STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065165	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Health and Rehabilitation Center	821 Duffield CT Loveland, CO 80537

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to ensure residents were free from abuse for one (#59) of two residents reviewed for abuse out of 35 sample residents. Specifically, the facility failed to: -Protect Resident #59 from sexual abuse by Resident #62; and, -Implement interventions for Resident #62 in order to prevent the abuse from occurring again. Findings include: I. Facility policy and procedure The Abuse policy was requested from the nursing home administrator (NHA) on 6/25/24 at 3:30 p.m. The Abuse policy was not provided, however, the NHA provided an undated print out titled What is Intimacy? on 6/25/24 at 4:43 p.m. It read in pertinent part, Intimacy can take many forms, from enjoying watching a movie together, to hand holding, to sexual intercourse. Residents have the right to engage in mutually consenting relationships, regardless of their marital status or sexual orientation. It is a protected resident right by statute. When an issue related to the sexual activity of a resident develops, (physical harm, dementia concerns, medical risk, need for medication, problematic pre or post sexual activity behavior, regular violations of others rights to privacy, or public masturbation), it is appropriate to open a care plan problem for that issue. Notation should also be made in the resident's record of educational efforts regarding safe sex practices. This could also include information about the ability of the resident to understand and retain the information and any staff efforts at continuing and tailoring the education to the particular resident's needs. Dementia does not mean that a person no longer has basic needs or wants. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Just like a preference for a particular type of dessert, a preference for intimacy can be expressed in a person with dementia long after their orientation and memory has deteriorated. A Form for Intimacy Capacity should be completed as an interdisciplinary team (IDT), as various staff will have different observations and knowledge. If it is determined that residents are not able to consent for intimacy, then a care plan must be in place demonstrating how the facility will keep each resident safe. A resident with dementia and/or cognitive impairment may have the ability to give consent regarding intimacy and sexual activity. People are complex and they change; residents may give consent in one instance and not another, we may complete the Sexual Intimacy Capacity for Consent Assessment multiple times for one resident. II. Facility investigation of sexual abuse incident between Resident #59 and Resident #62 The facility investigation, dated 3/25/24, documented the following information in pertinent part, Resident touched another resident over the pants during a group activity. Interviews were conducted with staff, residents and families. Documentation was reviewed. Resident #59 was assessed following the report of the incident and the resident was at baseline. There was no signs or symptoms of distress or discomfort. There was no treatment provided to the victim. The victim was not transferred to a higher level of care. One resident witnessed the event and stated another resident touched her shoulder but not sexually. There were no concerns from interviews. Conclusion of the internal investigation was unsubstantiated. -However, sexual abuse occurred due to Resident #62 touching Resident #59 in the vaginal area over her pants (see NHA below). Changes were made to the victims treatment regimen and/or care plan as a result of the occurrence: staff to alert leadership if resident expresses distress or discomfort to being touched. Actions were taken with the alleged assailant: medication review requested to ensure no medications influenced sexual behavior. Interventions were put into place to help prevent recurrence: staff education completed to understand intimacy guidelines. -The incident report form was not signed or dated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #62 (assailant) A. Resident status Resident #62, age 76, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries (stroke), mixed receptive expressive language disorder, unspecified symptoms and signs involving cognitive functions and awareness and cognitive communication deficit. The 10/16/23 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. He required partial/moderate assistance with oral hygiene, toileting, upper body dressing and personal hygiene. He required substantial/maximal assistance with showering/bathing himself, lower body dressing and putting on/taking off footwear. According to the MDS, Resident #62 had no physical behavioral symptoms directed towards others. B. Record review The care plan for other sexual disorder, initiated on 5/10/24 (over one month after the incident with Resident #59), documented