STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Derby Health & Rehabilitation, LLC	731 Klein Circle Derby, KS 67037

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 27168 The facility had a census of 61 residents. The sample included 15 residents. Based on record review and interview, the facility failed to provide Resident (R)8, R11, and R160, or their representative, the completed Centers for Medicare and Medicaid (CMS) Skilled Nursing Facility Advanced Beneficiary Notices (ABN) Form 10055. This placed the resident at risk of uninformed decisions about their skilled services. Findings included: - The Medicare ABN form 10055 informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included an option for the beneficiary to receive specific services listed, and bill Medicare for an official decision on payment. The form stated 1) I understand if Medicare does not pay, I will be responsible for payment but can make an appeal to Medicare, (2) receive therapy listed, but do not bill Medicare, I am responsible for payment for services, (3) I do not want the listed services. A review of the ABN provided to R8 revealed the resident received the wrong form. R8 received the CMS-R-131 instead of CMS Form 10055. The resident's skilled services ended on 04/05/24. A review of the ABN provided to R11 revealed the resident received the wrong form. R11 received the CMS -R-131 instead of CMS Form 10055. The resident's skilled services ended on 02/13/24. A review of the ABN provided to R160 revealed the resident received the wrong form. R160 received the CMS -R-131 instead of CMS Form 10055. The resident's skilled services ended on 02/12 /24. On 04/25/24 at 12:05 PM, Social Services X verified she had been employed at the facility for a year and the CMS-R-131 was the form she provided to R8, R11, and R160, and/or their representative, not the Form 10055. On 04/25/24 at 12:45 PM, Consultant GG verified the facility provided the CMS-R-131 form to R08, R11, and R160, and/or their representative, and failed to provide the 10055. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Medicare Denial Notices (Advance Beneficiary Notices-ABN) policy, dated March 13, 2024, recorded the facility would inform each resident before, or at the time of admission, and periodically during the resident's stay of services not covered under Medicare for the facility's per diem rate. The facility would provide each resident with a written description of legal rights which includes a description of the manner of protecting personal funds. The facility would provide written notification to residents with the necessary information to decide whether to appeal a decision to terminate Medicare care and services at least three days before the planned change in payor status or discharge. The SNFABN would provide information to the resident or representative to enable them to decide if the resident would choose to continue receiving skilled services that may not be covered under Medicare. The facility would inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for the services. The facility failed to provide R8, R11, and R160, or their representatives, the correct 10055 form when discharged from skilled care. This placed the residents at risk of uninformed decisions about their services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. 27168 The facility identified a census of 61 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to ensure residents remained free from abuse when multiple residents' medications were misappropriated. This deficient practice placed all residents who had controlled medications stored in the facility at risk for further misappropriation and impaired care related to missing or stolen medications. Findings included: - The facility's investigation report 6803 dated 04/03/24 documented on 03/25/24, Administrative Nurse E noted Resident (R)162's entire card of oxycodone (schedule II opioid pain medication with high use for misuse or addiction) five milligrams (mg) tablets were missing. The pharmacy delivered the card on 03/22/24 and it was received by Licensed Nurse (LN) H. Per the log, the card had 12 pills. The pharmacy was contacted and confirmed that on 03/22/23 at 07:00 PM, LN H received and signed for three narcotic cards including oxycodone 5 mg (12 pills), oxycodone-acetaminophen 5/325 mg (20 pills), and hydrocodone-acetaminophen (opioid pain medication mixed with Tylenol) 5/325 mg (30 pills). The report documented the facility was unable to locate the medications after a search of the medication carts in all four households was conducted. The report documented that upon identification of the missing medications, Administrative Nurse D contacted LN H via phone and LN H stated she was out of town but she remembered she received the narcotics and thought she could have accidentally placed them in the shred box with the medication labels. Administrative Nurse D verified the shred box was searched and no narcotics, labels, or