STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115351	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muscogee Manor & Rehabilitation Ctr	7150 Manor Road Columbus, GA 31907

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45811 Based on resident and staff interviews, record reviews, review of the facility's policy titled, Advance Directive Policy, and review of the facility's Admission Agreement-Statement of Acknowledgement, the facility failed to provide residents or resident representatives written information regarding choices and the right to accept or refuse medical or surgical treatment for one of seven sampled residents (R) (R56). This deficient practice had the potential to affect the resident or representative's ability to make informed decisions about their care. Findings included: Review of the policy titled, Advance Directive Policy, reviewed/revised date 11/21/2024 revealed under Policy Statement: It is the policy of [facility name] to establish, implement and maintain written policies and procedures for advance directive. Each resident with a decision-making capacity has the right to make their own decisions related to his/her medical care. An integral component of self-determination is the right to make choices pertaining to one's health, including the right to refuse or alter treatment plans, to accept or refuse medical or surgical treatment, refuse to participate in experimental research and to formulate advance directives. If a resident does not have decision-making capacity, this right may be exercised by an appropriately authorized representative for the resident. Review of the undated form titled, Admission Agreement-Statement of Acknowledgement, revealed under section six, Please check all statements that apply: The Resident has executed an Advance Directive. The Resident has not executed an Advance Directive. The Resident has not executed an Advance Directive but would like to obtain additional information about advance directives. There was no statement marked. Record review for R56 revealed medical diagnoses of but not limited to anoxic brain damage, tachycardia, and protein calorie malnutrition. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physician Orders included oxycodone HCl oral tablet 5 mg (milligram) give 1 tablet by mouth every hour as needed for pain/shortness of breath, please consult [name] Hospice per family request; admit Hospice- Dx (diagnosis) protein calorie malnutrition, and DNR (Do Not Resuscitate); POLST. Review of the care plan included, [R56] presents with a deteriorating/terminal condition/need for hospice, DNR. Self-care revealed the resident has a deficit in his self-care ability. He is blind in both eyes and hard of hearing. He is now fed by staff and needs maximum dependance assist from staff for activities of daily living (ADL) care. [R56] and his family have elected to make him a DNR. Interventions included, Complete/update Advanced Directives document. Interview on 11/19/2024 2:30 pm the Administrator in training revealed if the resident was unable to comprehend the information on the Advance Directive, the document should be provided to the family or resident representative for their signature. Interview on 11/21/2024 at 10:10 am the Social Service Director (SSD) revealed that advanced directives was a form in the admission packet. The SSD would give the document to the residents and/or family, and there was information for power of attorney, living will and code status. Once SSD gave the information to the residents/family member and they did not have any questions, they would sign the admission agreement and/or the POLST. If the resident was unable to sign the document, the family would sign it. Interview on 11/21/2024 at 2:15 pm the Administrator and Administrator in training revealed residents/representatives were given information about advance directives during the admission conference. The admission packet was completed by Social Services. If the resident was not able to document on the form, the responsible party would sign.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45811 Based on staff interviews and record review, the facility failed to submit for a Preadmission Screening and Resident Review (PASRR) Level II for a mental health diagnosis for one of 33 residents (R) (R82). This deficient practice had the potential for R82 not receive services and/or care according to his needs. Findings included: The facility revealed they did not have a policy on PASARR. Record review for R82 revealed pertinent diagnoses/conditions included secondary malignant neoplasm of bone (primary diagnosis), vascular dementia (12/7/2020), anxiety disorder, and psychosis not due to a substance or known physiological condition (4/27/2023). Review of Physician Orders included and order for treatment and evaluation as needed with [name] behavioral health services, refer to [name] related to cognitive decline, and Consult: Psychiatric/Psychology Services evaluation and treat as needed. Interview on 11/21/2024 at 10:00 am the Social Service Director (SSD) revealed clinical information was entered into the Georgia Medicaid Management Information System (GAMMIS) by the hospital; if the hospital did not enter the information the facility would enter the information. Criteria for Level II included depression, anxiety, insomnia, schizophrenia, and major depressive disorder. The SSD was made aware of changes