Resident #62 was at risk for signs and symptoms of hyper sexuality related to his diagnosis of other sexual disorders. Signs and symptoms included masturbating in public areas and he had expressed interest in women. Interventions included documenting the resident's behavior, administering medications per doctor's orders, encouraging him to cover up when walking back to his room, encouraging him to close his door when needing privacy, reminding him to wash himself when he finished masturbating and when found masturbating in public areas, staff were to remind Resident #62 to masturbate in his room. -The care plan failed to document interventions related to inappropriate touching of female residents. -Review of Resident #62's electronic medical record (EMR) revealed there were no progress notes related to the resident's inappropriate touching incident with Resident #59. Review of Resident #62's June 2024 CPO revealed the following physician's order for monitoring behaviors related to the use of antidepressant medication: Document the number of episodes of the target behavior. Target behaviors: 1. Masturbating in public 2. Interest in women, interventions document in progress notes (PN), ordered 5/29/24. -The physician's order was not obtained until over two months after the incident with Resident #59. IV Resident #59 (victim) A. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #59, age 68, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included bipolar disorder and dementia. The 9/27/23 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of five out of 15. She required partial/moderate assistance with toileting hygiene, showering/bathing herself and lower body dressing She required set up or clean up assistance with eating and oral hygiene. B. Record review The care plan for cognition, initiated on 2/12/24, documented Resident #59 had impaired cognitive function/dementia or impaired thought processes related to dementia. Resident #59 was alert and oriented to self, able to make basic decisions with assistance if given choices. Her needs were anticipated by staff and she became confused and required redirection and orientation. The resident understood consistent, simple, directive sentences. Interventions included asking yes/no questions in order to determine the resident's needs, communicating with the resident/family/caregivers regarding the resident's capabilities and needs and monitoring/documenting/reporting as needed (PRN) any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness. -Review of Resident #59's EMR revealed there was no progress note related to the incident with Resident #62. V. Staff interviews Registered nurse (RN) #3 was interviewed on 6/25/24 at 3:08 p.m. RN #3 said she heard Resident #62 had an incident where he touched a female resident on the arm. She said she was not aware of Resident #62 touching a female resident on the leg. She said Resident #62 had never been on one to one supervision. She said the facility did not have any resident's who resided on the secure unit who had consented to intimacy. RN #3 said staff stopped any unwanted behaviors or verbally aggressive behaviors before the behaviors could go any further. She said the staff on the unit made sure that no contact was happening between residents because the staff wanted the residents to feel safe and not afraid. She said if there was a resident to resident incident she would notify the nursing manager, management, family and doctor. She said she would have to fill out an incident report and write a note in the resident's chart. RN #3 said Resident #62 was not combative but was hyper-sexual. She said Resident #62 had been displaying sexually inappropriate behaviors since March 2024. She said Resident #62 had been exposing himself and masturbating in the hallway. She said the resident's behaviors were redirectable. RN #3 said the unit nurse manager was responsible for updating the care plans and putting in interventions for residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #4 was interviewed on 6/25/24 at 3:25 p.m. CNA #4 said he had never seen Resident #62 display sexually inappropriate behaviors towards female residents. He said he heard Resident #62 had touched a female resident on her leg. He said he heard that the touch was consensual. He said he did not think Resident #62 touching Resident #59 on the leg was inappropriate. CNA #4 said a consent assessment would be done by the RN if further intimacy was agreed upon by both residents. He said he did not know if any residents had filled out an intimacy consent assessment. CNA #4 said a progress note regarding the abuse should have been documented in both of the residents' charts. CNA #4 said Resident #62 had been placed on medications to help decrease his hyper-sexuality. He said he thought the medication had been helpful, as Resident #62 had had a decrease in his behavior of masturbating openly. He said the resident was easily redirectable when masturbating out in the hallway. CNA #4 said Resident #62 had