narcotic sheets were found. LN H was asked to come to the facility and fill out a witness statement and stated she would come to the facility on Friday. LN H then sent a text stating she would not be back in town until the following Monday and that she would come to the facility to fill out the witness statement. On Monday 04/01/24, LN H came to the facility and filled out a witness statement, then provided a urine sample. During the investigation, it was determined the three narcotic cards that were delivered on 03/22/24 were missing along with the narcotic count sheets. The facility contacted the police department and gathered statements from the facility staff. Administrative Nurse D reported the following residents were affected by the misappropriation: R162's oxycodone 5 mg, 12 tablets. R163's oxycodone-acetaminophen 5-325 mg, 20 tablets. R164's hydrocodone-acetaminophen 5-325 mg, 30 tablets. On 04/24/24 at 08:20 AM, a review of the nurse's medication cart on the 400 house revealed the narcotic medications were stored in a locked metal box affixed to the medication cart, which was also locked when not in use. On 04/30/24 at 08:10 AM, a review of the nurse's medication cart on the 100 house revealed the narcotic medications were stored in a locked metal box affixed to the medication cart, which was also locked when not in use. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/30/24 at 08:20 AM, a review of the nurse's medication cart on the 200 house revealed the narcotic medications were stored in a locked metal box affixed to the medication cart, which was also locked when not in use. On 04/30/24 at 08:30 AM, a review of the nurse's medication cart on the 300 house revealed the narcotic medications were stored in a locked metal box affixed to the medication cart, which was also locked when not in use. On 04/30/24 at 11:00 AM, Administrative Nurse D stated the staff were to receive the narcotic medications and place them in the medication room or cart and a narcotic count sheet would also be in the narcotic book along with the narcotic medication. Administrative Nurse D stated the residents in the facility were to remain free of all forms of abuse, neglect, and exploitation. The facility's Abuse, Neglect and Exploitation policy, undated, documented the facility had developed and implemented the policy and procedure to prohibit mistreatment, neglect, and abuse of all elders and misappropriation of elder property by any perpetrator including but not exclusive to; any staff member other elders. exploitation means misappropriation of elder property or intentionally taking unfair advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or pretense by a caretaker or another person. Facility staff will not use or allow others to use; verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. The policy is to ensure that all elders of the facility would be free of physical, emotional, and sexual abuse, neglectful treatment, and misappropriation of funds. The facility failed to ensure residents remained free from abuse when multiple residents' medications were misappropriated. This deficient practice placed all residents who had controlled medications stored in the facility at risk for further misappropriation, abuse, and lack of pain care management related to missing or stolen medications.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 26768 The facility had a census of 61 residents. The sample included 15 residents. Based on observation, interview, and record review the facility failed to ensure hazardous chemicals were stored safely. This placed the five residents identified by the facility as cognitively impaired and independently mobile at risk for accidents and hazard-related injuries. Findings included: - On 04/24/24 at 08:13 AM, observation in the 300-household revealed an unlocked housekeeping closet with the following hazardous items with Keep out of reach of children instructions stored on a waist-high shelf: One small can of fiberglass resin. One quart bottle of tile sealer. One spray bottle of ant killer. One spray can of ant and roach killer. On 04/24/24 at 08:15 AM, Certified Nurse Aide (CNA) M verified the findings. On 04/24/24 at 09:01 AM, Administrative Nurse D verified staff should ensure housekeeping closets were locked when not under supervision. The facility's Chemical Storage policy, dated 03/12/24, stated all chemicals that are deemed hazardous to residents would be stored in a locked area or used under supervision. This was defined as any chemical that would cause harm or stated to keep away from children. The facility failed to ensure hazardous chemicals were stored safely, placing the five residents identified by the facility as cognitively impaired and independently mobile at risk for injury.