STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. Building B. Wing	07/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health Care Center	2121 Avenue L Hawarden, IA 51023

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44474 Based on observations, staff interview and facility policy review the facility failed to provide for resident's dignity during dining. The facility reported a census of 46 residents. Findings include: During an ongoing observation on 7/25/24 starting at 12:23 p.m., revealed Staff H, Certified Nursing Assistant was feeding Resident #17 and Resident #18. Resident #17 was noted to be sitting herself forward in her wheelchair Staff H took her left arm and placed it across Resident #17's chest and continued to assist Resident #18 with eating. Staff H did not say anything to Resident #17 until after she had assisted Resident #18 with 3 more bites of food. Staff H got up from the table at 12:25 p.m., and asked another staff member to watch Resident #17. Staff H returned to the table at 12:34 p.m Staff H sat down and without talking to Resident #17 and Resident #18 assisted with eating their meal. Review of facility provided policy titled Resident Rights reviewed 6/2023 revealed the resident has the right to be treated with consideration, respect, and full recognition of his or her dignity and individuality. Interview on 7/28/24 at 9:24 a.m., with the Administrator revealed the staff should have been talking to the resident and not placing their arm across Resident #17's chest.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2024
NAME OF PROVIDER OR SUPPLIER: Hillcrest Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2121 Avenue L Hawarden, IA 51023	

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on facility record review and resident and staff interviews, the facility staff failed to provide reasonable accommodation of needs by not placing the call light within reach of residents for 2 out of 6 residents reviewed (Resident #1 and #6). The facility reported a census of 46 residents. 1. The Grievance Resolution form dated 5/28/24 at 1:00 PM identified Resident #1 stated the call light was left out of reach after cares. The resident called the front desk to ask for assistance. The grievance conclusion identified staff confirmed the call light was out of reach upon entering the resident's room. Corrective action identified as education to staff on call lights. The Grievance Resolution form dated 6/10/24 identified Resident #1 reported during a mechanical lift transfer the nurse left the resident unattended and without a call light. The form identified the resident felt fearful as if she may fall out of the chair before they got back. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #6 had a Brief Interview for Mental Status (BIMS) of 13 which indicated no cognitive impairment. The MDS documented Resident #13 dependent on staff for personal hygiene. The MDS showed diagnosis of heart and renal failure. In an interview on 7/27/24 at 10:24 AM, When asked if Resident #6 had her call light, she replied, probably not, that's not unusual. Resident #6 reported staff have failed to place the call light within reach, and she called the facility to get help. The Call Light policy last revised May 2007 identified to leave the resident comfortable. Place the call device within the resident's reach before leaving the room. In an interview on 7/28/24 at 10:46 AM, the Assistant Director of Nursing reported she expected staff to place the call light within the resident's reach.

