STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065172	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain View Rehabilitation and Nursing LLC	2438 E Fountain Blvd Colorado Springs, CO 80910

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 16177 Based on record review, interviews, and policy review, the facility failed to provide a written notice of transfer/discharge for two of two residents/representatives (Resident (R) 21 and R17) reviewed for hospitalization out of a total sample of 23 residents. This failure had the potential to cause uncertainty regarding the reason for transfer/discharge, the effective date of the transfer/discharge, and information on how to appeal the discharge. Findings include: Review of the policy Discharging/Transferring the Resident, revised 12/01/19, revealed, . For facility initiated discharges, once discharge or transfer is determined to be indicated or appropriate, the resident advocate or designee will provide the resident with a Notice of Discharge/Transfer that explains the reason for discharge, the effective date of the discharge, and information regarding how to appeal the discharge if desired . In emergency situations staff shall document the reasonable efforts that have been made to consult the resident or resident representative about the discharge . If the resident is being discharged to a hospital, ensure that a discharge/transfer form . are reviewed with the resident and/or resident representative prior to discharge to the extent reasonable and practical . 1. Review of R21's electronic medical record (EMR) revealed a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/24. Further review of this MDS revealed a Brief Interview of Mental Status (BIMS) score of 99, indicating R21 had severe cognitive impairment. Review of the EMR Assessments tab revealed a Transfer Form indicating R21 was discharged to the hospital on 09/08/24 with a mental status change, poor intake, and emesis (vomiting). Further review of the Transfer Form revealed that R21's emergency contact was notified via telephone on 09/08/24 of the discharge to the hospital. Further review of the EMR revealed no documentation that written transfer/discharge information was provided to R21's emergency contact. 2. Review of R17's EMR revealed a significant change MDS with an ARD of 09/05/24. Further review of this MDS revealed a BIMS score of 13 out of 15, indicating R17 was cognitively intact; however, R17 did have an emergency contact listed in the EMR. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR Assessments tab revealed a Transfer Form indicating R17 was discharged to the hospital on 09/16/24 for osteomyelitis (infection in the bone) and possible amputation of the second toe on the right foot. Further review of the Transfer Form revealed that R17's emergency contact was notified via telephone on 09/16/24 of the discharge to the hospital. Further review of the EMR revealed no documentation that written transfer/discharge information was provided to R17's emergency contact.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 16177 Based on record review, interviews, and policy review, the facility failed to provide a written notice of the bed hold policy for two of two residents/representatives (Resident (R) 21 and R17) reviewed for hospitalization out of a total sample of 23 residents. This failure had the potential to cause uncertainty regarding returning to their own room at the facility after hospitalization . Findings include: Review of the policy Holding Bed Space, adopted 12/2017, revealed, Our facility shall inform residents upon admission and prior to a transfer for hospitalization . of our bed-hold policy . when a resident is transferred for hospitalization . a representative of the business office or designee will provide written information concerning the facility's bed hold policy . 1. Review of R21's electronic medical record (EMR) revealed a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/24. Further review of this MDS revealed a Brief Interview of Mental Status (BIMS) score of 99, indicating R21 had severe cognitive impairment. Review of the EMR Assessments tab revealed a Transfer Form indicating R21 was discharged to the hospital on 09/08/24 with a mental status change, poor intake, and emesis (vomiting). Further review of the EMR revealed no written notification that the bed hold policy had been sent to the emergency contact. 2. Review of R17's EMR revealed a significant change MDS with an ARD of 09/05/24. Further review of this MDS revealed a BIMS score of 13 out of 15, indicating R17 was cognitively intact however R17 did have an emergency contact listed in the EMR. Review of the EMR Assessments tab revealed a Transfer Form indicating R17 was discharged to the hospital on 09/16/24 for osteomyelitis (infection in the bone) and possible amputation of the second toe on the right foot. Further review of the EMR revealed no written notification of the bed hold policy had been sent to the emergency contact. Review of a Bed Hold Authorization form, dated 09/16/24 and provided by the facility, revealed that the emergency contact agreed via telephone to authorize this facility to reserve a bed at the Bed Hold Rated listed above until I return to this facility . The bed hold rate was marked N/A on the form. The form was signed by Registered Nurse (RN) 1 who had placed the call to the emergency contact. During an interview on 09/18/24 at 11:15 AM, RN1 stated that when a resident was discharged to the hospital, she notified the responsible party of the bed hold policy over the phone and not in writing.

