169's code status.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 39411 Based on observations, interviews, record reviews, and policy review, the facility failed to ensure privacy of protected health information for 2 (Resident #32 and Resident #141) of 34 sampled residents. Specifically, instructions for care were posted in sight of roommates, visitors, and others who might not be authorized to view this information. Findings included: A review of the facility policy titled, Resident Rights, with a revision date of 01/01/2012, revealed, Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident's rights. The policy indicated, These rights include, but are not limited to, a resident's right to: D. Privacy and confidentiality. 1. A review of Resident #32's Admission Record revealed the facility admitted the resident on 03/08/2017 with diagnoses that included Alzheimer's disease, dementia, and dysphagia, A review of Resident #32's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/10/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. During observations on 01/10/2024 at 9:58 AM and 01/10/2024 at 10:20 AM, speech therapy recommendations were observed posted on the wall above Resident #32's bed. The sign was not covered and included the resident's name, diet, and safe swallowing strategies. In an interview on 01/10/2024 at 3:24 PM, the Speech Language Pathologist (SLP) stated he posted the sign for the staff who assisted the resident to eat. The SLP stated the instructions should have been covered when they were posted and said he had forgotten. 2. A review of Resident #141's Admission Record revealed the facility admitted the resident on 06/07/2023 with diagnoses that included hemiplegia and hemiparesis related to cerebral infarction and dysphagia. A review of Resident #141's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/07/2023, revealed Resident #141 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. During an observation on 01/10/2024 at 8:30 AM, a sign with aspiration precautions and feeding instructions was observed posted above Resident #141's bed. The sign was not covered and included the resident's name, aspiration precautions, and safe swallowing strategies. In an interview on 01/11/2024 at 1:19 PM, the Director of Nursing stated signs must be covered if posted and all departments were expected to keep patient information private. In an interview on 01/11/2024 at 1:52 PM, the Administrator stated all resident medical information should be protected, and no information about a resident should be posted without a cover.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 39411 Based on observation, interviews, record review, and policy review, the facility failed to develop and implement a care plan for 1 (Resident #141) of 1 sampled resident reviewed for communication. Specifically, a care plan for communication was not developed for Resident #141, who spoke a language other than English. Findings included: Review of a facility polity titled, Person Centered Care Plan, with a revision date of November 2018, revealed, It is the policy of this Facility to provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial well-being. Review of Resident #141's Admission Record revealed the facility admitted the resident on 06/07/2023 with diagnoses that included hemiplegia and hemiparesis related to cerebral infarction, dysphagia, type 2 diabetes, and epilepsy. Review of Resident #141's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/07/2023, revealed Resident #141 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. Review of Resident #141's care plan, revealed no evidence to indicate the resident's care indicated the resident spoke a language other than English and there were no interventions established for communicating with the resident in their primary language. A review of a document titled, Social Determinants of Health, dated 12/08/2023, revealed Resident #141's language was identified as non-English, and the resident needed or wanted an interpreter to communicate with a doctor or healthcare staff. During an observation on 01/08/2024 at 2:51 PM, Resident #141 was greeted by the surveyor. There was no response from Resident #141. The surveyor was informed by the resident's roommate that Resident #141 was from another country and could not speak English. In an interview on 01/11/2024 at 11:10 AM, Registered Nurse (RN) #19 stated nurses could initiate and update care plans. RN #19 said communication was an issue for Resident #141, but he had not thought about creating a care plan for communication. In an interview on 01/11/2024 at 12:26 PM, Social Worker (SW) #20 stated she could initiate and update care plans and a care plan for communication should have been created when Resident #141 was admitted . SW #20 stated the resident's care plan also should have been updated when the Social Determinants of Health form was completed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/11/2024 at 1:19 PM, the Director of Nursing (DON) stated the initial care plans were completed upon admission and could be updated by nursing, social services, or rehabilitative services staff. The DON stated a care plan that addressed the resident's language barrier should have been developed for Resident #141. In an interview on 01/11/2024 at 1:52 PM, the Administrator stated the nurses assigned to Resident #141 were responsible for updating the care plans. The Administrator stated the need for a translator should have been addressed in Resident #141's care plan.