been placed on fifteen minute checks which had been effective. He said staff used a lot of non-pharmacological interventions, such as increasing his activity participation and going outside frequently, to help distract Resident #62. The NHA was interviewed on 6/25/24 at 4:38 p.m. The NHA said both residents were sitting in an activity when Resident #62 reached over and put his hand on Resident #59's vaginal area. She said this was her first experience with a resident being sexually inappropriate. She said if both resident's were deemed consensual then they would not document the sexually inappropriate touch. She said after the investigation, she unsubstantiated the incident. The NHA said Resident #59's consent was based on her interview. The NHA said Resident #59 was interviewed and she said she was okay and said she would not mind if that happened again. The NHA said she did not know if both residents had a history of a relationship prior to the inappropriate touch. She said Resident #59 consenting to the touch should have been documented. The NHA said she did not know if Resident #59 fully understood what had happened with Resident #62. She said as soon as staff saw what happened they stopped it immediately. She said the team was going to work on more assessments from social services and do more through investigations. The NHA said Resident #59 was moved off the unit four days after the sexually inappropriate touch because she no longer benefited from the secure unit. The NHA said Resident #62 had been referred to an all male secure unit at another facility. She said Resident #62 had never displayed any sexually inappropriate behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed a second time on 6/26/24 at 4:51 p.m. The NHA said the team, which consisted of the NHA, the director of nursing (DON) and the unit nurse supervisor, initiated a one to one supervision for Resident #62 on 6/25/24 (during the survey). She said they had determined being on fifteen minute checks was not enough for Resident #62 to prevent a further incident of inappropriate touching and felt a one to one supervision would be more appropriate. She said that she was doing education with all the staff on the secure unit. The NHA said Resident #62 had been on the secure unit for a while and there had been no concerns until March 2024. She said she felt like she did the right thing in the moment following the incident. She said she did not substantiate the incident as abuse abuse, but she said she had reported it. The NHA said if Resident #59 had said no, then the abuse would have been substantiated. The NHA said the interdisciplinary team (IDT), which included the NHA, the DON, the unit nurse manager and the social worker would put care plan interventions in place. She said when the incident between Resident #62 and Resident #59 happened, she and the social worker talked about the incident. She said she did not document anything regarding the incident in the residents' charts but reported it to the occurrence reporting portal. RN #4 was interviewed on 6/27/24 at 11:59 a.m. RN #4 said she had never seen Resident #62 touch a female resident. She said, to her knowledge, she had never seen any inappropriate behaviors with Resident #62 and female residents. She said she watched Resident #62 closely. RN #4 said she did not know if Resident #59 could consent to an intimate relationship. She said residents had a right to a relationship but staff would have to consider the residents' cognitive abilities. RN #4 said she had no concerns about the care Resident #62 received. She said staff on the secure unit were very attentive. She said she watched Resident #62 more closely because of the incident that happened in March 2024. RN #4 said any abuse incidents had to be reported to the NHA, the DON and the unit manager. She said she would have to complete a risk assessment form and write a progress note and place the resident on fifteen-minute checks. CNA #5 was interviewed on 6/27/24 at 12:55 p.m. CNA #5 said she had not seen any behavioral changes in Resident #62 after the abuse allegation. She said prior to the abuse incident, both residents had not spent any time together. She said Resident #59 did not communicate well. She said Resident #59 would talk to staff if they asked her a question but she kept to herself. She said Resident #59 did not exhibit any behaviors that would provoke Resident #62. She said Resident #62 had never been aggressive towards staff or residents. CNA #5 said Resident #62 would benefit from an all-male secure unit. She said Resident #62 had not had any other inappropriate behaviors but he did touch his private area when he was out in the hallway. She said Resident #62 had a stroke but he knew what he was doing. CNA #5 said if she witnessed abuse she would report it to the charge nurse or the nurse on the floor and they would take over on what needed to be done. She said she did not have to do any documentation because the nurses were responsible for all of the documentation.