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 61 residents. The sample included 15 residents of which two were reviewed for the gastrostomy tube (G-tube: surgical creation of an artificial opening into the stomach through the abdominal wall) feeding management. Based on observation, record review, and interview, the facility failed to provide G-tube care per the physician's orders for Resident (R)41 when staff failed to administer the required amount of water prior to the nutritional feeding through the G-tube. This placed the resident at risk for G-tube related complications. Finding included: - R41's Electronic Health Record (EHR) revealed diagnosis of dysphasia (swallowing difficulty), cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R41's Quarterly Minimum Data Set (MDS), dated [DATE], documented R41 had moderately impaired cognition. R41 was dependent on staff for toileting, dressing, and personal hygiene. R41 was dependent on staff for mobility and transfers. The MDS recorded the resident had a feeding tube. R41's Care Plan, dated 02/02/24, recorded R41 required a tube feeding for nutritional maintenance. The plan directed the staff to administer tube feedings of Jevity 1.5 (nutritional liquid supplement), one carton four times a day, per G-tube with water flushes of 45 milliliters (ml) before and after feedings. The care plan recorded staff would monitor R41's weight and make nutritional interventions as needed. R41's Physician Order. dated 01/17/23, directed the staff to administer Jevity liquid, one carton through the tube four times a day; provide 45 ml water flush before and after feedings, with an additional 175 ml free water six times a day. On 04/29/24 at 12:00 PM, observation revealed Licensed Nurse (LN) G administered one carton of Jevity through the G-tube followed by 45 ml of water. LN G did not administer the 45 ml water flush prior to administering the medications and feeding, per the physician's order. On 04/29/24 at 02:00 PM, Consultant GG verified the nursing staff should administer the water flushes before and after the nutritional feeding per R41's physician's order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Enteral Nutrition policy, dated 02/07/2022, documented the staff would provide the residents with enteral feedings to provide nutrients and fluids using the gastrointestinal tract to provide an individual's nutritional needs. The policy documented that the bolus route required that the resident had a functioning stomach that could handle a larger amount of fluid infused at one time the resident's tolerance. The policy documented the formula is administered using a 60 ml syringe and given at a rate based on the nutritional feeding order would contain the name of the formula, flow rate, hours of administration, route of administration and total ml to be delivered per 24-hour period with additional water to meet hydration needs to be given via free water flush. The facility failed to flush R41's G-tube with 45 ml of water, before a nutritional feeding as ordered, placing the resident at risk for complications related to the G-tube.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 61 residents. The sample included 15 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to ensure the Consultant Pharmacist identified and reported Resident (R) 47's blood pressure medication administered outside the physician-ordered blood pressure parameters. This deficient practice placed R47 at risk for unnecessary medications and related complications. Findings included: - R47's Electronic Medical Record (EMR) documented diagnoses including end-stage renal disease (ESRD-a terminal disease of the kidneys), atrial fibrillation (rapid, irregular heartbeat), and hypocalcemia (abnormally low level of calcium in the blood). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R47 required supervision for eating and was dependent on staff assistance for toileting, bathing, and dressing. R47 received antianxiety (a class of medications that calm and relax people) and opioid (narcotic) medications. R47's Care Plan dated 03/29/24 directed staff to provide one or two-person assistance for activities of daily living. The plan documented R47 received hemodialysis (a procedure where impurities or wastes were removed from the blood) on Mondays, Wednesdays, and Fridays and received high-risk medications. The Physician Order, dated 04/05/24, directed staff to administer midodrine (a drug used to treat low blood pressure),10 milligrams (mg), three times daily. Hold if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was greater than (>)130. R47's EMR recorded the following blood pressures which exceeded the ordered parameter and the midodrine was incorrectly administered: 04/07/24 at 08:06 am, 139/83 millimeters (mm) of mercury (Hg) 04/07/24 at 09:28 PM, 132/83 mm/Hg 04/08/24 at 09:24 AM, 132/83 mm/Hg 04/13/24 at 10:56 AM, 145/79 mm/Hg 04/14/24 at 08:37 AM, 141/85 mm/Hg 04/14/24 at 08:58 PM, 172/119 mm/Hg 04/15/24 at 07:33 AM, 143/84 mm/Hg (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/16/24 at 07:30 AM, 141/84 mm/Hg 04/18/24 at 09:07 AM, 138/84 mm/Hg 04/18/24 at 09:49 PM, 141/83 mm/Hg 04/19/24 at 