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 39411 Based on observations, interviews, record review, and policy review, the facility failed to implement the use of alternative communication methods for 1 (Resident #141) of 1 sampled resident reviewed for communication. Specifically, the facility did not implement methods for communication with Resident #141 who spoke a language other than English. Findings included: A review of the facility policy titled, Translation or Interpretation Services, with a revision date of 12/01/2023, revealed, The Facility provides assistance to residents with limited English proficiency and/or hearing deficiency through translation and interpretation services. Review of Resident #141's Admission Record revealed the facility admitted the resident on 06/07/2023 with diagnoses that included hemiplegia and hemiparesis related to cerebral infarction, dysphagia, type 2 diabetes, and epilepsy. Review of Resident #141's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/07/2023, revealed Resident #141 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. Review of Resident #141's care plan with an initiation date of 06/11/2023, revealed the resident had a cerebrovascular accident with weakness on their left side. The care plan did not indicate the resident spoke a language other than English and there were no interventions established for communicating with the resident in their primary language. A review of a document titled, Social Determinants of Health, dated 12/08/2023, revealed Resident #141's language was identified as non-English, and the resident needed or wanted an interpreter to communicate with a doctor or healthcare staff. During an observation on 01/08/2024 at 2:51 PM, Resident #141 was greeted by the surveyor. There was no response from Resident #141. The surveyor was informed by the resident's roommate that Resident #141 was from another country and could not speak English. During an observation of the breakfast meal on 01/10/2024 beginning at 8:35 AM, Resident #141 was greeted by the surveyor. There was no response. Certified Nurse Aide (CNA) #9 was observed using hand gestures and English to communicate with Resident #141 and the resident did not indicate they understood CNA #9 and did not respond. The hand gestures used by CNA #9 consisted of thumbs up, waving, and pointing to foods and fluids. In an interview on 01/10/2024 at 2:57 PM, Registered Nurse (RN) #19 stated he used a translation application on his personal cell phone that was pre-loaded with simple questions that Resident #141 could respond to by nodding their head yes or no. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/10/2024 at 3:24 PM, the Speech Language Pathologist (SLP) stated Resident #141 spoke some English, but he also used an electronic internet translator and a communication board to communicate with Resident #141. In an interview on 01/10/2024 at 4:14 PM, CNA #10 stated she communicated in English when speaking to Resident #141. CNA #10 said she pointed to items and spoke slowly to try to help Resident #141 understand what she was saying. At this time, CNA #10 asked how the resident how they were doing, and Resident #141 did not respond. CNA #10 asked Resident #141 if they wanted water, and Resident #141 did not respond. CNA #10 got very close to Resident #141's face and spoke loudly and asked if the resident if they were in pain, and there was no response from Resident #141. In an interview on 01/10/2024 at 4:37 PM, CNA #11 who was employed by a staffing agency stated she was asked to sit with Resident #141. CNA #11 stated she was not informed of Resident #141's communication needs. In an interview on 01/11/2024 at 10:25 AM, RN #19 was asked to demonstrate the translation application on his personal phone. RN #19 used the application to ask the resident in their primary language if they ate breakfast. Resident #141 became very animated and responded in their primary language, repeating themself twice. RN #19 stated he did not understand what Resident #141 said. RN #19 stated there was a telephone translator available for the staff to use but it was not handy for short conversations. In an interview on 01/11/2024 at 12:26 PM, Social Worker (SW) #20 stated Resident #141 understood some English and answered simple questions with a yes or no. She said the resident seemed to understand but she was not sure. SW #20 said the facility had a language line that could be used to obtain an interpreter. SW #20 stated the information for using the language line was posted in each nurses' station. SW #20 stated she did not know if anyone had used the service. In an interview on 01/11/2024 at 1:04 PM, CNA #12 stated he had never used the language line to obtain an interpreter and did not know there was one. In an interview on 01/11/2024 at 1:19 PM, the Director of Nursing stated staff anticipated Resident #141's needs and used gestures to communicate with Resident #141. In an interview on 01/11/2024 at 1:52 PM, the Administrator stated there were no staff who spoke Resident #141's primary language and staff needed to be trained on the use of the translation services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49044 Based on observations, interviews, record review, the facility failed to ensure staff set the low air loss mattresses (a mattress designed to distribute a resident's body weight over a broad surface and help prevent skin breakdown) according to the resident's weight for 2 (Resident #35 and Resident #77) of 3 sampled residents reviewed for pressure ulcer/injury. Findings included: 1. A review of Resident #35's Admission Record revealed the facility admitted the resident on 