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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** 50315 Based on observations, record review and interviews, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater. Specifically, the medication administration observation error rate was 6.25%, or two errors out of 32 opportunities for error. Findings include: I. Facility policy The Medication Administration policy and procedure, revised 2/9/24, was received from the nursing home administrator (NHA) on 6/27/24 at 12:45 p.m. It documented in pertinent part, Resident medications are administered in an accurate, safe, timely, and sanitary manner. Medications are administered in accordance with written orders of the attending physician or physician extender. II. Manufacturer's recommendations According to the National Library of Medicine, Levothyroxine Sodium capsules package insert (2024), retrieved on 7/2/24 from https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=686ba2cf-7651-44de-9b4d-eeaaf2a0e364&audience=professional, Administer Levothyroxine Sodium capsules as a single daily oral dose, on an empty stomach, one-half to one hour before breakfast. III. Resident #49 A. Resident status Resident #49, age 87, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, anxiety and hypothyroidism (a condition where the thyroid gland does not produce enough hormones to meet the body's needs). The 4/19/24 minimum data set (MDS) assessment revealed the resident had a cognitive impairment and the brief interview for mental status (BIMS) was not completed. She required no assistance with transfers, walking and personal hygiene. She required supervision for showering. B. Observations On 6/26/24 at 9:15 a.m. licensed practical nurse (LPN) #1 was observed passing medications to residents on the East hallway. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 prepared medications which included four different tablets and one eye drop for Resident #49. She put all of the tablets, which included a Levothyroxine Sodium (thyroid medication) 100 micrograms (mcg) tablet, into one medication cup and proceeded to Resident #49's room to administer the medications to the resident. Resident #49 was sitting upright in her recliner with her bedside table in front of her. She was eating her breakfast when LPN #1 entered the room. LPN #1 handed Resident #49 the medication cup with the tablets and instructed the resident to take them with water. The resident swallowed the pills and LPN #1 administered the eye drops to the resident before exiting the room. C. Record review Resident #49's June 2024 CPO documented the following physician's order: Levothyroxine Sodium tablet 100 mcg, give one tablet by mouth one time a day for hypothyroidism, give 30 minutes before food on an empty stomach, revised 9/8/23. -However, LPN #1 administered the Levothyroxine Sodium tablet while Resident #49 was already eating her breakfast (see observation above). IV. Resident #14 A. Resident status Resident #14, age 76, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included bipolar disorder and hypothyroidism. The 4/29/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required maximal assistance with transferring, dressing and showering. B. Observations On 6/26/24 at 9:21 a.m. LPN #1 was observed passing medications to residents on the East hallway. LPN #1 prepared medications which included nine different tablets, one eye drop and a nasal spray for Resident #14. She put all of the tablets, which included a Levothyroxine Sodium 75 mcg tablet, into one medication cup and proceeded to Resident #14's room to administer the medications to the resident. LPN #1 handed the cup of pills to the resident and directed her to take them with water. Resident #14 swallowed the pills andLPN #1 administered the eye drops and nasal spray to the resident before exiting the room. C. Resident (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14 was interviewed on 6/26/24 at 9:30 a.m. Resident #14 said she had already eaten breakfast before LPN #1 administered her medications. D. Record review Resident #14's June 2024 CPO documented the following physician's order: Levothyroxine Sodium tablet 75 mcg, give one tablet (75 mcg) by mouth daily before breakfast, take on an empty stomach 30 to 60 minutes before breakfast and other medications, revised 1/16/24. -However, LPN #1 administered the Levothyroxine Sodium tablet after Resident #14 had already eaten her breakfast (see resident interview above). -Additionally, LPN #1 administered the Levothyroxine Sodium tablet with eight other medications (see observation above). V. Staff interviews LPN #1 was interviewed on 6/26/24 at 10:20 a.m. LPN #1 said with the number of residents she needed to pass medications to, she could not get to all of the residents before breakfast. The director of nursing (DON) was interviewed on 6/27/24 at 11:50 a.m. The DON said nursing staff was to follow physician's orders when administering medications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48114 Based on interviews, record review and observations, the facility failed to ensure residents consistently receive food prepared by methods that conserved nutritive value, palatable in taste, texture and temperature. Specifically, the facility failed to ensure the residents' food was palatable in taste, texture and temperature. Findings include: I. Facility policy and procedure The Menus policy and procedure, revised September 2017, was received from the nursing home administrator (NHA) on 6/27/24 at 12:40 p.m. It read in pertinent part, Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu-planning guide. Menu cycles will be developed and tailored to the needs and requirements of the facility. Menu cycles will include standardized recipes. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. II. Resident group interview A group interview was conducted on 6/26/24 at 11:00 a.m. with five alert and oriented residents (#54, #28, #43, #39 and #40), who were interviewable per facility and assessments. The residents regularly attended the resident council meeting. According to the residents, the concerns were brought up in previous resident councils however not resolved. Residents in the group had the following concerns: -Resident #43 said kitchen staff served fruit on the same plate as the meal. Resident #40 agreed. -Resident #43 said the food was served cold and the potatoes were often undercooked. Resident #40 and Resident #39 agreed. -All residents in the group said there was not much variety in the food and it was very bland. -Resident #39 said the eggs were always served cold. III. Additional resident interviews (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #131 was interviewed on 6/25/24 at 9:14 a.m. Resident #131 said he was on a pureed diet and the food did not taste good. Resident #36 was interviewed on 6/24/24 at 10:50 a.m. Resident #36 said the kitchen often ran out of oatmeal so he received cheerios instead. He said he ate in his room for all his meals and said when his meals arrived they were not hot. He said his meals were always delivered late. He said the cooks did not know how to cook the food right. He said the kitchen often ran out of what they were serving and offered something different than what was on the menu. He said there was no process for staff to take his room tray order. He said he got the main meal delivered to him. He said they offered an alternative menu of about five items, but that menu never changed. He said when meat was served, it was very tough to cut and he was not able to chew it. Resident #23 was interviewed on 6/24/24 at 11:54 a.m. Resident #23 said the quality of the food was poor. Resident #130 was interviewed on 6/24/24 at 1:49 p.m. Resident #130 said the food was very repetitive. He said he got peas three times a week. He said his food was either burnt or not properly cooked. He said one of the pieces of french toast he was served today (6/24/24) was burnt. Resident #68 was interviewed on 6/24/24 at 2:43 p.m. He said the food was dry and tasteless, and the meat was hard to cut with a knife. He said the menus were not offered prior to the meal service and the main menu was not followed. He said residents got whatever the kitchen served and he had just learned to eat whatever they served him because he needed to eat. He said condiments, such as salt or butter, were frequently not provided with meals. IV. Resident council minutes The resident council notes for 1/26/24 documented the group was concerned about the food having been served cold and an unappetizing appearance. -There was no documented follow-up regarding the concerns the residents voiced in the 1/26/24 resident council meeting. The resident council notes for 2/20/24 documented the food was still being served cold. -There was no documented follow-up regarding the concerns the residents voiced in the 2/20/24 resident council meeting. The resident council notes for 3/19/24 documented the food was still being served cold. -There was no documented follow-up regarding the concerns the residents voiced in the 3/19/24 resident council meeting. V. Food committee minutes The food committee meeting minute notes were received from the DS on 6/27/24 at 10:30 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Health and Rehabilitation Center	821 Duffield CT Loveland, CO 80537

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The food committee meeting minute notes from 5/7/24 documented the residents reported the chicken pot pie was not good. The residents said the food was served cold and sometimes warm. -The food committee notes did not document a resolution to the concerns brought up by the residents. The food committee meeting minute notes from 5/21/24 documented the asparagus was overcooked, the meat was overcooked and the chicken was tough. -The food committee notes did not document a resolution to the concerns brought up by the residents. The food committee meeting minute notes from 6/12/24 documented the residents would like more fresh fruit served and bigger portions. -The food committee notes did not document a resolution to the concerns brought up by the residents. VI. Lunch menu for 6/26/24 The facility's posted lunch menu for 6/26/24 read: Encrusted pork loin, braised cabbage, whipped sweet potatoes, dinner roll with margarine, mandarin oranges and coffee. VII. Observations During a continuous observation on 6/26/24, beginning at 10:50 a.m. and ending at 12:58 p.m., the following was observed during the lunch meal preparation and service in the main kitchen. At 11:05 a.m. hot water was boiled on the stove in a metal container and instant mashed potatoes were added and mixed together. The mashed potatoes were at 110 degrees F. At 11:30 a.m. the first plate was served. At 11:43 a.m. the secured unit hot box was ready to be taken to the secured unit. At 11:45 a.m. the main dining room service began. At 12:10 p.m. the dietary supervisor (DS) began plating the next hallway and placed the plates in the hot box. At 12:25 p.m. the hot box was ready to be delivered to the unit. At 12:30 p.m. Resident #68 was served his lunch meal. He received one piece of pork loin (not encrusted), braised cabbage, whipped sweet potatoes, a dinner roll and coffee. -Resident #68 did not receive margarine for his roll. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:42 p.m. the braised cabbage ran out so the district manager (DM) warmed up green beans for the vegetable substitute. At 12:45 p.m. the green beans were warmed up. and were at 127 degrees F. At 12:58 p.m. the last plate was placed in the hot box and delivered to the unit. VIII. Test trays Two test trays were evaluated immediately by four surveyors after the last resident had been served their room tray for lunch on 6/26/24 at 1:12 p.m. A. Regular diet test tray The regular diet test tray consisted of pork loin (not encrusted), mashed potatoes with gravy and a dinner roll. -The temperature of the pork loin was 115.5 degrees F. The pork loin was lukewarm, dry and had no flavor. The meat was hard to chew. -The temperature of the mashed potatoes and gravy were 136 degrees F. The mashed potatoes had no flavor and there were no condiments on the tray. -There were no vegetables served on the regular diet test tray. -Margarine was not provided for the dinner roll. B. Pureed diet test tray The pureed diet test tray consisted of pureed pork loin, mashed potatoes and gravy and pureed green beans. -The pork loin was 124.7 degrees F. The pork loin had no flavor. -The mashed potatoes and gravy were 136 degrees F. The mashed potatoes had no flavor and there were no condiments on the tray. -The pureed green beans were 127 degrees F. The green beans had no flavor. IX. Additional record review Grievances from Resident #36 were obtained from the NHA on 6/26/24. One grievance submitted by Resident #36 on 5/8/24 documented that the chicken was not cooked well enough and he could not chew it. The baked potato was not cooked all the way and was hard on one side and soft on the other. The meal calendars were not followed. Ice cream was left out and was always melted. Another grievance from Resident #36 on 5/8/24 documented that the activity calendar was always wrong. The meal on it did not match the menu or what the kitchen cooked. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	X. Staff interviews The cook was interviewed on 6/26/24 at 12:25 p.m. The cook said for lunch today (6/26/24) she used three cans of sweet potatoes. She said the kitchen ran out of sweet potatoes at 12:25 p.m. She said if the kitchen ran out of food they would find an equal substitute. The cook said the substitute for the sweet potatoes was mashed potatoes. The DS and the DM were interviewed together on 6/26/24 at 2:40 p.m. The DS and the DM said the staff were responsible for putting the condiments on the resident's lunch trays. The DS said the condiments were in a bin next to the kitchen window where the trays were distributed. He said the certified nurse aides (CNA) were responsible for handing out condiments to the residents who preferred to eat in their rooms. The DS said he would make the change and start putting salt and pepper on the trays before they go out. The DS said he was not aware of residents having food complaints. He said if the residents had a concern with the food that the resident's would tell him verbally. He said the facility held a food committee twice a month. He said the food committee started back in April 2024. Certified nurse aide (CNA) #2 was interviewed on 6/26/24 at 5:30 p.m. CNA #2 said all condiments, such as margarine were supposed to be placed on resident meal trays by CNAs prior to delivering the tray to the resident. The DS and the DM were interviewed again on 6/27/24 at 10:15 a.m. The DM said the corporate chefs and the dietitians created the menus for the facility. The DM said they had a four week menu cycle and they changed it two times a year spring to summer and fall to winter. CNA #3 was interviewed on 6/27/24 at 12:40 p.m. CNA #3 said all residents received the main menu dish. She said she did not collect the resident's preferences for the meals. She said when a resident did not like their meal, the resident would tell her and she would pass the message on to the kitchen. She said all resident meal orders were submitted verbally to the kitchen staff. She said if she had five residents who did not want the main dish, she would go to the kitchen five times to report what the resident's preferences were for that meal. The nursing home administrator (NHA) was interviewed on 6/27/24 at 12:55 p.m. The NHA said the food committee met twice a month. She said she was not aware of any food complaints. She said the facility recently implemented a summer menu where they had a chef come in and do cooking demonstrations for the residents. She said they had a chef come in already and the residents really loved it. She said she planned on having the chefs come in more frequently for the residents to try new foods. The NHA said all residents were assessed for meal preferences upon admission and the meals served were based on the resident's preferences. She said if a resident did not like what was being served they could order off the alternative menu. The NHA said the facility used to publish the main menu in the daily chronicles (daily resident newsletter), but they were no longer doing so, as it was not accurately reflecting the menus for residents who were on special diets. She said now the main menu for the day was posted in the dining room. (continued on next page)

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