STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015434	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Rehabilitation and Healthcare Center	4164 Halls Mill Road Mobile, AL 36693

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on interviews, medical record review, hospital record review, and review of a facility policy titled, Change in Medical Condition of Residents, the facility failed to ensure the Medical Director (MD) and/or Certified Registered Nurse Practitioners (CRNPs) were notified when Resident Identifier (RI) #320, a resident with a history of inappropriate sexual behaviors, attempted to touch a Certified Nursing Assistant (CNA) between her legs and grabbed a therapist on the buttocks on 02/19/2024. Findings Include: Review of a facility policy titled, Change in Medical Condition of Residents, with an effective date of 01/22/2024, revealed the following: PURPOSE: To keep the physician, who is in charge of medical care . informed of the residents medical condition so they may direct the plan of care as needed. STANDARD: Notification of the physician . should occur promptly, according to federal regulations, when there is a change in the residents condition. A change in condition is defined as: . A significant change in a residents physical, mental or psychological status . Examples of a change in condition may include: . New behavioral problems . PROCESS: . III. Documenting the Change of Condition a) Document the symptoms and observations associated with the change in condition, the date and time of contact with the physician . RI #320 was admitted to the facility on [DATE]. RI #320 had diagnoses to include Cognitive Communication Deficit, Anxiety Disorder, and Dementia with other Behavioral Disturbance. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of RI #320's Admission Minimum Data Set assessment with an Assessment Reference Date of 02/15/2024, indicated RI #320's Brief Interview for Mental Status was 03 of 15, which indicated that RI #320 had severely impaired cognition. A review of RI #320's local hospital Discharge Summary dated 02/09/2024 revealed that RI #320 presented to the local hospital from another nursing home for inappropriate behavior and groping staff. The Discharge Summary also included that RI #320 had inappropriate sexual behavior. A review of the Progress Notes for RI #320 revealed the Assistant Director of Nursing (ADON) documented on 02/19/2024 at 8:57 AM that . CNA reports inappropriate behavior-trying to touch her groin while getting ready for therapy . and on 02/19/2024 at 10:42 AM . Therapy reports inappropriate behavior-resident grabbing therapist's rear end. Therapist moved away from resident to remove from situation . On 10/16/2024 at 5:27 PM, a telephone interview was conducted with the ADON. When asked who he informed about the incidents occurring on 02/19/2024, the ADON said he would have informed the CRNP or the Director of Nursing (DON). The ADON said the evidence he had informed the CRNP or DON would be in the nurses' notes. A review of RI #320's Progress Notes revealed there was no evidence the Medical Director (MD) or either CRNP had been notified of the incidents involving RI #320 touching staff on 02/19/2024. On 10/14/2024 at 11:14 AM, an interview was conducted with the Administrator (ADM). The ADM said she was not sure when she was made aware of RI #320's behaviors toward staff on 02/19/2024. When asked should the doctor have been notified of the behaviors, the ADM said yes. On 10/12/2024 at 9:53 AM a telephone interview was conducted with CRNP #11 who said she visited RI #320 on 02/22/2024. CRNP #11 said during the assessment RI #320 was moving his/her hand up her inner thigh and made inappropriate sexual comments. CRNP #11 said prior to the incident she was not aware that RI #320 had been inappropriate with anyone at the facility. On 10/13/2024 at 1:52 PM, the surveyor conducted an interview with the MD and CRNP #10. When asked were either of them notified on 02/19/2024, that RI #320 attempted to touch a staff member in an inappropriate sexual manner and then touched a therapist on her buttocks, both stated no. The MD said they should have been notified of the incident. The MD said if they had been notified about the incident they would have sent RI #320 out for a psychiatric evaluation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on an interview, review of a facility policy titled, Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation, review of the facility's investigative file and review of a Facility Reported Incident (FRI) received by the State Agency, the facility failed to ensure an allegation of sexual abuse involving Resident Identifier (RI) #320 and RI #71 on 02/22/2024, was submitted to the State Agency within the required timeframe of two hours. This deficient practiced affected one of 17 FRIs reviewed for timely reporting of allegations of abuse. This deficiency was cited as a result of the investigation of complaint/report number AL00047058. Findings Include: Review of a facility policy titled, Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation, with a revision