in the diagnosis by communicating with the providers and staff during clinical meetings. Interview on 11/21/2024 at 12:30 pm with the SSD revealed R82 had diagnoses of dementia and unspecified psychosis not due to a substance or known physiological condition. She revealed she was in the process of submitting a Level II for R82 that day. Interview on 11/21/2024 at 12:45 pm with the Medical Records Coordinator revealed that for new admissions from the hospital that a DMA-6 was completed, and this document indicated the resident had diagnoses appropriate for admission to the facility. If the resident would be at the facility more than 30 days, the hospital would enter information in the Georgia portal; this information was shared with the facility. Diagnoses or criteria for Level II included dementia, schizophrenia, combative behaviors, and trouble adapting. The care plan nurse would identify behaviors and communicate this information to the appropriate person or the staff member responsible for submitting Level II. If a resident had a diagnosis of dementia, and other mental disorders, the Medical Records Coordinator revealed a Level II should be submitted. Interview on 11/21/2024 at 2:15 pm with the Administrator and Administrator in training revealed the hospital sends the PASARR information with the resident when they were admitted . Any kind of mental health diagnosis would be used to submit a Level II. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/2024 at 10:00 am the SSD revealed for admission there were two clinical liaisons who communicated with providers to get documents; depending on what hospital they come from the information may be entered into GAMMIS by the hospital; if the hospital did not enter the information the facility would enter the information; Criteria for Level II includes mental health diagnoses. She used diagnoses when residents came into facility to see if a Level II would be triggered. Criteria for Level II included depression, anxiety, insomnia, Schizophrenia, major depressive disorder. SSD will talk with providers in building and during clinical meetings; this was how SSD was made aware of any change in diagnoses, through ongoing communication. Interview on 11/21/2024 at 12:30 pm the SSD revealed diagnoses for R82 included dementia and unspecified psychosis not due to a substance or known physiological condition. She revealed she was in the process of submitting a Level II for R82. The PASRR Level I was reviewed and revealed admission 12/7/2020. Interview on 11/21/2024 at 12:45 pm the Medical Director Coordinator revealed, for new admissions from the hospital, basically the DMA-6 stated resident could be admitted ; if Level I indicated less than a 30-day stay they do not have to key in information; if the resident would be here more than 30 days, the hospital would enter information in Georgia portal; this information was shared with the facility; if the resident stayed long term a new Level I was done and the facility was responsible for getting a new Level I. If admitted from another nursing home the level 2 was transferred. If the person came from home the facility would submit the information. Diagnoses or criteria for Level II included dementia, Schizophrenia, combative behaviors, and trouble adapting. The care plan nurses would identify behaviors and communicate this information to the appropriate person or who was responsible for submitting a Level II. If a resident has a diagnosis of Dementia and other mental disorders, they will still submit a Level II. Interview on 11/21/2024 at 2:15 pm with the Administrator and Administrator in training revealed there was someone who handled the PASARR process; the hospital sends the PASARRs with the resident. Any kind of mental health diagnosis would be used to submit a Level II.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47947 Based on observations, staff interviews, record review, and review of the facility's policy titled, Care Plan Policy, the facility failed to ensure that a care plan was developed and/or implemented for three of 23 residents (R) (R19, R24, and R6). Specifically, the facility failed to implement the care plan for (R19 and R24) for monitoring and recording meal intake and the facility failed to develop and implement a care plan for (R6) for oxygen use. Findings included: Review of the policy titled Care Plan Policy review/revision date March 28, 2024, revealed under Procedure, Number 5. It is the responsibility of the care plan coordinator to review timely a resident's status and any change in needs following a hospital stay or any other unexpected event as deemed appropriate. It is also the responsibility of the care plan coordinator to ensure concerns/changes for a resident are care planned and/or updated. 10. The CNA task record will be updated during the care plan conference to refect interventions defined on the care plan. 11. The DON, Nurse Manger and Licensed Charge Nurses are responsible for ensuring provision of care in accordance with the care plan. 1. Review of the clinical record revealed R19 was admitted to the facility with diagnoses of but not limited to Alzheimer's disease, vascular dementia, and major depressive disorder. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. Review of the care plan revised on 8/31/2024 revealed [R19] was at risk for weight loss secondary to periods of confusion, impaired cognition, inattention, edentulous status and disorganized thinking at times. Interventions included, give diet, fluids, supplements, snacks as ordered, record percentage eaten, offer food replacement for less than 25% (percent) food not consumed. Review of the Nutritional Task-Amount Eaten for September through November 2024 revealed that the percentage of meal eaten by R19 varied from 0% to 100%. Continued review revealed there was no documentation for intake percentages for 9/1/2024, 9/4/2024, 9/8/2024, 9/11/2024 to 9/12/2024, 9/15/2024 to 9/16/2024, 9/18/2024 to 9/20/2024, 9/22/2024, 9/25/2024 to 9/26/2024, 9/28/2024, 9/30/2024 to 10/1/2024, 10/3/2024 to 10/7/2024, 10/11/2024, 10/13/2024 to 10/16/2024, 10/20/2024, 10/23/2024 to 10/25/2024, 10/27/2024 to 11/3/2024, 11/6/2024 to 11/14/2024, and 11/17/2024 to 11/18/2024. 2. Review of the clinical record revealed R24 was admitted to the facility with diagnoses of but not limited to adult failure to thrive, major depressive disorder, and abnormal weight loss. Review of the Quarterly MDS assessment dated [DATE] assessed a BIMS score of 14, which indicated little to no cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan revised 8/31/2024 revealed [R24] was at risk for changes in weight and nutritional deficits. [R24] is edentulous and receives a mechanically altered diet of soft and bite sized. Interventions included give diet, fluids, supplements, snacks as ordered, record percentage eaten. Review of the Nutritional Task-Amount Eaten for September through November 2024 revealed R24 consumed between 51-75% and 76-100% of meals. Continued review revealed there was no documentation for intake percentages from 9/1/2024 to 9/2/2024, 9/4/2024, 9/6/2024, 9/8/2024, 9/10/2024 to 9/13/2024, 9/15/2024 to 9/16/2024, 9/18/2024, 9/20/2024 to 9/23/2024, 9/25/2024 to 10/6/2024, 10/8/2024, 10/11/2024, 10/16/2024 to 10/18/2024, 10/20/2024 to 10/23/2024, 10/25/2024 to 10/27/2024, 10/29/2024, 11/1/2024 to 11/6/2024, 11/8/2024 to 11/12/2024, 11/14/2024 to 11/16/2024, and 11/19/2024 to 11/20/2024. Interview on 11/21/2024 at 12:20 pm Registered Nurse (RN) DD confirmed that percentage of amount eaten should be documented for every meal, and CNAs were responsible for documenting this information in facility electronic medical records (EMR) system daily. Interview on 11/21/2024 at 12:30 pm with Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that if the care plan had interventions to record percentage of consumed meals, it should be recorded daily and for every meal. CNAs were responsible for documenting consumed amounts in the EMR system, and to report them to the nurses. 44959 3. Review of the clinical record revealed R6 was admitted to the facility with diagnoses of but not limited to chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, atherosclerotic heart disease of native coronary artery without angina pectoris. Review of the Quarterly MDS assessment dated [DATE] for R6 assessed a BIMS score of 10, indicating moderate cognitive impairment. Review of Section O (Special Treatments and Programs) reported oxygen use. Review of a Physician order dated 3/25/2024 revealed O2 (oxygen) at 2 liters per minute to keep O2 Sat 92% and above every shift for SOB, oxygen tubing and neb tubing change every Monday every day shift every Monday oxygen: tubing and humidifier change every Monday Review of R6 care plan dated 11/6/2024 revealed there was no care plan with specific goals and interventions for oxygen use. Observation during initial screening on 11/19/2024 at 10:00 revealed R6 in bed with the oxygen on and the oxygen was set at 2.5 L/M. Additional observations on 11/19/2024 at 12:20 pm, and on 11/20/2024 at 10:05 am revealed R6 had on oxygen and the oxygen was set at 2.5 L/M. Interview on 4/10/2024 at 10:19 am Licensed Practical Nurse (LPN) EE confirmed that R6's oxygen was on and set at 2.5 liter, and that the respiratory therapist checked the oxygen during visits and decided what level it should be set at unless there was a change by the physician. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/2024 at 9:40 am the MDS Coordinator CC revealed that she was responsible for creating the care plan for oxygen for R6. She revealed that she linked the oxygen to COPD and had planned to go back to look at it to create a care plan for oxygen with more detailed goals and intervention but did not create the plan. Interview with DON and ADON on 11/21/2024 at 10:00 am regarding their expectation from staff when it came to physician order and care plan, the DON revealed that she expected staff to follow any physician order that was implemented. The DON revealed that if oxygen was ordered at 2 liters that she expected staff to set the oxygen at 2 liters and nothing more. She revealed that care plans were implemented according to diagnosis and if there was an order for oxygen that it should care planned.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138 Based on observations, staff interviews, record reviews, and review of the facility's policy titled Accident/Hazard Prevention, the facility failed to ensure a working door alarm to prevent the elopement of one of 31 residents (R) (R73) housed on a COVID unit. This failure had the potential to place R73 at risk for avoidable accidents and adverse consequences. Findings included: Review of the policy titled, Accident/Hazard Prevention initiated 6/10/2023 revealed, It is our policy to assure safety for our resident, employees, and visitors through the utilization of a program designed to reduce the likelihood of accidents. The Safety Program included: 5. Compliance monitoring will be completed as indicated by administration, DON/ADON, and maintenance director to include, but is not limited to storage of chemicals, locked medicine carts, locked med rooms, water temperature, spills, obstructive hallways, slippery floors, burned out light bulbs, torn window screens, broken glass, proper disposal of trash and garbage, electrical cords, and accessible spray containers. 