11:33 AM, 146/79 mm/Hg 04/21/24 at 10:16 PM, 138/70 mm/Hg 04/22/24 at 10:10 AM, 138/84 mm/Hg 04/23/24 at 08:19 AM, 135/85 mm/Hg 04/23/24 at 08:59 PM, 137/81 mm/Hg 04/24/24 at 04:46 PM, 136/80 mm/Hg 04/25/24 at 09:07 AM, 139/80 mm/Hg The Progress Note, dated 04/22/24, stated the Consultant Pharmacist medication review stated available chart data was reviewed and no significant irregularities were noted. The recommendation indicated to refer to the nursing recommendation. The Physician Assistant Note, dated 04/23/24, stated R47 was seen that day. The report did not mention anything regarding R47's midodrine or blood pressure. R47's EMR lacked evidence the physician was notified of the midodrine administration outside of physician-ordered parameters. The Pharmacist Recommendation Report for 04/01/24 to 04/23/24 stated, Please review recent Medication Administration Record/Treatment Administration Record (MAR/TAR) for potential holes. The patient's midodrine order currently includes a hold parameter. Please add the blood pressure assessment and documentation to the MAR for this medication. The report lacked comment on the administration of midodrine when the SBP was out of the ordered parameters. On 04/25/24 at 09:17 AM, observation revealed R47 in bed eating breakfast. Certified Medication Aide (CMA) R administered medications, including 10 mg midodrine, to R47. CMA R gave the pills whole in applesauce and when asked what R47's blood pressure was, CMA R stated at 09:07 AM R47's blood pressure was 139/80 mm/Hg. On 04/24/24 at 01:25 PM, CMA R stated if R47's SBP was greater than 130, staff were to hold the midodrine. CMA R verified she should have held R47's midodrine because R47's SBP was 139. On 04/25/24 at 01:31 PM, Administrative Nurse E verified staff were to hold R47's midodrine if the SBP was greater than 130. She verified staff had administered the midodrine when they should have held it numerous times. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/24 at 09:27 AM, Administrative Nurse E verified the consultant pharmacist had not noted the midodrine error in the monthly review. On 04/29/24 at 12:51 PM, Administrative Nurse D stated she expected the CP to note the administration of midodrine when a SBP was out of the parameters and bring it to her and the physician's attention. The Consultant Pharmacist Services Provider Requirements policy, dated 03/13/24, stated the consultant pharmacist provides pharmaceutical care services including: Reviewing the medication regimen of each elder at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the elder's clinical record. Communication of the potential or actual problems detected related to medication therapy orders to the responsible physician and the director of nursing. Reviewing the MARS and physician orders monthly at the facility to ensure proper documentation of medication orders and administration of medication to elders. Communicating recommendations for changes in medication therapy and monitoring of medication therapy. Submitting a written report of findings and recommendations resulting from the review. The facility failed to ensure the CP identified and reported the administration of midodrine when staff should have held it, placing the resident at risk for unnecessary medications and related complications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 61 residents. The sample included 15 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to hold Resident (R) 47's blood pressure medication per the physician-ordered blood pressure parameters. This deficient practice placed R47 at risk for unnecessary medications and related complications. Findings included: - R47's Electronic Medical Record (EMR) documented diagnoses including end-stage renal disease (ESRD-a terminal disease of the kidneys), atrial fibrillation (rapid, irregular heartbeat), and hypocalcemia (abnormally low level of calcium in the blood). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R47 required supervision for eating and was dependent on staff assistance for toileting, bathing, and dressing. R47 received antianxiety (a class of medications that calm and relax people) and opioid (narcotic) medications. R47's Care Plan dated 03/29/24 directed staff to provide one or two-person assistance for activities of daily living. The plan documented R47 received hemodialysis (a procedure where impurities or wastes were removed from the blood) on Mondays, Wednesdays, and Fridays and received high-risk medications. The Physician Order, dated 04/05/24, directed staff to administer midodrine (a drug used to treat low blood pressure),10 milligrams (mg), three times daily. Hold if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was greater than (>)130. R47's EMR recorded the following blood pressures which exceeded the ordered parameter and the midodrine was incorrectly administered: 04/07/24 at 08:06 am, 139/83 millimeters (mm) of mercury (Hg) 04/07/24 at 09:28 PM, 132/83 mm/Hg 04/08/24 at 