date of 05/01/2024, revealed the following: PURPOSE: . Certain incidents and accidents involving residents must also be reported to the appropriate state agencies . VI. Investigations and Facility Response to Incidents or Accidents . b) . Reporting Steps . Notify the Administrator of any usual situation in the facility, whether reportable or not immediately. The Administrator/designee in administrator absence will report to the State Agency and all other required agencies, per regulations. All allegations of abuse . must be reported within 2 hours . RI #71 was admitted to the facility on [DATE]. RI #320 was admitted to the facility on [DATE]. The Alabama Department of Public Health Online Incident Reporting System form, submitted on 02/23/2024 at 3:22 PM documented: . Incident Type . Abuse - Sexual . Date and time of when administrator was notified of the incident: 02/23/2024 Time: 01:30 PM . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date and time of alleged incident: 02/22/2024 Time: 01:35 PM . Contained within the facility's investigative file was a typed statement dated 02/22/2024, signed by the Assistant Director of Nursing (ADON), which revealed the following: I was informed by a CNA (Certified Nursing Assistant) that (RI #320) attempted to put (his/her) hands in another resident's (RI #1's) shirt (blouse) . On 10/11/2024 at 9:38 AM, an interview was conducted with the ADON. The ADON said abuse should be reported to the Abuse Coordinator, the Administrator (ADM). The ADON was asked when did he report the incident involving RI #320 and RI #71 to the ADM. The ADON said he did not because he was told someone else had already reported it. When asked when should any type of abuse be reported to the Abuse Coordinator, the ADON said immediately. On 10/12/2024 at 7:08 PM, an interview was conducted with the ADM. The ADM said she was the Abuse Coordinator and she had the responsibility of reporting abuse to the State Agency. When asked the time frame for reporting abuse, the ADM said within two hours. The ADM said the incident between RI #320 and RI #71 occurred on 02/22/2024, and she was made aware of the incident on 02/23/2024, almost 24 hours later. The ADM said when the failure to report to her was found out the facility did a Quality Assurance Performance Improvement plan. ********** The facility took corrective action to address the late reporting of abuse following the incident that occurred on 02/22/2024. The facility's actions included: On 06/12/2024 the facility identified that the incident was reported late. On 06/12/2024 the ADON and Registered Nurse (RN) #13 were provided 1:1 in-service on the facility's Abuse Policy and Procedure including timely reporting of all allegations. On 06/12/2024 all staff were educated on the facility's Abuse Policy and Procedure including timely reporting of all allegations. All staff receive abuse training upon hire, quarterly, and as needed. On 06/12/2024 the facility replaced existing Abuse Reporting signs with neon-colored signs that say REPORT ANY ABUSE TO . and names and the contact information for who to notify. A new resident council template was developed to assist with identifying any abuse. Staff interviews will be conducted with 5 staff for 12 weeks. Results will be reviewed in monthly QAA for 3 months and then reassessed ********** (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon review and verification of the information provided in the facility's corrective action plan, in-service/education records, QAA Meetings minutes, and the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions on 06/12/2024, with on-going monitoring implemented; thus, past noncompliance was cited.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on interviews, medical record review, review of a facility policy titled, Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation, and review of the facility's investigative file, the facility failed to conduct a thorough investigation and obtain witness statements from all staff who witnessed Resident Identifier (RI) #320 put his/her hand under RI #71's blouse on 02/22/2024. Interviews with staff, the facility's timeline of events, and investigative documentation contained conflicting information. Findings Include: Review of a facility policy titled, Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation, with a revision date of 05/01/2024, revealed the following: PURPOSE: . The facility will investigate and document all incidents and accidents involving residents . The investigation protocol for incidents and accidents is set forth in Section VI of this Policy . VI. Investigations and Facility Response to Incidents or Accidents . b) Investigation . Steps . The Administrator is responsible for conducting a thorough investigation and obtaining witness statements. A complete and thorough investigation must be conducted on all incidents . If reportable to the State Agency, the facility will make an investigation report within five (5) working days to the State Agency. This report will be in writing and will contain: . 3. Time of the incident. 4. Name of witness . 