6.Maintenance request notebooks are located at each nurse's station for utilization by any employee to request prompt attention to needed repair work. Record review of the Admission Record for R73 revealed diagnoses of but not limited to Alzheimer's disease with early onset, dementia, and wandering. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C- Cognitive Patterns assessed a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment, Section I - Active Diagnoses-progressive neurological condition, hypertension, hyperlipidemia, Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression, Section P - Restraints and Alarms-not used. Review of R73's care plan dated 2/20/2024 revealed focus area, Wander/Elopement [R73] is at risk for injuries r/t (related to) wandering. R73 is on a closed dementia unit and can ambulate at will without assistance. R73 has diagnoses (dx) of dementia and has cognitive deficits. Goal: Safety will be maintained through the review date. Interventions included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book and providing structured activities. Review of nurses note dated 2/17/2024 at 4:45 pm revealed R73 was redirected several times during the afternoon shift, attempted leaving COVID isolation wing, noted ambulating without assistance, denies pain/Shortness of Breath (SOB) at this time, will continue with the current plan of care. Review of nurses note dated 2/17/2024 at 6:40 pm revealed R73 was noted outside by neighbors of this facility, neighbors summoned police, police returned R73 to facility. Observation on 11/19/24 at 11:27 am revealed R73 currently housed on the [NAME] Wing/locked unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/24 at 10:40 am with Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed R73 was moved from the locked unit due to COVID, an alarm was placed on the door of the unit to ensure safety. R73 was last seen in her room at 5:50 pm washing her hands. The facility received a call around 6:40 pm stating that R73 was located at another facility about one minute away. R73 was able to bypass two doors to exit the facility. Interview on 11/21/2024 at 11:35 am with Maintenance Director (MD) revealed a system failure occurred with the alarm that was placed on the COVID unit, resulting in R73 being able to bypass two doors to exit the facility. Interview/walkthrough on 11/21/2024 at 11:55 am with MD revealed a door alarm was placed on the COVID unit where R73 was placed due to COVID. R73 was able to exit the unit due the alarm system failure and proceed to door two located in the hallway across from therapy as R73 pressed a green button to exit the facility. Interview on 11/21/24 at 1:00 pm with Licensed Practical Nurse (LPN) AA revealed R73 was moved to another unit due to COVID. R73 was not on one-on-one monitoring, but an alarm was placed on the door to ensure the resident's safety. Interview on 11/21/2024 at 2:13 pm with Administrator and Administrator in training revealed an assessment was completed upon admission, all wanderers or elopement residents are placed on the [NAME] Wing (lock down unit) so they can wander as they please. Administrator revealed there was an alarm on the door on the COVID unit, but it was inoperable, but after moving residents to that unit due to COVID, a working alarm was placed on the door. The Administrator revealed R73 should not have been moved from her unit, they were trying to figure things out with COVID going on, moving forward they had learned to keep residents who wander in their same environment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44959 Based on observations, resident and staff interviews, record reviews, and review of the facility's policy titled, Oxygen, Therapy, the facility failed to ensure oxygen was administered as ordered by the physician for one of twelve residents (R) (R6) receiving oxygen. The deficient practice had the potential to place R6 at risk for medical complications, and a diminished quality of life. Findings included: Review of the facility policy titled, Oxygen, Therapy Guidelines, review/revision date June 21, 2023 revealed under Purpose, This protocol would enable the Respiratory Therapist or Nurse to monitor and adjust the oxygen therapy to meet preset criteria and it will be done more quickly and seamlessly than the conventional way of responding to potentially serious changes in the patient condition , calling the physician and then obtaining an order to make necessary changes. Further review under Clinical Responsibilities 11, the following guidelines will be adhered to in all oxygen therapy patients at all times. The physician will be contacted within 24 hours so that an order may be received for the new liter flow if a change is made by the RT or nursing. Review of the clinical record revealed R6 was admitted to the facility with diagnoses of but not limited to chronic obstructive pulmonary disease, emphysema, chronic bronchitis, atherosclerotic heart disease of native coronary artery without angina pectoris. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R6 had a Brief Interview for Mental Status (BIMS) score of 10, indicating little to no cognitive impairment. Review of Section O (Special Treatments and Programs) indicated oxygen use. Review of the Physician orders dated 3/25/2024 revealed O2 (oxygen) at 2 liters per minute (LPM) to keep O2 Sat (saturation) 92% (percent) and above every shift for SOB (shortness of breath), oxygen tubing and neb tubing change every Monday, every day shift; oxygen: tubing and humidifier change every Monday Observation during initial screening on 11/19/2024 at 10:00 revealed R6 in bed with the oxygen on and the oxygen was it was set at 2.5 LPM. Additional observations on 11/19/2024 at 12:20 pm, and on 11/20/2024 at 10:05 am, revealed R6 in bed with the oxygen on and it was set at 2.5 LPM. Interview on 11/20/2024 at 10:19 am Licensed Practical Nurse (LPN) (LPN EE) confirmed that R6's oxygen was set at 2.5 liters and revealed that the Respiratory Therapist decided what level it should be set at unless there was a change by the physician. Interview on 11/21/2024 at 9:40 am with the MDS Coordinator 1 revealed that she was responsible for creating R6's care plan for oxygen. She revealed that she linked the oxygen to COPD and had planned to go back and look at it to create a care plan for oxygen with more detailed goals and interventions, but did not create the plan. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/2024 at 10:00 am with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON revealed her expectation from staff when it comes to physician orders and care plan, she expected staff to follow any physician order that was implemented on the floor. DON revealed that if oxygen was ordered for 2 liters that she expected staff to set the oxygen to 2 liters and nothing more. She revealed that care plans were implemented according to diagnoses and if there was an order for oxygen that it should be care planned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115351	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muscogee Manor & Rehabilitation Ctr	7150 Manor Road Columbus, GA 31907

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 - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50272 Based on observations, staff interviews, record reviews, and review of facility's policy titled, Food Service Policy and Procedures, the facility failed to prepare food by methods that conserve nutritive value, flavor, and appearance of food. Specifically, the facility failed to use a recipe when preparing pureed food. This deficient practice has the potential to affect 13 residents who were ordered a pureed diet. Findings included: Review of the facility's undated policy titled, Food Service Policy and Procedure, under the section titled Pureed Diets revealed, To ensure that residents who have been placed on a puree diet receive the best possible product without compromising flavor and, texture food & nutrition will at all times adhere to strict preparation procedure. 1. Meats starches & vegetables will be placed in the food processor until well blended. 2. Gravy or broth will be gradually added to products until a gravy like texture has been achieved. When processing starches and vegetables, use the liquid that is strained from the starch or vegetable. Do not use plain tap water. Do not overly add liquid as this will affect the nutritional value. 3. Staff will then gradually add thickener (Thick-It) two teaspoons per four-ounces of food. Example, if you have processed 20 ounces of chicken, you would need to gradually add a total of 10 teaspoons of thickener to the chicken that is being processed. 4. Food & Nutrition staff will taste all products to ensure the desired flavor has been achieved. 5. Food processors will be clean prior to processing another product. Clean between uses. 6. When processing liquids such as water or fruit juices staff will add three to three and a half teaspoons to achieve a nectar consistency and 3 and a half to four teaspoons to achieve a honey consistency. 7. Always refer to instructions provided on each individual recipe (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/30/2024 at 10:00 am, and interview at that time, revealed [NAME] BB prepping boiled spaghetti to be pureed. The Food and Nutrition Manager (FNM) approached with a document outlining instructions for pureeing food, which was placed in front of [NAME] BB. Upon reviewing the document, [NAME] BB looked confused. When asked about the document, [NAME] BB revealed that was the first time she had seen the document. Further questioning about the process revealed that [NAME] BB measured the spaghetti by breaking it in half and placing it in a container. [NAME] BB was then observed using a ladle to scoop thickened powder from a bag, which she added to the grinder. When asked about the specific measurement of thickened powder, [NAME] BB explained that she used the size of the ladle as a reference, rather than following any precise measurement or recipe. [NAME] BB revealed that based on her experience working in the kitchen for a long time, she simply knew how much to add. [NAME] BB further revealed that the puree was intended for 10 residents, and that the desired consistency was supposed to be nectar