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36246 Based on record review, interview, and facility policy review, the facility failed to 1.) develop care plans with measurable goals for seven of 23 sampled residents (Resident (R) 8, 9, 14, 37, 57, 69, 286) and 2.) failed to develop care plans to address vision and hearing and/or dental status for two of 23 sampled residents (R286 and R9). This had the potential for the residents to have unmet care needs. Findings include: Review of the facility's Care Plans, Comprehensive and Revisions policy, adopted 12/19/16 revealed, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan will: Include measurable objectives and timeframes . 1. Review of R8's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed R8 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, anxiety, sleep apnea, abnormalities of gait and mobility, hypothyroidism, and type two diabetes. Review of R8's Care Plans, located under the Care Plan tab of the EMR, indicated a Care Plan developed to address R8's hypothyroidism contained a goal of I will be free of s/s [signs and symptoms] of hypothyroidism through the review date. A Care Plan developed to address her risk for falls contained a goal of My risks and injury potential will be minimized through the next review date. A Care Plan developed to address R8's use of oxygen due to poor gas exchange and sleep apnea contained a goal of I will have no s/sx [signs or symptoms] of poor oxygen absorption through the review date. 2. Review of R9's Admission Record, located in the Profile tab of the EMR, revealed R9 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, history of falling, and personal history of TBI (traumatic brain injury). Review of R9's Care Plans, located under the Care Plan tab of the EMR, revealed a care plan developed to address R9's risk for falls related to his TBI contained a goal of My risks and injury potential will be minimized through the next review date. A Care Plan developed to address R9's cognitive deficit related to the TBI contained a goal of R9 will be able to communicate basic needs daily through the review date. There was no Care Plan developed to address R9's dental status. 3. Review of R14's Admission Record, located in the Profile tab of the EMR, revealed R14 was admitted to the facility on [DATE] with diagnoses including transient cerebral ischemic attack, bipolar disease, insomnia, and age-related osteoporosis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R14's Care Plans, located under the Care Plan tab of the EMR, indicated a Care Plan developed to address R14's use of anti-depressant medications related to her insomnia contained a goal of R14's risk for discomfort or adverse reactions related to anti-depressant therapy will be minimized through the review date. A Care Plan developed to address R14's fall risk contained a goal of The resident's risk for injury will be minimized through the review date. A Care Plan developed to address R14's use of anti-psychotic medication for her bipolar disease contained a goal of R14 will reduce the use of psychotropic medication through the review date. 4. Review of R37's Admission Record, located in the EMR under the Profile tab, revealed R37 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, obstructive sleep apnea, type two diabetes, hypertension, right above the knee amputation, and idiopathic neuropathy. Review of R37's Care Plans, located under the Care Plan tab of the EMR, indicated a Care Plan developed to address R37's use of the medication Oxycodone (opioid pain medication) contained a goal of I will be free of any discomfort or adverse side effects from pain medication through the next review. A Care Plan developed to address R37's hypertension contained a goal of I will remain free of signs and symptoms of hypertension through the review date. 5. Review of R57's Admission Record, located in the EMR under the Profile tab, revealed R57 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), history of falling, and dependence on supplemental oxygen. Review of R57's Care Plans, located under the Care Plan tab of the EMR, indicated a Care Plan developed to address R57's high fall risk contained a goal of My risks and injury potential will be minimized through the next review date. A Care Plan developed to address R57's altered cardiovascular status contained a goal of I will be free from complications of cardiac problems through the review date. A Care Plan developed to address R57's use of pain medication contained a goal of I will be free of any discomfort or adverse side effects from pain medication through the review date. 6. Review of R69's Admission Record, located in the EMR under the Profile tab, revealed R69 was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure with hypoxia, cerebral infarction, and hereditary neuropathy. Review of R69's Care Plans, located under the Care Plan tab of the EMR, indicated a Care Plan developed to address R69's pain related to neuropathy, immobility, and osteoarthritis contained a goal of The resident's risk for side effects of analgesia will be minimized through the review date. A Care Plan developed to address R69's risk for feelings of hopelessness and passive suicidal ideation due to loss of independence, potential placement, and brain injury contained a goal of R69 will display decreased episodes of emotional crisis through the review period. 7. Review of R286's Admission Record, located in the EMR under the Profile tab, revealed R286 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease and acquired absence of right leg below the knee. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R286's Care Plans, located under the Care Plan tab of the EMR, indicated a Care Plan developed to address R286's risk for falls due to the right below the knee amputation contained a goal of no falls or injuries by next 90-day review. A Care Plan developed to address R286's need for Skilled Nursing Care related to a recent hospital stay for toxic encephalopathy contained a goal of R286 will return to prior function level after rehab by the review date. There was no care plan developed to address R286's hearing and vision deficit. During an interview with Registered Nurse (RN) 2 on 09/18/24 at 9:15 AM, RN2 stated the expectation was that Care Plan goals would be measurable.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16177 Based on interviews, record review, and policy review, the facility failed to provide activities other than television for one of three residents (Resident (R) 59) reviewed for Transmission Based Precautions (TBP) out of a total sample of 23 residents. This failure had the potential to cause feelings of boredom and further isolation from others. Findings include: Review of the policy, Activity Programs, version 12/19/16, revealed . The Activities Program is ongoing and includes . facility sponsored individual activities (including one-on-one activities) and independent individual activities . Activities are offered 7 (seven) days a week . our activity programs consist of individual . activities that are designed to meet the needs and interests of each resident . Activities are documented in the resident's medical record . Review of R59's electronic medical record (EMR) revealed an annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/08/24 that documented R59 was initially admitted to the facility on [DATE]. Further review of the EMR revealed a significant change MDS with an ARD of 06/17/24 that documented a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating R59 had moderate cognitive impairment. Review of the EMR Care Plan tab revealed an Activities care plan, initiated on 03/22/23, that indicated R59 did not like to participate in group activities but did like to listen to a variety of music, reading, keeping up with the news, watching television, socializing with family and friends . I prefer to complete activities independently at my leisure and am provided with supplies during activity carts . offering her supplies to complete activities independently at her leisure . Review of the EMR Assessment tab revealed an Activities-Initial Review (Admission) form, dated 07/03/24, that indicated R59's activity preferences to be . listening to a variety of music . reading and listening to audiobooks . wish 1:1 [visits] with staff . Review of the EMR Orders tab revealed a physician's order, dated 09/12/24, stating, Resident requires contact and droplet precautions with isolation for 10-20 days due to positive COVID-19 status. May discontinue isolation and transmission-based precautions when resident has met CDC criteria. Review of the EMR Care Plan tab revealed an At risk for complications r/t [related to] COVID-19 infection care plan, initiated on 09/12/24, for Resident will be educated and encouraged to stay in their room for the duration of the isolation . Resident will be isolated for a period of at least 10 days or longer until symptoms are improved and they have had no fever for at least 24 hours without use of antipyretic medication . During a continuous observation on 09/16/24 from 9:30 AM through 12:45 PM, no staff were observed entering R59's room other than to serve and set up the lunch tray. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 09/17/24 from 8:30 AM through 11:10 AM, no staff were observed entering R59's room other than Certified Nurse Aide (CNA) 5 who went in to answer the call light. CNA5 exited R59's room within five minutes stating R59 wanted help repositioning in bed. During an interview on 09/17/24 at 11:22 AM, R59, who was in contact and droplet isolation for COVID, was asked what activities she did all day since she was not able to leave her room while on isolation. R59 said she watched TV most of the day and talked on the phone occasionally and stated that staff did not come into her room for activities. R59 asked if there was still a library in the facility because she loved to read books and magazines but did not have any to read. This surveyor replied that the Activities Department would be asked about bringing books and magazines to her. R59 smiled and thanked this surveyor. Review of the Documentation Survey Report, dated September 2024 and provided by the facility, revealed no 1:1 activities were provided on 09/16/24 or 09/17/24 and one was provided on 09/18/24 after discussion with the facility staff about the lack of activities provided to R59 while in isolation. During an interview on 09/18/24 at 9:30 AM, the Activity Director (AD) was asked how activities were provided to the residents on contact/droplet isolation for COVID. The AD replied that activity carts and supplies are provided biweekly and the CNAs are asked to leave the TV and/or radio on for stimulation. During an interview on 09/18/24 at 2:59 PM, the Activity Staff (AS) was asked to review the Documentation Survey Report, dated September 2024 for the blanks showing no 1:1 activities for R59 were provided on 09/16/24 or 09/17/24. The AS verified that no 1:1 activities had been provided to R59 on those dates. The AS stated that when a resident is on isolation I suit up [put on PPE] and provide the activity cart to see if they want anything. The AS stated, I don't remember if I did that this week [for R59]. During an interview on 09/19/24 at 10:46 AM, the Director of Nursing (DON) stated that 1:1 visits should continue [for those residents in isolation].