13. Any other details . RI #71 was admitted to the facility on [DATE]. RI #320 was admitted to the facility on [DATE]. The Alabama Department of Public Health Online Incident Reporting System form, submitted on 02/23/2024 at 3:22 PM documented: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. Incident Type . Abuse - Sexual . Incident Detail . Name of staff member who became aware of the incident: (RN #13) . Date and time of alleged incident: 02/22/2024 .Reported by (RN #13) to (Assistant Director of Nursing) that resident (RI #320) was observed to place (his/her) hands under (RI #71's) blouse . A review of the facility's VERIFICATION OF INVESTIGATION form or five-day summary, with an incident date of 02/22/2024 and an incident time of 12:50 PM, documented the following: DETAILED DESCRIPTION OF INCIDENT / ALLEGATION: While residents (RI #320) and resident, (RI #71) were sitting in the dining area of East Wing. CNA, (CNA #12) reported she witnessed resident, (RI #320) roll (his/her) wheelchair up to (RI #71) and put (his/her) hand under the front of (RI #71's) blouse . WITNESS INFORMATION: IDENTIFY ALL INDIVIDUALS WHO MAY HAVE PERTINENT KNOWLEDGE EITHER PRIOR TO, DURING, OR AFTER THE ALLEGED EVENT . This section on the form did not have names of staff who witnessed the incident. Also, there were conflicting times as when the incident occurred. The initial report identified the incident time as 1:35 PM; and the five-day summary identified the incident time as 12:50 PM. A review of undated and untimed facility timeline documented the following: . 2/22/24 at 2:10 am, nurse noted Mood and Behavior: Mood is pleasant, no unwanted behaviors witnessed, At 12:30 PM, resident received a flu-shot. At 3pm, nurse noted resident was sent to the hospital for inappropriate touching of staff and resident. A CNA reported to the ADON that they witnessed (RI #320) with (his/her) hand under the blouse of a female resident . Contained within the facility's investigative file was only one witness statement to the incident occurring between RI #320 and RI #70 on 02/22/2024. The witness statement was a handwritten statement given by Certified Nursing Assistant (CNA) #12, dated 02/23/2024, which documented the following: I saw (RI #320) put (his/her) hand under (RI #71's) shirt (blouse) on Feb (February) 22, 2024. I immediately moved (him/her) to a different table. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/12/2024 at 7:08 PM, an interview was conducted with the Administrator (ADM). The ADM said as the Abuse Coordinator she was responsible for investigating allegations of abuse. When asked when did the incident between RI #320 and RI #71 occur, the ADM said on 02/22/2024. The surveyor asked the ADM which staff were present when the incident occurred. The ADM said CNA #12, CNA #14 and RN #13. The ADM said she had not been able to locate Registered Nurse (RN) #13's statement and had recently done a telephone interview with CNA #14 to obtain her statement. The ADM said once she became aware she communicated with team to ensure residents were protected. The ADM said when the video of the incident was reviewed the video clearly showed that RI #320 did not touch RI #71's breast. On 10/12/2024 at 10:40 AM, a telephone was conducted with RN #13 who confirmed that he witnessed the incident involving RI #320 and RI #71 on 02/22/2024. On 10/14/2024 at 11:14 AM, the surveyor had the ADM to review the facility's initial report, five-day summary and the facility's timeline and asked the ADM was the investigation of the event involving RI #320 and RI #71 thorough. The ADM said when she looked back at the timeline, the body of the timeline could have included more specifics with names and time of events to prevent questions. On 10/14/2024 at 8:01 PM, a follow-up interview was conducted with the ADM. The ADM said when she and the Director of Nursing (DON) reviewed the video RI #320 placed his/her hand at the hem of RI #71's blouse. When asked did she review the statement CNA #12 gave about RI #320's hand being under RI #71's blouse, the ADM said she did. The ADM she did not attempt to have CNA #12 clarify her statement.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738 Based on interview, record review and review of the Centers for Medicare & (and) Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, the facility failed to ensure Resident Identifier (RI) #70's Significant Change (SC) Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 08/29/2024, was coded accurately. The MDS indicated that RI #70 received an anticoagulant medication during that look back assessment period, but RI #70 did not. This deficient practice affected RI #70, one of 47 sampled residents whose MDS assessments were reviewed. Findings Include: A review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, dated 10/2019, revealed the following: . SECTION N: MEDICATIONS . Coding Instructions . N0410E, Anticoagulant . Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period . RI #70 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #70's Significant Change MDS assessment with an ARD date of 08/29/2024, under Section N - Medications, coded that RI #70 received an anticoagulant medication during that look back assessment period. An Order Summary Report (Physician's Orders) for RI #41, with an Order Date Range of 08/01/2024 to 10/31/2024, revealed RI #70 received the medication Aspirin 81 Oral Tablet Chewable 1 tablet by mouth two times a day for Coronary Artery Disease. On 10/14/2024 at 11:30, an interview was conducted with the MDS Coordinator (MDSC). When asked did she complete RI #70's SC MDS assessment with the ARD of 08/29/2024, the MDSC said yes. The MDSC said RI #70 was not prescribed an anticoagulant for that assessment period, RI #70 was on Aspirin. The MDSC said the MDS assessment was coded that RI #70 received an anticoagulant, but it should have been coded as antiplatelet. The MDSC said the MDS assessment was coded that way in error.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21055 Based on interviews, medical record review and review of a facility policy titled, Distressed Behavior Management Program, the facility failed to ensure Resident Identifier (RI) #320's sexually inappropriate behaviors were addressed and managed with appropriate interventions. On 02/09/2024, the facility admitted RI #320 who had a documented history of inappropriate behaviors including groping. On 02/12/2024 a care plan was developed to address inappropriate sexual advances toward females. On 02/19/2024, RI #320 attempted to place his/her hands between a Certified Nursing Assistant's (CNA's) legs and placed his/her hands on a physical therapist's buttocks. There was no evidence of discussions for behavior management, no new interventions implemented to manage RI #320's inappropriate sexual behaviors after the 02/19/2024 incidents, and no evidence the Medical Director (MD) or Certified Registered Nurse Practitioners (CRNPs) were notified of RI #320's inappropriate sexual behaviors on 02/19/2024. Findings Include: Review of a facility policy titled, Distressed Behavior Management Program, with an effective date of 06/01/2023, revealed the following: PURPOSE: Identifying residents who currently exhibit some type of distressed behavior symptoms for which additional or new treatment programs may be considered . STANDARD: Residents who display mental or psychosocial adjustment difficulty should receive appropriate services, in an attempt to correct the problem . RI #320 was admitted to the facility on [DATE]. RI #320 had diagnoses to include Cognitive Communication Deficit, Anxiety Disorder, and Dementia with other Behavioral Disturbance. A review of RI #320's Admission Minimum Data Set assessment with an Assessment Reference Date of 02/15/2024, indicated RI #320's Brief Interview for Mental Status was 03 of 15, which indicated that RI #320 had severely impaired cognition. A review of a Discharge Summary from the hospital RI #320 was discharged from revealed the following: . admitted : 12/18/2023 .discharge date : 2/9/2024 . Discharge Diagnoses: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Principal Problem: Dementia with other behavioral disturbance, unspecified dementia severity, unspecified dementia type . Active Problems: Poor social situation . Hospital Course: [AGE] year-old (male/female) . who presented from (name of another nursing home) for inappropriate behavior and groping staff . Patient Active Problem List . Poor social situation . Inappropriate sexual behavior . A review of RI #320's care plan titled Hx (history) of and potential for inappropriate sexual advances toward females, with an initiated date of 02/12/2024, revealed the GOAL for RI #320 was The resident will have no inappropriate sexual advances toward females daily through next review or length of stay . A review of RI #320's Progress Notes (nurses notes) documented the following: . Effective date: 02/09/2024 19:02 (7:02 PM) . Note Text: Admission Note: . (He/She) has an history of behavior with hitting and touching . On 02/19/2024 at 8:57 AM the Assistant Director of Nursing (ADON) documented .Type: Behavior Charting . CNA reports inappropriate behavior-trying to touch her groin while getting ready for therapy . On 02/19/2024 at 10:42 AM the ADON documented .Type: Behavior Charting . Therapy reports inappropriate behavior-resident grabbing therapist's rear end. Therapist moved away from resident to remove from situation . On 10/12/2024 at 3:10 PM, the surveyor conducted an interview with the Director of Social Services (DSS). The DSS said she developed RI #320's behavior care plan on 02/12/2024 after she reviewed RI #320's medical history that included his/her history of inappropriate sexual behaviors. The DSS said at another facility RI #320 was touching people inappropriately. The DSS said after RI #320 exhibited inappropriate sexual behaviors on 02/19/2024 new interventions should have been addressed on the care plan and she did not see where they had been. On 10/14/2024 at 7:10 PM, a follow-up interview was conducted with the DSS. When asked what new interventions could have been implemented after the 02/19/2024 incident, the DSS said the doctor could have been called to see about sending RI #320 out for a psychiatric