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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. 44420 Based on record review and interviews the facility failed to use the mechanical lift in an appropriate manner to avoid hazards and prevent accidents for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 46 residents. The findings include: The Grievance Resolution Form dated 6/10/24 showed the facility received a report from Resident #1 that identified staff banged her foot on the mechanical lift during a transfer. A staff member instructed the other to be more careful with transfers. The resident reported the incorrect placement of her body in the wheelchair caused her to feel that she may slip out. The nurse then left the resident unattended, and without the call light, while she went to get help. Resident #1 reported feeling fearful as if she may fall out of her chair before staff returned to the room. Resident #1 also reported when staff later returned her to bed they used the emergency button to lower her into bed which released quickly and scared her. The nurse stated to the Certified Nursing Assistant (CNA), we only use this in an emergency. The Grievance Resolution form also showed the Director of Nursing (DON) notified staff with the proper follow up and CNAs were spoken to and educated on proper use of equipment and safety. The Summary of Findings found that CNAs had used the emergency button to lower the resident. Corrective Action showed a plan of an educational inservice. The Grievance Resolution Form dated 6/12/24 showed the facility received a tearful report from Resident #1 that identified the CNAs used the emergency button again while placing the resident in a chair. The Grievance Resolution form also showed the Director of Nursing (DON) notified staff with the proper follow up and CNAs were educated on proper use of equipment. The Summary of Findings found that CNAs had used the emergency button to lower the resident into the chair. Corrective Action showed a plan of an educational inservice. The Grievance Resolution Form dated 6/24/24 showed the facility received a report from Resident #1 that identified on 6/23/24 CNA's transferred the resident alone twice using the mechanical lift. Resident #1 stated the lift wasn't hooked up correctly and the CNA got another CNA and was told the resident was not hooked up correctly.The Grievance Resolution form also showed the Director of Nursing (DON) notified all staff on proper use of all transfer equipment. The Summary of Findings found a staff member did transfer the resident alone. Corrective Action showed there will be more education on safe transfers. All transfer equipment required two staff members to operate. In an interview on 7/26/24 at 2:54 PM, Staff A, CNA reported some of the CNA's used the emergency button on the mechanical lift. Staff A reported that staff received education not to use the emergency button because it released quickly and could cause someone to get hurt. In an interview on 7/26/24 at 3:03 PM, Staff G stated, someone was using the emergency button on the lift but no one got hurt. Staff was educated about it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/27/24 at 9:40 AM, the Director of Nursing reported his knowledge of staff using the emergency button to lower residents during mechanical lift transfers. The DON reported staff received follow up and education regarding the proper way to use mechanical transfer equipment. In an interview on 7/28/24 at 10:46 AM, the Assistant Director of Nursing reported that she expected staff to avoid using the emergency button on the mechanical lifts and expected staff to follow the policy when using mechanical lifts to transfer residents. The Mechanical lift policy last reviewed in October 2022 instructed staff to ensure the sling is applied correctly, securely and comfortably to the patient. Transfer the patient to the desired location with minimal disruption and maintaining their dignity and comfort. Lower the patient gently and safely to their new position. Always use a minimum of two healthcare personnel during patient transfer with a mechanical lift, with one operating the left and one assisting.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on observation, staff interview and facility policy, the facility failed to provide complete and appropriate incontinence care in a manner to prevent urinary tract infections for 1 of 3 residents observed (Resident #12). The facility reported a census of 46 residents. Finding include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #12 documented diagnoses of non-traumatic brain dysfunction, dementia and dysphagia. The MDS documented Resident #12 totally dependent for toileting hygiene, showering and personal hygiene. The MDS showed the Brief Interview for Mental Status (BIMS) score of 01 which indicated severe cognitive impairment. On 7/27/24 at 1:20 PM observed Staff A, Certified Nursing Assistant (CNA) and Staff J, CNA removed Resident #12's pants, unfastened the brief, pulled down the brief then rolled the resident onto her left side. Staff J then held the resident's right leg while Staff A stood behind the resident, reached between the resident's legs to the front perineal area then cleansed the area by wiping from the perineal area back between the resident's legs. Staff A's arm touched areas between the resident's legs with each wipe. The resident's lateral position failed to allow proper physical and visual access to the resident's perineal area. Staff A then cleansed the right buttock and hip. Staff A removed the soiled gloves, placed the gloves on the bed, touched her scrub pants at the side pocket and thigh pocket. Staff A then opened the bathroom door to perform hand hygiene. Staff J cleansed the resident's left buttock, hip then discarded used wipes and gloves. Staff J failed to perform hand hygiene then arranged the resident's blankets, pillows and wet wipe package. Staff J then retrieved the trash bag from the receptacle, tied the bag in a knot, placed the bag on the floor then assisted Staff A to comfortably position the residents by moving the pillows and blankets. The Perineal Care policy revised May 2007 identified: 1. Position resident on back with knees bent and slightly apart. 