02/10/2012. Per the Admission Record, the resident had a medical history to include multiple sclerosis, cognitive communication deficit, hemiplegia affecting the left nondominant side, vascular dementia, and obesity. A review of Resident #35's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 10/15/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was at risk of developing pressure ulcers/injuries, had one Stage 3 pressure ulcer, and had moisture associated skin damage. A review of Resident #35's care plan, initiated on 12/01/2023, revealed the resident had a stage 4 pressure injury to their buttocks/perineum related to a history of ulcers and immobility. A review of Resident #35's Order Review History Report, revealed an order dated 10/17/2023, for a low air loss mattress to prevent progression of right buttock bed sore. The order directed staff to monitor function and placement every shift. A review of Resident #35's Progress Notes, dated 01/09/2024 at 3:40 PM, revealed on 01/03/2023, the resident weighed 131 pounds. During an observation on 01/08/2024 at 2:10 PM, Resident #35 was lying in bed and the resident's low air loss mattress was set on 5. The front panel of the low air loss mattress control unit indicated a 5 was used for a resident who weighed 210 pounds. During wound care observation on 01/10/2024 beginning at 10:46 AM, the surveyor noted Resident #35's low air loss mattress setting was set on 5. During an interview on 01/11/2024 at 8:59 AM, the wound physician stated the mattress settings would make a difference and he expected staff to adjust the settings based on the resident's weight. During an interview on 01/11/2024 at 3:09 PM, the Administrator stated low air loss mattresses were typically given to residents who had pressure ulcers. The Administrator said he expected nursing staff to adjust the mattress settings based on a resident's weight and make additional adjustments for any weight changes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/11/2024 at 3:32 PM, the Director of Nursing (DON) she expected staff to know how to set the low air loss mattress settings according to a resident's weight. The DON stated the charge nurse initially entered the mattress setting and floor staff were to check the settings every shift to make sure it was correct. 2. A review of Resident #77's Admission Record revealed the facility admitted the resident on 07/19/2017. Per the Admission Record, the resident had a medical history to include multiple sclerosis, paraplegia, cognitive communication deficit, contractures, and Stage 3 and unstageable pressure ulcers. A review of Resident #77's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/13/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS indicated the resident was at risk of developing pressure ulcers, had three Stage 3 pressure ulcers, and had one unstageable pressure ulcer. A review of Resident #77's care plan, initiated on 11/01/2023, revealed the resident had Stage 3 pressure ulcers to the left hip, right medial knee, right lateral knee, and left calf. Interventions indicated the resident required a pressure relieving/reducing device bed and a licensed nurse was to check functioning and settings according to the resident's current weight. A review of Resident #77's Order Review History Report, revealed an order dated 11/19/2023, for a low air loss mattress. A review of Resident #77's Weight Summary, revealed on 12/09/2023, the resident weighed 148.3 pounds. During wound care observation on 01/10/2024 at 3:25 PM and on 01/11/2024 at 1:35 PM, Resident #77's low air loss mattress was set on 7. The front panel of the low air loss mattress control unit indicated a 7 was used for a resident who weighed 280 pounds. During an interview on 01/11/2024 at 8:59 AM, the wound physician stated the mattress settings would make a difference and he expected staff to adjust the settings based on the resident's weight. During an interview on 01/11/2024 at 3:09 PM, the Administrator stated low air loss mattresses were typically given to residents who had pressure ulcers. The Administrator said he expected nursing staff to adjust the mattress settings based on a resident's weight and make additional adjustments for any weight changes. During an interview on 01/11/2024 at 3:32 PM, the Director of Nursing (DON) she expected staff to know how to set the low air loss mattress settings according to a resident's weight. The DON stated the charge nurse initially entered the mattress setting and floor staff were to check the settings every shift to make sure it was correct.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37935 Based on observation, interviews, record reviews, and facility policy review, the facility failed to provide supervision while smoking for 2 (Resident #125 and Resident #161) of 4 sample residents reviewed for accidents. Findings included: A review of the facility's policy titled, Smoking Residents, effective date of 08/18/2023, revealed, The IDT [interdisciplinary team] will develop an individualized plan of for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke. A review of Resident #161's Admission Record indicated the facility admitted the resident on 05/20/2023, with diagnoses that included hemiplegia (paralysis) and hemiparesis (weakness) following a cerebral infarction (stroke) of the right dominant side, chronic obstructive pulmonary disease, and nicotine dependence. A review of Resident #161's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2023, revealed Resident #161 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. A review of Resident #161's care plan, dated 07/14/2023, revealed the resident was at potential risk for injury and complications because the resident smoked. A review of Resident #161's Smoking and Safety assessment dated [DATE], revealed the resident required staff supervision when smoking. 