evaluation. The DSS said RI #320 could have been evaluated to see if his/her medication needed adjusting or the psychiatric facility would have given the facility new suggestions on how to deal with RI #320's behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/13/2024 at 5:32 PM an interview was conducted with the Director of Nursing (DON). The DON said she was informed on either 02/19/2024 or 02/20/2024 during the morning meeting of RI #320's behavior of inappropriately touching staff that occurred on 02/19/2024 . On 10/14/2024 at 7:25 PM, the surveyor conducted a follow-up interview with the DON. The DON said according to the discharge summary, RI #320 was discharged from another nursing home because RI #320 had inappropriate behaviors of groping staff. The DON said the discharge summary did not say RI #320 had any inappropriate behaviors toward residents. When asked could there have been the potential for RI #320 to exhibit sexual inappropriate behaviors toward residents, the DON said it could have been. When asked what new interventions could have been implemented when RI #320 exhibited inappropriate sexual behaviors on 02/19/2024, the DON said other than one-on-one monitoring, which they did not do long term, RI #320 could have been referred to CRNP #10, who had credentials for psychiatric care. The surveyor asked the DON, based on the fact that RI #320 had a history of sexually inappropriate behaviors, what else could have been done when the behaviors resurfaced. The DON said RI #320 could have been referred to psych. A review of RI #320's DAILY PROGRESS NOTE, dated 02/19/2024, 02/20/2024 and 02/21/2024, did not reveal CRNP #10 had evaluated RI #320 for his/her inappropriate sexual behaviors. On 10/14/2024 at 11:14 AM, the surveyor conducted an interview with the Administrator (ADM). The surveyor asked the ADM when was she made aware RI #320 had attempted to touch a staff in an inappropriate manner and touched the therapist on her buttocks on 02/19/2024. The ADM said it could have been at a standup meeting where behaviors were discussed. When asked did she think RI #320 should have been transferred when he/she had the inappropriate behaviors on 02/19/2024, the ADM said yes. On 10/13/2024 at 1:52 PM, an interview was conducted with the Medical Director (MD) and CRNP #10. The MD said if he had been notified of RI #320's inappropriate sexual behaviors on 02/19/2024 he would have sent RI #320 out for a psychiatric evaluation.

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	015434	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Rehabilitation and Healthcare Center	4164 Halls Mill Road Mobile, AL 36693

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 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. 20304 Based on observation, interview, the facility's 2024-2025 Fall/Winter Menu, the facility's recipe for Pureed Bread, the facility's Scoop Size chart, the facility's Diet Master, and the facility's policies for Menu Planning and Accuracy and Quality of Tray Line Service; the facility failed to provide the approved portions of puree meat and puree bread for Lunch on 10/08/2024 and 10/09/2024. This had the potential to affect 5 of 5 residents receiving Puree Diets. Findings include: The facility's policy for Menu Planning, dated 2023, included the following: . Policy: Nutritional needs of individuals will be provided in accordance with the established national standards . through nourishing, well-balanced diets . Procedure: 1. Menu planning will be completed by the facility . a. Regular and therapeutic menus will be written to provide a variety of foods . in adequate amounts . to satisfy recommended daily allowances. 4. The registered dietitian nutritionist (RDN) or designee will approve all menus. The facility's policy for Accuracy and Quality of Tray Line Service, dated 2023, included the following: Procedure: . 4. the meal will be checked against the therapeutic diet spread sheet to assure that foods are served as listed on the menu. The facility's recipe for Pureed Bread, undated, documented the following: . Service Portion: #20 Scoop portion pureed bread. The facility's Scoop Size chart, undated, documented that a #20 scoop equals two ounces (oz). The facility's 2024-2025 Fall/Winter Menu for Week 3, Tuesday, Lunch included the following for the Puree (Pur) diet: . 3 oz Pur Glazed Ham . Pur Bread . (continued on next page)