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36246 Based on interview, review of the facility's Controlled Drugs Count Record/Date sheets, and policy review, the facility failed to ensure a narcotic count was consistently completed at each shift change on four of four medication carts. Failure to properly account for the narcotics had the potential to result in missing narcotic medication. Findings include: Review of the facility policy titled, Controlled Substances, adopted 12/19/16, indicated, . The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances . Nursing staff must count controlled medications at the end of each shift, The nurse coming on duty and the nurse going off duty must make the count together . Review of the Controlled Drugs Count Record/Date for four of the four medication carts used by the facility revealed the following: 1.The Controlled Drugs Count Record/Date for the Weeping [NAME] unit medication cart was missing a nurse's signature as follows: 09/18/24: oncoming for 6:00 AM to 6:00 PM During an interview on 09/18/24 at 9:11 AM, Registered Nurse (RN) 2 stated she was busy and forgot to sign the record. RN2 confirmed the Controlled Drugs Count Record/Date was supposed to be signed by both the oncoming and off going nurses at each shift change. 2. The Controlled Drug Count Record/Date for the Spring Canyon unit medication cart was missing nurse signatures as follows: 09/01/24: oncoming at 6:00 AM to 6:00 PM 09/01/24: off going at 6:00 AM to 6:00 PM 09/02/24: oncoming at 6:00 PM to 6:00 AM 09/02/24: off going at 6:00 PM to 6:00 AM 09/14/24: oncoming at 6:00 PM to 6:00 AM 09/14/24: off going at 6:00 PM to 6:00 AM 09/18/24: off going at 6:00 AM to 6:00 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/18/24: oncoming at 6:00 AM to 6:00 PM During an interview on 09/18/24 at 9:58 AM, RN3 stated she forgot to sign the record on 09/18/24. RN3 confirmed the Controlled Drugs Count Record/Date was supposed to be signed by both the oncoming and off going nurses at each shift change. 3. The Controlled Drug Count Record/Date for the Columbine unit medication cart was missing nurse signatures as follows: 09/02/24: oncoming at 6:00 AM to 6:00 PM 09/02/24: off going at 6:00 AM to 6:00 PM 09/02/24: oncoming at 6:00 PM to 6:00 AM 09/02/24: off going at 6:00 PM to 6:00 AM 09/10/24: oncoming at 6:00 AM to 6:00 PM 09/10/24: off going at 6:00 AM to 6:00 PM 09/14/24: oncoming at 6:00 PM to 6:00 AM 09/14/24: off going at 6:00 PM to 6:00 AM 09/18/24: oncoming at 6:00 AM to 6:00 PM 09/18/24: off going at 6:00 AM to 6:00 PM During an interview on 09/18/24 at 10:15 AM, Licensed Practical Nurse (LPN) 1 stated she must have forgotten to sign it the morning of 09/18/24. 4. The Controlled Drug Count Record/Date for the Evergreen unit medication cart was missing signatures as follows: 09/01/24: off going at 6:00 AM to 6:00 PM 09/09/24: oncoming at 6:00 AM to 6:00 PM 09/09/24: off going at 6:00 AM to 6:00 PM During an interview on 09/18/24 at 11:50 AM, LPN2 said she always signed the Controlled Drug Count Record/Date when she came on duty and confirmed it was supposed to be signed by the two nurses performing the count for narcotics at every change of shift to indicate count was done and was correct.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 16177 Based on interviews and review of the facility Dietary Manager job qualifications, the facility failed to have a Certified Dietary Manager and/or full time Dietitian oversight to perform the functions of the kitchen and nutrition services for all 83 residents receiving food from the kitchen. This failure increased the potential that the residents would not be provided the diets specific to their needs and basic kitchen sanitation would not be maintained. Findings include: During the initial tour of the kitchen on 09/16/24 at 9:40 AM, the Dietary Manager (DM) stated that he had started working as the dietary manager about a week ago. When asked if he was certified as a dietary manager, the DM stated that he was enrolled in an online Certified Dietary Manager (CDM) course and had finished about 40 hours out of a 120 - hour course. Further interview with the DM on 09/16/24 at 9:40 AM revealed that the facility's Registered Dietitian (RD) came to the facility twice a week