2. Expose perineal area. 3. Wet washcloth and soap lightly. Fold into a mitt. If using another cleaning agent, use according to the manufacturer's instructions. 4. Wash pubic area, including upper, inner aspect of both thighs and front portion of perineum. A. Use long strokes from the most inner down to the base of the labia (Wash from the cleanest area to the dirtiest area). B. After each stroke, refold the washcloth to allow use of another area. 5. Follow the same sequence for the rinsing area. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Dry area thoroughly. 7. Instruct or assist residents to turn on side with top leg slightly bent. 8. Rinsh cloth and soap lightly. 9. Wash the perineal area thoroughly, with each stroke beginning at the base of the labia and extending up over the buttocks. A. Refold cloth, as before, to provide a clean area. B. Washing should alternate side to side, ending with the center anal area. 10. Rinse cloth and entire area in the same sequence as above. Dry arrow thoroughly and leave residents comfortably positioned. In an interview on 7/28/24 at 10:46 AM, the Assistant Director of Nursing (ADON) reported perineal care should be performed by the resident first laying on her back for proper positioning. The ADON reported staff should follow policy when performing perineal care and hand hygiene.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on facility record review and resident and staff interviews, the facility staff failed to consistently answer call lights within a reasonable amount of time. Residents reported call light response time over 15 minutes for 3 out 6 residents reviewed (Residents #1, #8, and #15). The facility reported a census of 46 residents. 1. The Grievance Resolution form dated 5/28/24 at 1:00 PM identified Resident #1 turned on the call light at 6:30 AM. The call light wasn't answered until 7:30 AM. The resident reported incontinence due to the delay. The investigation listed on the grievance included staff educated on answering call lights in a timely manner. The Grievance identified corrective action included education to staff regarding call light response time. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #8 had a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. The MDS documented Resident #8 dependent or required substantial assistance for personal hygiene. The MDS showed diagnosis of hemiplegia and overactive bladder. In an interview on 7/26/24 at 10:41 AM Resident #8 reported staff failed to assist her to the bathroom every two hours like she is supposed to be doing. Resident #8 stated the evenings are worse than others and feels like the staff went home to bed instead of working. Resident #8 reported she overheard a staff member state, I am not helping her, she just went to the bathroom. Resident #8 reported ambulating to the bathroom independently due to extended call light wait times, which made staff mad as she is supposed to have help. The resident explained she peed on herself and was tearful talking about it. Resident #8 stated that she felt upset and bad when that happened. The Care Plan for Resident #8 instructed staff to be sure the call light is within reach and encouraged to use it to call for assistance as needed. The Call Light log for Resident #8 (Hall #2, room [ROOM NUMBER]) showed the following occurred during the three day look back period of 7/24/24 - 7/27/24: On 7/24/24 3:07 PM call light response time took over 21 minutes. On 7/24/24 6:51 PM call light response time took over 16 minutes. On 7/24/24 7:28 PM call light response time took over 24 minutes. On 7/25/24 7:03 AM call light response time took over 51 minutes. On 7/25/24 8:59 AM call light response time took over 17 minutes. On 7/25/24 9:24 AM call light response time took over 24 minutes. On 7/25/24 9:21 PM call light response time took over 18 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/26/24 8:38 AM call light response time took over 18 minutes. On 7/27/24 ay 6:56 AM call light response time took over 24 minutes. In an interview on 7/26/24 at 2:54 PM, Staff A, Certified Nursing Assistant (CNA) reported call lights are answered after 15 minutes depending on who worked. Staff A reported nurses and office staff are supposed to help if CNAs are unable to answer a call light, but they often don't. 3. The MDS dated [DATE] documented Resident #15 had a BIMS of 13 which indicated no cognitive impairment. The MDS documented Resident #15 required partial to moderate assistance with toileting hygiene, showering and personal hygiene. The MDS showed diagnosis of heart and renal failure. In an interview on 7/27/24 at 11:18 AM, Resident #15 reported the call light response time took up to 40 minutes to 1.5 hours. Resident #15 reported this happened five times a week. The Call Light log for Resident #15 (Hall #2, room [ROOM NUMBER]) showed the following occurred during the five day look back period of 7/21/24 - 7/26/24: On 7/21/24 8:05 AM call light response time took over 19 minutes. On 7/22/24 3:29 PM call light response time took over 22 minutes. On 7/25/24 6:54 AM call light response time took over 32 minutes. On 7/25/24 9:11 AM call light response time took over 27 minutes. On 7/25/24 2:49 PM call light response time took over 18 minutes. On 7/26/24 4:30 AM call light response time took over 27 minutes. On 7/26/24 8:09 AM call light response time took over 20 minutes. The Call Light policy last revised May 2007 instructed staff to answer call lights with a reasonable amount of time (15 minutes or less). In an interview on 7/28/24 at 10:46 AM, the Assistant Director of Nursing (ADON) reported she expected staff to answer call lights within 15 minutes. The ADON reported staff received education to answer call lights within 15 minutes related to a grievance received from a resident.