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's 2024-2025 Fall/Winter Menu for Week 3, Wednesday, Lunch included the following for the Puree diet: . Pur Baked Chicken . 2 oz Pur Dinner Roll . The facility's Diet Master, dated 10/08/2024, listed five residents receiving Puree diet meal trays. On 10/08/2024 at 11:20 AM, preparations for the residents' lunch meal service were observed. At 11:27 AM, the steamtable was being set up with pans of hot food. At 11:45 AM, the AM [NAME] was asked about Puree Bread for the trayline. The AM [NAME] said the bread was pureed with the meat (Ham). The serving utensil for the Puree Ham was a 3 oz spoodle. The lunch trayline started at 12:02 PM. On 10/09/2024 at 11:35 AM, the Dietary Manager was observed taking food temperatures on the trayline for the residents' lunch meal. There was no Puree Bread on the trayline. The pan of Puree Baked Chicken had a 3 oz spoodle for the serving utensil. At 12:01 PM, the Assistant Dietary Manager said she had pureed the Baked Chicken for the trayline and that she had added bread to it. The lunch trayline started at 11:59 AM. At 12:48 PM, a Puree diet test tray with nectar-thick liquids was prepared. At 12:55 PM, the test tray was tasted with the Registered Dietitian. The food on the test tray included the following: Puree Baked Chicken, Puree Rice, Puree Broccoli, Applesauce, Nectar-thick Water with Lemon, and Nectar-thick Sweet Tea with Lemon. On 10/09/2024 at 1:00 PM, the Registered Dietitian (RD) was interviewed following the tasting of the test tray. The RD said the serving size for Puree Baked Chicken should be 3 ounces; although the amount was not specifically listed on the Fall/Winter (F/W) Menu for Week 3, Wednesday, Lunch. The RD also said the serving size for a Pureed Dinner Roll was 2 ounces. The RD further said the residents complained about pureed bread when it was served by itself, so the facility combined the bread with the meat on the menu for the Puree diets. When asked what amount should be served since the chicken and the bread were pureed into one combined product, the RD said 5 ounces. On 10/09/2024 at 5:01 PM, a follow-up interview was conducted with the Registered Dietitian. When asked the problem in serving 3 ounces of combined Puree Baked Chicken (or Puree Ham) and Puree Dinner Roll (or Bread) instead of 5 ounces, the RD said it is not meeting the menu requirements. The RD further said the residents could be affected due to inadequate nutrients being provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 20304 Based on observation, interview, the facility's 2024-2025 Fall/Winter Menu, the 2022 United States (U.S.) Food and Drug Administration (FDA) Food Code, the facility's Diet Master, and the facility's policies for Purpose and Objectives of the Food and Nutrition Services Department and Resource: Minimum Cooking, Holding and Reheating Temperatures; the facility failed to ensure Puree Scalloped Potatoes were reheated to a minimum of 165 degrees ( ) Fahrenheit (F) for 15 seconds after cooling to 125 F on 10/08/2024, prior to the residents' Lunch service. This had the potential to affect 5 residents who received pureed meals from the kitchen out of 108 residents receiving meals from the facility kitchen. Findings include: The 2022 U.S. FDA Food Code included the following: . 3-403.11 Reheating for Hot Holding. (A) . TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74 C [Centigrade/Celsius] (165 F) for 15 seconds. The facility's policy for Purpose and Objectives of the Food and Nutrition Services Department, dated 2023, included the following: . 1. Provide food and drink . at a safe and appetizing temperature . The facility's policy for Resource: Minimum Cooking, Holding and Reheating Temperatures, dated 2023, included the following: Cooking is a critical control point in preventing foodborne illness. Summary Chart for Minimum Food Temperatures and Holding times for Reheating Foods for Hot Holding . Food that is cooked, cooled, and reheated (should reach a minimum temperature of) 165 F (for a minimum of) 15 seconds The facility's 2024-2025 Fall/Winter Menu for Week 3, Tuesday, Lunch included the following for the Puree (Pur) diet: . 4 oz (ounces) Pur Scalloped Potatoes . The facility's Diet Master, dated 10/08/2024, listed 108 residents receiving meal trays and five of those were Puree diets. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/08/2024 at 11:20 AM, preparations for the residents' lunch meal service were observed. At 11:27 AM, the steamtable was being set up with pans of hot food for the residents' lunch meal. At 11:45 AM, the food temperatures were observed being checked and the Puree Scalloped Potatoes were found to be 125 F. The Puree Scalloped Potatoes were removed from the steamtable and reheated to 146 F by the AM Cook. At 12:00 PM, the Assistant Dietary Manager said the temperature had reached 146 F and allowed the Puree Scalloped Potatoes back on the steamtable. At 12:02 PM, the AM [NAME] was asked if reheating the Puree Scalloped Potatoes up to 146 F was okay, since the food's temperature had fallen below 135 F and gone into the temperature danger zone. the AM [NAME] said yes. The lunch trayline started at 12:02 PM. At 12:07 PM, the Dietary Manager was asked if reheating the Puree Scalloped Potatoes to 146 F was adequate, when it had fallen below the upper danger zone temperature of 135 F. The Dietary Manager said no, it should be reheated to 165 degrees Fahrenheit. On 10/09/2024 at 5:01 PM, the Registered Dietitian (RD) was interviewed. The RD was asked the problem in only reheating the Puree Scalloped Potatoes to 146 F after the temperature had dropped to 125 F while on the trayline. The RD said it should have been reheated to 165 degrees Fahrenheit for 15 seconds. The RD further said bacterial growth could be a problem and it could make the residents sick.