thick. [NAME] BB did not refer to a formal recipe for guidance. Interview on 11/20/2024 at 10:56 am with the FNM revealed that her expectations were for cooks to be properly trained, follow recipes, and execute their duties correctly. FNM revealed being aware that the cook was not following the recipe but revealed that she could print them out for reference. The FNM clarified that the intended consistency for the puree was a nectar-thick liquid, and it was meant to serve 12 residents. Interview on 11/21/2024 at 10:20 am the Administrator revealed his expectations were that dietary staff were trained and knew how to properly puree items, and there should be a recipe followed for pureed diets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50272 Based on observations, staff interviews, record reviews, and review of the facility's policies titled, Food Storage, Floor Stock, and Accepting Food Deliveries, the facility failed to ensure proper labeling and storage of food with open and expiration dates, failed to discard food items by the expiration dates, and failed to properly cover opened food items. This deficient practice had the potential to affect 85 residents who received food orally. Findings included: Review of facility's policy titled, Food Storage dated 2021, revealed under section titled Procedure: 2. Food should be dated as it is placed on the shelves if required by state regulation. 3. Date marking should be visible on all high-risk food to indicate the date by which a ready-to-eat, TCS food should be consumed, sold, or discarded. Refrigerated Food Storage: 2. All foods should be covered, labeled, and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. Frozen Foods: 3. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. Review of facility's policy titled, Floor Stock dated 2021, revealed under section titled Procedure: 2.c. The food and nutrition services staff will: Rotate stock and remove outdated items. Record review of facility's policy titled, Accepting Food Deliveries dated 2021, revealed under section titled Procedure: 4. Perishable foods will be properly covered, labeled, and dated and promptly stored in the refrigerator or freezer as appropriate. Observation on [DATE] at 9:24 am with the Food and Nutrition Manager (FNM) revealed and confirmed the following items in the walk-in cooler: Five clear boxes of cheddar cheese slices with no expiration date. One clear box of Swiss cheese slices with no expiration date. One container of [named brand] low fat cottage cheese with an expiration date of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[DATE]. Observation on [DATE] at 9:31 am with the FNM revealed and confirmed the following items in the freezer: Three bags of turkey burgers with no expiration date. Nine cups of milkshakes in clear containers with no expiration date. One opened bag of beef patties not properly sealed with no expiration date. One opened bag of French toast sticks not properly sealed with no expiration date. One opened bag of strawberries not properly sealed with no expiration date. One opened bag of biscuits not properly sealed with no expiration date. One opened bag of French fries not properly sealed with no expiration date. Nine loaves of bread with no expiration date. Observation on [DATE] at 9:40 am with the FNM revealed and confirmed the following items in the pantry: One opened jug of [name brand] golden barbeque sauce that was opened and not refrigerated. Nine bags of mini marshmallow with an expiration date of [DATE]. Observation on [DATE] at 10:06 am of the resident pantry located on the [NAME] Wing, with the FNM, revealed and confirmed the following expired foods items: One [name brand] prune juice with an expiration date of [DATE]. Three graham honey crackers with an expiration date of [DATE] and [DATE]. Two original graham crackers with the expiration of [DATE] and [DATE]. One sugar lemon cookie with an expiration date of [DATE]. Observation on [DATE] at 10:33 am of the resident pantry located on [NAME] Wing with the FNM revealed and confirmed: 21 packages of [name brand] easy mix instant food thickener with an expiration date of [DATE]. The FNM discarded the expired packages. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 10:56 am the FNM revealed her expectation that everyone in the kitchen know that expired foods were a no and that they work as a team to oversee and label food items and throw out any expired food items before the expiration date. Interview on [DATE] at 10:07 pm the FNM revealed she was not in charge of checking to see if the resident pantries had any expired food items. FNM further revealed the unit secretary assigned to that floor was normally responsible for checking the resident's pantry for any expired food items, but they currently don't have one. Interview on [DATE] at 10:10 am the Licensed Practical Nurse (LPN) AA in charge of the [NAME] Wing revealed she had not looked in the drawers for expired items and she only checked the juices. Interview on [DATE] at 10:18 am the Administrator revealed that everything should be labeled upon entry and should have an expiration date on it. He revealed there shouldn't be any expired items because the FNM did rounds every day to check food items. He further revealed his expectation that all food items would be properly closed. The Administrator further revealed the unit managers oversee verifying all expired items in the residents' pantries.