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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. 44474 Based on review of the planned menu, observation and staff interviews facility staff failed to follow the planned menu for residents. The facility identified a census of 46 residents. Findings include: The facility's Week 1 menu identified the following items as part of the planned menu for the lunch meal on 7/25/24: Fried Chicken Potato Salad Green Beans with bacon Strawberry Sponge Shortcake Milk Observation on 7/25/24 starting at 12:23 p.m. the lunch meal being served consisted of: Chicken wrap Potato salad Potato chips Lemon Pudding Interview on 7/26/24 at 8:44 a.m., with Staff C, Dietary Manager revealed on 7/25/24 she did not have enough fried chicken for the noon meal as she did not order enough and she called the dietician for substitutions so she made a decision to make chicken wraps. Staff C revealed she has only been in her position for approximately a week and half but has worked in the kitchen since April and has not had any training as a dietary manager. Staff C further revealed she was not able to serve the strawberry sponge shortcake as they only got 1 spongecake on the truck so she decided to serve lemon pudding. Asked Staff C for the log of substitutions she revealed she did not have that in the facility and she kept it at home. Interview on 7/26/24 at 2:22 p.m., with Staff D, Dietician revealed she had not been contacted on 7/25/24 by the facility for any menu changes. Staff D further revealed if there are going to be substitutions they need to be appropriate nutritional exchange. She revealed she was unaware of any changes to the menu on 7/25/24. She revealed the facility has new dietary staff again and she is trying to teach them when they need to call her and making sure that they are ordering enough food for the facility. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility provided policy titled Dining and Meal Service last updated 11/2019 revealed The dining experience will be person-centered with the purpose of enhancing each individual patients or residents quality of life and being supportive of each individual's needs during dining. individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional and special dietary needs. Interview on 7/26/24 at 12:56 p.m., with the Administrator revealed she expected residents to get the menu that was planned.