for consultation with the DM. On 09/19/24, the facility Administrator provided the job descriptions signed by the DM and verification that the DM was not certified and did not have current ServSafe certification but was enrolled in a CDM course and a ServSafe Food Protection Manager Certification Exam. Review of the job descriptions provided by the Administrator revealed a job description for a cook position, signed by the DM and the Administrator on 09/01/24. Further review revealed a job description for a DM, signed by the DM and the Administrator on 09/07/24. During an interview on 09/19/24 at 2:05 PM, the Administrator stated that the DM was originally hired as a cook but then was hired as the DM a week later. The Administrator verified that the DM was not certified and that the RD did not work full time at the facility but came to the facility twice a week to oversee the kitchen and to perform nutritional assessments and develop plans of care for the residents. Review of the Job Description: Director of Food and Nutrition Services, signed by the DM and the Administrator on 09/07/24, revealed, . the primary purpose of the director of food and nutrition services is to plan, organize, develop, and direct the overall operation of the dietary department in collaboration with the facility's contracted Registered Dietitian . to assure that quality nutritional services are provided on a daily basis and that the dietary department is maintained in a clean, safe and sanitary manner . (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of the Job Description: Director of Food and Nutrition Services, signed by the DM and the Administrator on 09/07/24, revealed, . 1. Must have one or more of the following certifications/qualifications: certified dietary manager, certified food service manager . 2. Must have and maintain an active food handler's permit/ServSafe certification . Supervise and assist in food preparation, following appropriate menus . ensure cooks and dietary sides have the necessary information and equipment to carry out their job functions including . cleaning schedules and checklists, temperature logs . Supervise staff to ensure the kitchen is clean and sanitary at all times . Cross Reference: F803D Menus Meet Resident Needs and F812 Food Procurement-Sanitation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065172	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain View Rehabilitation and Nursing LLC	2438 E Fountain Blvd Colorado Springs, CO 80910

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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	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. 16177 Based on observation and interview, the facility failed to serve the preplanned portion sizes during the lunch service on 13 of 13 trays observed out of a total of 83 trays plated for lunch. This failure increased the potential of residents not receiving the preplanned nutritional diet. Findings include: During observation of the lunch tray line on 09/19/24 from 11:30 to 11:40 AM with the Dietary Manager (DM), the portion of carrots plated on the first 12 trays appeared to be large, taking up half of the plate. After the 12th tray, this surveyor asked the DM what the portion size for the carrots was per the menu. Without looking at the menu, the DM stated that the carrots were to be a 3-ounce serving. The DM was asked if the scoop being used by the cook was the correct size. The DM looked at the scoop and verified that the scoop was a 4-ounce scoop and not a 3-ounce scoop. The DM then removed the 4-ounce scoop and replaced it with a 3-ounce scoop. Continued observation of the lunch tray line revealed that the mechanical chopped meat was being served with the wrong scoop size. The DM verified that the meat was to be a 4-ounce scoop but the cook was using a 3-ounce scoop. This was observed on one tray before the DM changed the scoop size. During this observation, the DM verified that the cook placed the scoops prior to the food service began and he (the DM) did not identify that the carrots and mechanical chopped meat had the incorrect scoops. Review of the Week at a Glance-Week 2 menu, provided by the Administrator on 09/19/24, revealed that the meat and the vegetable portion size was four ounces.