09:24 AM, 132/83 mm/Hg 04/13/24 at 10:56 AM, 145/79 mm/Hg 04/14/24 at 08:37 AM, 141/85 mm/Hg 04/14/24 at 08:58 PM, 172/119 mm/Hg 04/15/24 at 07:33 AM, 143/84 mm/Hg 04/16/24 at 07:30 AM, 141/84 mm/Hg (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/18/24 at 09:07 AM, 138/84 mm/Hg 04/18/24 at 09:49 PM, 141/83 mm/Hg 04/19/24 at 11:33 AM, 146/79 mm/Hg 04/21/24 at 10:16 PM, 138/70 mm/Hg 04/22/24 at 10:10 AM, 138/84 mm/Hg 04/23/24 at 08:19 AM, 135/85 mm/Hg 04/23/24 at 08:59 PM, 137/81 mm/Hg 04/24/24 at 04:46 PM, 136/80 mm/Hg 04/25/24 at 09:07 AM, 139/80 mm/Hg The Physician Assistant Note, dated 04/23/24, stated R47 was seen that day. The report did not mention anything regarding R47's midodrine or blood pressure. R47's EMR lacked evidence the physician was notified of the midodrine administration outside of the physician-ordered parameters. On 04/25/24 at 09:17 AM, observation revealed R47 in bed eating breakfast. Certified Medication Aide (CMA) R administered medications, including 10 mg midodrine, to R47. CMA R gave the pills whole in applesauce and when asked what R47's blood pressure was, CMA R stated at 09:07 AM R47's blood pressure was 139/80 mm/Hg. On 04/24/24 at 01:25 PM, CMA R stated if R47's SBP was greater than 130, staff were to hold the midodrine. CMA R verified she should have held R47's midodrine because R47's SBP was 139. On 04/25/24 at 01:31 PM, Administrative Nurse E verified staff were to hold R47's midodrine if the SBP was greater than 130. She verified staff had administered the midodrine when they should have held it numerous times. The facility's Medication Administration policy, dated 03/14/24, stated staff were to document and follow holding or notification parameters for ordered medications. The facility failed to hold a blood pressure medication per the physician-ordered parameters, placing R47 at risk for unnecessary drugs and related complications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Derby Health & Rehabilitation, LLC	731 Klein Circle Derby, KS 67037

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26768 The facility had a census of 61 residents. Based on observation, interview, and record review the facility failed to store, prepare, and serve food in a sanitary manner for residents in two of four kitchens and dining rooms. This deficient practice placed residents at risk for food-borne illness. Findings included: - On 04/24/24 at 09:07 AM, observation in the 100-household kitchen freezer revealed a bag of chicken tenders, undated, and a box of hamburger patties opened, and the plastic bag torn leaving the patties open to air. On 04/24/24 at 12:17 PM, observation in the 300-household dining room revealed Certified Nurse Aide (CNA) M served plated food to residents. CNA M touched a resident's shoulders and chair, rubbed his face, and did not wash or sanitize his hands before serving more residents' plates. CNA M wiped his hands on his clothing, scratched his hair rubbed his face numerous times, and continued serving all 12 residents in the dining room without washing or sanitizing his hands. On 04/24/24 at 02:15 PM, observation of the 100 and 300 household kitchens revealed both kitchen toasters had numerous dried crumbs on top and edges, and both oven doors had dried food spills. On 04/29/24 at 12:10 PM, observation of the dining room service in 200-household revealed two staff served residents' meals. CNA M scratched his head and beard, rubbed his eyes, and did not wash or disinfect his hands before handling the residents' coffee cups or glasses. The April 14-20/2024 Cleaning Schedule directed staff to clean the toaster and microwave daily, and the ovens weekly. Staff had initialed as completed cleaning of the toasters and microwave in three days but not the oven. On 04/24/24 at 09:07 AM, Dietary Staff BB verified the findings in the freezers and stated staff were to date items when opened. On 04/24/24 at 02:15 PM, Dietary Staff BB verified the ovens and toasters should have been cleaned. On 04/29/24 at 12:32 PM, DM BB verified staff should wash or disinfect their hands if they have touched their hair or face and clothing before serving residents beverages and meals. The facility's Food Preparation and Sanitation policy, dated 03/14/24, stated any food handlers would perform hand hygiene regularly after touching ears, nose, mouth, or hair. The Dietary Food Storage policy, dated 03/13/24, stated all food items should be labeled with the name and discard date. The policy directed staff to wrap food properly and never leave any food item uncovered and not labeled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Some	The facility's Sanitation of Dining and Food Service Areas policy, dated 03/13/24, stated a cleaning schedule would be posted for all cleaning tasks and would be held responsible for all cleaning tasks. The facility failed to serve food in a sanitary manner for residents in two of the dining rooms and kitchens, placing the residents at risk for food-borne illness.