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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. 44474 Based on observations, facility record review and resident and staff interviews the facility failed to ensure proper temperatures for foods served to residents. The facility reported a census of 46 residents. Finding Include: Ongoing observation on 7/26/24 starting at 12:03 p.m., revealed the following: a. Observation of 3 dietary trays sitting on the table with covers on upon entering the kitchen. b. Observation during meal service Staff C, Dietary Manager called call room trays were ready. Verified with Staff C the room tray was ready to leave the kitchen and go to the resident. Asked Staff C to take meal temperatures. Temperatures are as follows: Fish Sticks- 94.3 degrees Fahrenheit (F), Carrots 93.5 degrees F and cheesy rice 102 degrees F. Staff C left the cover off of the meal tray. Approximately 10 minutes later Staff C revealed the room tray needed to be remade. c. Puree food on a tray with covers went to service window. Asked Staff C what the food was. Staff C revealed it was pureed cheesy rice and she had just taken it out of the microwave. Asked Staff C to check the temperature of the food. Temperature of the bowel of puree cheesy rice was 127 degrees F. Staff C covered the bowl back up and placed it in the service window. Verified with Staff C those are ready to serve the residents. Staff C confirmed they were ready to be served. The Administrator stopped the service and educated Staff C the meal was not hot enough to serve. Review of the Center for Disease Control website titled Food Safety dated April 29, 2024 revealed when reheating, use a food thermometer to make sure that microwaved food reaches 165 degrees F. Interview on 7/26/24 at 12:56 p.m., with the Administrator revealed she expected the food to be proper temperature when served to residents.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 44474 Based on observations and diet orders the facility failed to assure the food was prepared and appropriate to meet resident's needs according to their assessment, diet orders and care plan. Observations determined that 3 residents did not get the food in their ordered texture and 2 of the 3 residents have an order for an altered diet and are identified as moderately impaired cognition, (Resident #5, #6 and #7). This failure resulted in residents receiving Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of July 25, 2024 on July 26, 2024 at 4:07 p.m. The Facility Staff removed the Immediate Jeopardy on July 26, 2024 through the following actions: a. Staff education was provided to the individual's passing meals on 7/25/24. b. The dietary manager was also re-educated on all diets on 7/25/24. c. All diets were reviewed and dietary cards were updated with new pictures and new diets on 7/25/24. d. The dietary staff were all reeducated about appropriate diets by the administrator on 7/26/24. e. Dietary staff educated the process of [NAME] verifying the diet served matches the plate and diet cards then put into the serving window and dietary aide or staff member who is serving double checks to ensure correct food is matching diet card before going to serve plate. f. Education given to dietary staff in regards to ensuring we are all aware of Which Resident is who and serving the correct plate to the correct resident. g. Resident who was served incorrect diet immediately was placed on speech therapist caseload 7/26/24. h. Education given to all staff in regards to therapeutic diets on 7/25/24. i. The other residents involved will also be evaluated for therapeutic caseload . j. When new staff are hired we are to train and educate in regard to diet orders process of modified diet process of serving drinks and food. k. All kitchen staff meetings occurring with continuing education. l. Monthly QAPI meetings discussing the kitchen. m. Continued education with all staff in regards to food processes modified diet serving processes and diet orders. (continued on next page)