35314 A review of Resident #125's Admission Record indicated the facility admitted the resident on 06/16/2023, with diagnoses that included disorganized schizophrenia, lack of coordination, tremor, and tobacco use. A review of Resident #125's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/18/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. A review of Resident #125's care plan, dated 07/14/2023, revealed the resident smoked and was at risk for potential for injury and complications due to noncompliance with apron use and storage of smoking materials. Interventions directed the staff to provide supervision while smoking. A review of Resident #125's Smoking and Safety assessment dated [DATE], revealed the resident required staff supervision when smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/08/2024 at 2:25 PM, Resident #125 was observed on the patio of the secure unit, smoking. During the observation there was no staff present to provide supervision. The surveyor noted Resident #125 handed a lit cigarette to Resident #161. Resident #161 smoked the cigarette and handed the lit cigarette back to Resident #125. Resident #125 took a puff of the cigarette, stood up, and disposed of the cigarette into a disposal container. During an interview on 01/09/2024 at 3:00 PM, Certified Nursing Assistant (CNA) #16 stated during the smoke break on 01/08/2024 at approximately 1:30 PM, he had to help a resident get back to their room. CNA #16 acknowledged he left Resident #125 outside smoking. During an interview on 01/09/2024 at 2:44 PM, CNA #4 stated during the smoke break on 01/08/2024, CNA #16 took three residents outside to smoke. According to CNA #4, one of the residents became ill and CNA #16 took the resident inside and left Resident #125 and Resident #161 outside alone. CNA #4 stated another facility staff member should have gone outside to continue supervision of the residents while they smoked. Per CNA #4, the staff were required to supervise the residents for safety reasons. During an interview on 01/10/2024 at 8:45 AM, CNA #5 stated residents were not allowed to smoke without staff supervision. According to CNA #5, Resident #125 should not be left alone on the patio smoking without staff supervision. During an interview on 01/10/2024 at 9:01 AM, CNA #6 stated staff must supervise the residents to ensure the residents were safe when they were outside smoking. During an interview on 01/09/2024 at 3:01 PM, Registered Nurse (RN) #8 stated all residents that smoked always required staff supervision. During an interview on 01/11/2024 at 2:01 PM, the Director of Nursing (DON) stated the staff were not allowed to leave residents that required supervision for smoking alone. The DON stated the CNA should not have left Resident #125 and Resident #161 outside alone when another resident became ill. Per the DON, another staff should have been alerted and one staff should have remained outside with the residents until they finished smoking. During an interview on 01/11/2024 at 2:30 PM, the Administrator stated staff ensured all residents who required supervision while smoking, were supervised. The staff should always maintain eyesight of the residents. The Administrator stated if there was an emergency, another staff should have relieved and replaced the staff member.

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Novato Healthcare Center	1565 Hill Road Novato, CA 94947

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 39411 Based on observation, interviews, and policy review, the facility failed to ensure concentration of sanitizer in the dish machine was at the correct concentration level. This deficient practice affected all residents who received food from the kitchen. Findings included: A review of the facility policy titled, Dish Machine Operation and Cleaning, with a revision date of 10/01/2014, revealed, B. Routinely monitor soap, sanitizer and rise [sic] agent to ensure adequate supply throughout operation of the dish machine. An initial tour of the kitchen was conducted with the Registered Dietitian (RD) on 01/08/2024 at 10:15 AM. Upon inspection of the dish machine, the RD conducted a test of the rinse solution using a chlorine test strip. The test strip turned a light purple color, which indicated the level of chlorine was 10 parts per million (PPM). A second test was performed at 10:30 AM by the RD with a second rinse cycle. The test strip remained a light purple color. The RD obtained a new set of test strips at 10:42 AM and conducted a third test, which measured 25 PPM. In an interview on 01/08/2024 at 10:42 AM, the RD stated the sanitizer should measure 50 PPM for proper sanitation. In an interview on 01/08/2024 at 10:45 AM, the Dietary Manager (DM) stated staff tested the chemicals in the dish machine at the start of each meal. The DM stated boosting the chemicals was part of starting the dish machine. The DM stated no low levels of chemicals were reported by staff. She said the dish machine would not be used if the machine did not work properly. In an interview on 01/11/2024 at 1:19 PM, the Director of Nursing stated she expected the dietary department manager to monitor all equipment to ensure it worked properly. In an interview on 01/11/2024 at 1:52 PM, the Administrator stated the DM was responsible for making sure all equipment was in working order.