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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 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. 16177 Based on observations, interviews, and policy review, the facility failed to maintain the kitchen in a sanitary condition and failed to maintain temperature and sanitizer logs for the dish machine. This failure increased the risk of contamination of food served to all 83 residents who received food from the kitchen. Findings include: Review of the policy, Dietary Sanitization, adopted 12/19/16, revealed, The food service area shall be maintained in a clean and sanitary manner . All utensils, counters, shelves and equipment shall be kept clean . All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils . Dishwashing machines must be operated in accordance with manufacturer's instructions . Low-Temperature Dishwasher (Chemical Sanitization) wash temperature 120 degrees. Final rinse with 50 parts per million (ppm) with hypochlorite (chlorine) for at least 10 seconds . Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent an accumulation of grime. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. During the initial kitchen tour on 09/16/24 at 9:40 AM, the following observations were made with the Dietary Manager (DM): Two plastic three-shelf carts holding clean dishes had food debris, dust, and water splatter marks on all three shelves, the wheels, and the handles of the cart. A plastic three-shelf cart used for condiments such as sugar, salt, and pepper packets had dust and splatter marks on the shelves, the wheels, and the handles of the cart. The bottom shelves of the two prep tables were observed with dust and splatter marks on the shelves and on the items stored on the shelves, including a meat slicer. Clean oven trays were observed stored on the bottom shelf of one of the prep tables. The meat slicer was uncovered and had dust, dried food debris, and a cookie wrapper on it. The reach-in refrigerator had juice spilled on the bottom shelf. The reach-in freezer had unidentifiable spills on the bottom shelf. The outside of the doors of the reach-in refrigerator and freezer were streaked with spilled food debris and fingerprints. The kitchen floor was dirty with food debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DM was observed running the dish machine. When asked where the temperature gauge was located, the DM showed this surveyor that the gauge was under the machine and turned so that the face of the gauge could not be read. The DM stated that the temperatures of the wash and final rinse were to be above 120 degrees and were taken with a thermometer. The DM demonstrated taking the temperatures of the water during the wash and the rinse. The wash temperature was 118 degrees and the final rinse was 123 degrees. The DM stated that the dish machine was a low temp machine. When asked how the level of the sanitizer was measured, the DM stated with test strips. When asked what the sanitizer measured at, the DM stated, Haven't done that yet today, although the dish machine was being used for the breakfast dishes. The DM was asked where the temperature and sanitizer logs were maintained. The DM responded that the logs were taped to the outside of the reach-in refrigerator door. Observation with the DM revealed there were no temperature or sanitizer logs for the dish machine. A return tour of the kitchen on 09/16/24 at 2:55 PM revealed the same observations as above. Review of the ECOLAB ES-400 Dish machine manufacturer's information, provided by the Administrator, revealed a minimum wash and rinse temperatures of 120 degrees. Further review of the ECOLAB ES-400 Dish machine manufacturer's information revealed that the chlorine sanitizer was to be between 50 and 100 ppm. During an interview on 09/19/24 at 10:34 AM, the Administrator verified that temperature/sanitizer logs were not being maintained since initiating new temperature log forms on 09/01/24. The Administrator stated that the temperature/sanitizer logs were to be maintained with each wash at least three times a day. During a follow up tour of the kitchen on 09/19/24 at 11:30 AM, the sanitation concerns seen on 09/16/24 had been corrected. During an interview on 09/19/24 at 11:42 AM, the DM verified that temperature and sanitizer logs for the dish machine had not been initiated until with the dinner meal on 09/16/24. During continued interview on 09/19/24 at 11:47 AM, the DM stated that cleaning the kitchen was on my list of things to do but I spent my first week [as DM] meeting with the residents. The DM did verify that the sanitation observations on 09/16/24 were not due to the kitchen not being cleaned for one week and that the kitchen staff should be able to identify and correct to maintain a sanitary kitchen.