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F 0805

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

n. Daily and weekly audits to ensure timeliness of food served correct diet served temperatures, hand washing and glove use.

o. Management staff as well as dietary staff will use the diet order cards with reference to therapeutic diet sheets and recipes and reference to the diet manual as well as confirm any questions with the dietitian prior to meals being placed in front of a resident.

p. A certified dietary manager from a sister facility will be here on 7/28/24 to provide ongoing side by side training with dietary staff. Ongoing training will be held for the next 7 days with all dietary staff until return demonstration of correct meal service is obtained for three consecutive meals ongoing audits and education will be provided weekly times for weeks with return demonstration of skills each week and sign off sheets completed for competency. Skills will be based on puree mechanical soft and serving size and liquid consistency.

The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures.

The facility identified a census of 46 residents.

Findings Include:

Observation of meal service on 7/25/24 starting at 12:23 p.m., revealed the following observations:

Resident #6 received her meal try and told the aide seated next to that she could not eat the meal they served her as she cannot eat lettuce. Resident #6 received a chicken wrap with pieces of lettuce, tomato, and a pieces of chicken in the wrap. One piece was noted to be approximately half dollar size. On the plate was also potato salad and potato chips with lemon pudding in a cup next to the plate. Staff sitting next her said you're right as your diet is a mechanical soft diet. Resident #6 at this time requested a peanut butter and jelly sandwich. Staff B, Speech therapist (ST) confirmed Resident #6 was to have ground meat and a mechanical soft diet.

Resident #7 received his meal of a chicken wrap with pieces of lettuce, tomato, and pieces of chicken in the wrap with potato chips and potato salad on the plate. Resident #7 immediately began eating the potato chips on his plate. Staff B was in the dining room and was asked if Resident #7 was to have potato chips on a mechanical soft diet and she revealed no and removed the plate from the resident and requested appropriate texture from the dietary staff.

Resident #5 received her plate of a chicken wrap with pieces of lettuce, tomato and pieces of chicken in the wrap with potato chips and potato salad on the plate. Resident #5 picked up her wrap to take a bite. Staff B approached the resident and confirmed Resident #5 was a mechanical soft diet and this was not appropriate for her. Removed the meal and requested an appropriate texture meal from the dietary staff.

Review of facility provided document titled Diet Type Report revealed the following information:

a. Resident #5 diet type included a mechanical soft diet.

b. Resident #6 diet type included a mechanical soft diet with ground and moist meat.

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NAME OF PROVIDER OR SUPPLIER: Hillcrest Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2121 Avenue L Hawarden, IA 51023	

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Resident #7 diet type included a mechanical soft diet with ground meat. Review of Resident #5's Order Summary Report signed by the physician on 7/10/24 revealed a regular diet with mechanical soft texture. Review of Resident #6's Order Summary Report signed by the physician on 7/8/24 revealed a regular diet with mechanical soft texture and ground moist meats. Review of Resident #7's Order Summary Report signed by the physician on 7/8/24 revealed a regular diet with mechanical soft texture and ground meats. Interview on 7/25/24 at 1:17 p.m., with Staff B revealed if an altered diet is ordered then the diet should be followed. Interview on 7/26/24 at 8:44 a.m., with Staff C, Dietary Manager revealed on 7/25/24 she did not have enough chicken for the noon meal and she called the dietician to for substitutions so she made a decision to make chicken wraps. Staff C revealed she has only been in her position for approximately a week and half but has worked in the kitchen since April and has not had any training as a dietary manager. Interview on 7/26/24 at 2:22 p.m., with Staff D, Dietician revealed she had not been contacted on 7/25/24 by the facility for any menu changes. Staff D further revealed mechanical soft diets should not have had the chicken that was not ground or cut up lettuce. Staff D stated the mechanical soft diet residents should not be eating potato chips either. She explained that the consistency was not correct for them. Mechanical soft diets are not to have anything hard or crunchy. Interview on 7/26/24 at 10:24 a.m., with Resident #6 revealed the facility had given her the wrong food yesterday. She told the lady she could not eat it as she cannot eat lettuce. She further explained that she has told the kitchen several times she cannot eat certain foods but they send them to her anyway. Interview on 7/26/24 at 11:36 a.m., with Resident #9 revealed he had been given the wrong food yesterday and the staff took it away. Interview on 7/26/24 at 2:26 p.m., with Staff E, Certified Nursing Assistant (CNA) revealed there has been issues with the residents getting appropriate thickened liquids. CNA's usually catch it before the residents drink it. Interview on 7/26/24 at 2:54 p.m., with Staff F, CNA revealed they have been serving meals out of the kitchen and sandwiches with crust will be served to mechanical soft residents and the CNA's will catch it and take it back to have them correct the diet. Staff F further revealed they have had to correct the kitchen staff as they served a resident regular liquids when they should have been thickened liquids. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 7/26/24 at 3:03 p.m., with Staff G, CNA revealed Resident #9 was served chicken fried steak in the wrong consistency and he started to eat it and the staff had to take it away. Staff G further revealed Resident #5 had been served a tortellini dish and the staff had to tell the kitchen staff that she couldn't have it as it was the wrong consistency and that the residents are getting the wrong drinks. Some residents are thickened liquids and are not getting them and the seasoned staff have been fixing it. Review of facility provided policy titled Therapeutic Diets with a reviewed date of 5/2021 revealed the following information: a. A therapeutic diet must be prescribed by the residents attending physician. b. A tray Identification system is established to ensure that each resident receives his or her diet as ordered. c. Mechanically altered diets will be considered therapeutic diets. Interview on 7/26/24 at 12:56 p.m., with the Administrator revealed she expects all residents to receive the proper texture they are ordered.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 44474 Based on observations, resident and staff interviews and facility policy review the facility failed to provide alternatives or substitutions during meals to residents. The facility reported a census of 46 residents. Finding Include: 1. Review of the grievances provided by the facility revealed the following: a. Summary of the grievance- 4/1/24 There have been numerous residents with weight loss concerns since the change of dietary rules for residents' choice with meals. Options have been taken away from them. It's been told to the residents if its not on the menu, they can't have it This includes toast, yogurt, applesauce, pudding, eggs, ect. Steps taken to investigate- Executive Director educated staff there is a daily menu with alternative menu option as well. Summary of findings- Residents will choose between a daily menu or an alternative menu. Many choices-yogurt is also available per request. Corrective action- Education to staff about residents rights. b. Summary of the grievance- 6/14/24 Resident #1 revealed she had asked for an egg sandwich for breakfast and was told it was not on the menu. Steps taken to investigate the grievance- Talked with resident that the kitchen can only serve what is listed on the menu. Summary of findings and conclusion- Kitchen can only serve what is on the menu. Corrective action taken- It was explained to resident the dietary is only to serve what is offered on the menu. There are substitutes offered also. 2. Interview on 7/26/24 at 2:54 with Staff F, Certified Nursing Assistant (CNA) revealed Resident #17 will often request an egg sandwich or eggs on toast but is told he cannot have the meal because it is not on the menu. Staff F revealed they have to stick to the menu and only have deli sandwich, grilled cheese and chicken noodle soup as alternate options. 3. Interview on 7/26/24 at 3:46 p.m., with Resident #1 revealed she had to eat what was on the menu or an alternative and was unable to request what she wanted to eat. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided policy titled Dining and Meal Service last updated 11/2019 revealed The dining experience will be person-centered with the purpose of enhancing each individual patients or residents quality of life and being supportive of each individual's needs during dining. individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional and special dietary needs. Interview on 7/26/24 at 8:57 a.m., with the Administrator revealed there were no changes in the dietary department and they have an always available menu for the residents. When asked again the Administrator revealed they had recently changed the al la carte menu. She explained that if scrambled eggs were on the menu then that is the only egg the kitchen was going to make. When asked what if someone does not like scrambled eggs? The Administrator paused and revealed if it requested then we can make something else in a situation like that. She further revealed that had not been an option prior to this conversation. The Administor revealed this change was made to help with time management in the kitchen.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 44474 Based on observations, resident and staff interviews, and facility policy reviews the facility failed to provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. The facility identified a census of 46 residents. Findings include: 1. Observation on 7/25/24 at 12:23 p.m., the first meal was served in the dining room and the last meal was served at 1:25 p.m. 2. Interview on 7/26/24 at 11:36 a.m., with Resident #9 revealed meals are always late. They usually are about 30 minutes late. 3. Interview on 7/26/24 at 12:35 p.m., with Resident #16 revealed on 7/25/24 supper was approximately 30 minutes late. 4. Interview on 7/26/24 at 2:26 p.m., with Staff E, Certified Nursing Assistant (CNA) revealed meals lately have been about 15 minutes late. 5. Interview on 7/26/24 at 2:54 p.m., with Staff F, CNA revealed meals are usually 15 minutes late depending on the day. 6. Interview on 7/26/24 at 3:03 p.m., with Staff G, CNA revealed meals are usually late around 20 minutes but depending on who is cooking that day. Review of facility provided policy title Dining and Meal Service updated 11/2019 revealed meals in the dining room will be served at the following hours: breakfast 7:30 a.m., lunch 12:00 p.m. and dinner 5:00 p.m Interview on 7/26/24 at 8:57 a.m., with the Administrator revealed the lunch meal is to be served at noon and she expected it to be served at noon.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on observations, record review, staff interviews and policy reviews, the facility failed to provide proper hand hygiene with perineal care for 1 of 3 residents reviewed (Resident #12). The facility also failed use proper hand hygiene during dining service for 2 out of 3 residents reviewed (Resident #17 & #18) and when preparing food in the kitchen. The facility reported a census of 46 residents. Finding include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #12 documented diagnoses of non-traumatic brain dysfunction, dementia and dysphagia. The MDS documented Resident #12 totally dependent for toileting hygiene, showering and personal hygiene. The MDS showed the Brief Interview for Mental Status (BIMS) score of 01 which indicated severe cognitive impairment. On 7/27/24 at 1:20 PM observed Staff A, Certified Nursing Assistant (CNA) and Staff J, CNA removed Resident #12's pants, unfastened the brief, pulled down the brief then rolled the resident onto her left side. Staff J then held the resident's right leg while Staff A stood behind the resident, reached between the resident's legs to the front perineal area then cleansed the area by wiping from the perineal area back between the resident's legs. Staff A's arm touched areas between the resident's legs with each wipe. The resident's lateral position failed to allow proper physical and visual access to the resident's perineal area. Staff A then cleansed the right buttock and hip. Staff A removed the soiled gloves, placed the gloves on the bed, touched her scrub pants at the side pocket and thigh pocket. Staff A then opened the bathroom door to perform hand hygiene. Staff J cleansed the resident's left buttock, hip then discarded used wipes and gloves. Staff J failed to perform hand hygiene then arranged the resident's blankets, pillows and wet wipe package. Staff J then retrieved the trash bag from the receptacle, tied the bag in a knot, placed the bag on the floor then assisted Staff A to comfortably position the residents by moving the pillows and blankets. The Perineal Care policy revised May 2007 identified: 1. Position resident on back with knees bent and slightly apart. 2. Expose perineal area. 3. Wet washcloth and soap lightly. Fold into a mitt. If using another cleaning agent, use according to the manufacturer's instructions. 4. Wash pubic area, including upper, inner aspect of both thighs and front portion of perineum. A. Use long strokes from the most inner down to the base of the labia (Wash from the cleanest area to the dirtiest area). B. After each stroke, refold the washcloth to allow use of another area. 5. Follow the same sequence for the rinsing area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Dry area thoroughly. 7. Instruct or assist residents to turn on side with top leg slightly bent. 8. Rinsh cloth and soap lightly. 9. Wash the perineal area thoroughly, with each stroke beginning at the base of the labia and extending up over the buttocks. A. Refold cloth, as before, to provide a clean area. B. Washing should alternate side to side, ending with the center anal area. 10. Rinse cloth and entire area in the same sequence as above. Dry arrow thoroughly and leave residents comfortably positioned. In an interview on 7/28/24 at 10:46 AM, the Assistant Director of Nursing (ADON) reported perineal care should be performed by the resident first laying on her back for proper positioning. The ADON reported staff should follow policy when performing perineal care and hand hygiene. 44474 2. During an ongoing observation on 7/25/24 starting at 12:23 p.m., revealed Staff H, Certified Nursing Assistant was feeding Resident #17 and Resident #18. Staff H assisted Resident #17 with a bite of food and then assisted #18 with a bite of food without providing hand hygiene prior to assisting the other resident. 3. During an ongoing observation on 7/26/23 starting 12:03 p.m., revealed Staff C, Dietary Manager and Staff I, [NAME] serving meals in the kitchen. During the observation both staff were wearing gloves and multiple glove changes were occurring throughout service. Hand hygiene was not performed after each glove removal and prior to applying new gloves. Review of the facility provided policy titled Hand Washing revised 5/2007 revealed it is the policy of this Facility to cleanse hands and prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. Review of the facility provided policy titled Using Gloves revised 3/2016 revealed wash hands after removing gloves. Note gloves do not replace hand washing. Interview on 7/28/24 at 9:34 a.m., with the Administrator revealed she would expect staff to have washed their hands after removing gloves and between helping residents.