STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195310	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Many Healthcare and Rehabilitation Center	120 Natchitoches Hwy 6 East Many, LA 71449

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51082 Based on record review and interview the facility failed to notify the Ombudsman in writing of resident transfer/discharge for 1 (#71) out of 1 resident reviewed for discharge. The total sample size was 29. Findings: Review of the facility's policy titled Transfer or Discharge Notice with a review date of 01/2023 read in part . Residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge. 6. A copy of the notice is sent to the Office of the State Long Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. Record Review of Resident #71's Electronic Health Record (EHR) revealed an admitted [DATE] and a discharge date of [DATE]. Resident #71 had diagnoses that included in part .Displaced Comminuted Fracture of Shaft of Right Femur; Subsequent encounter for Closed Fracture with routine healing; Muscle Weakness; Primary Osteoarthritis other specified site; Unilateral Primary Osteoarthritis, Right Knee; Cognitive Communication Deficit; Age-Related Osteoporosis without current pathological fracture; Anxiety Disorder. Record Review of Resident #71's Discharge MDS with an ARD of 12/10/2024 revealed a discharge date of [DATE]. Record Review of Resident #71's EHR revealed no documentation that the Ombudsman had been notified of Resident #71's discharge to another facility on 12/10/2024. Interview on 01/14/2025 at 2:26 p.m. with S5 Social Services Director (SSD) revealed Resident #71 was discharged to a behavioral hospital due to an increase in behaviors. S5 SSD stated S6 Business Office Manager was responsible for sending notification of transfers and discharges to the Ombudsman. Interview on 01/14/2025 at 2:29 p.m. with S6 Business Office Manager confirmed she did not submit in writing to the Ombudsmen a notification of Resident #71's discharge. Interview on 01/14/2025 at 2:49 p.m. with S3 Corporate RN confirmed the facility should submit a notification in writing to the Ombudsmen of resident transfers and discharges, but did not.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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** 51082 Based on record review and interview, the facility failed to refer a resident with a newly diagnosed mental disorder to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for 1 (#5) of 1 residents investigated for PASARR in a final sample of 29 residents. Findings: Record Review of Resident #5's medical record revealed he was admitted to the facility on [DATE] with diagnoses that included in part .Major Depressive Disorder, Anxiety Disorder, Cerebral Infarction without residual deficits, Vascular Dementia Unspecified Severity without Behavioral Disturbance. Further review revealed he was diagnosed with Schizoaffective Disorder on 10/10/2023. Record Review of Resident #5's Quarterly MDS with an ARD of 01/30/2025 revealed a BIMS summary score of 99, indicating BIMS was unable to be completed. Record Review of the Resident #5's Care Plan with a Target Date of 01/22/2025 revealed in part .The resident had the potential to be verbally aggressive, yelling at staff, cursing at staff (initiated 10/09/2023). Interventions: Psychiatric/Psychogeriatric consult as indicated. Administer medications as ordered. Monitor/document for side effects and effectiveness. The resident uses psychotropic medications (initiated 10/09/2023). Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness. Monitor/record occurrence of for target behavior symptoms and document per facility protocol. Further review of Resident #5's record revealed there was no evidence that a new review or a Level II PASARR had been submitted to the appropriate state-designated authority after the new diagnosis of Schizoaffective Disorder on 10/10/2023. Interview on 01/13/2025 at 12:40 p.m. with S5 Social Services Director revealed she was responsible for sending referrals to the appropriate state-agencies for Level II PASARR evaluations. After review of Office of Behavioral Health (OBH) PASRR Level II Resident Review Form, S5 Social Services Director stated Resident #5 didn't meet criteria for a Level II PASARR evaluation. Interview on 01/13/2025 at 2:37 p.m. with S5 Social Services Director reviewed Resident #5's diagnoses list and confirmed Resident #5 had a diagnosis of Schizoaffective Disorder on 10/10/2023. S5 Social Services Director confirmed the OBH PASRR Level II Resident Review Form that was submitted for Resident #5 was incorrect, and a Level II PASARR evaluation should have been submitted, but was not.

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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** 51096 Based on observation, record review and interview the facility failed to ensure the implementation of a comprehensive person centered care plan for 1 (Resident #44) of 29 sampled residents. The facility failed to ensure Resident #44's NPO status was implemented. Findings: Review of Resident #44's clinical record revealed an admitted [DATE], with diagnoses which included dysphagia-oropharyngeal phase; hemiplegia and hemiparesis following cerebral infarction protein-calorie malnutrition; dysphasia following other cerebrovascular disease; dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; adult failure to thrive and age-related physical debility. Review of Resident #44's Quarterly MDS with an ARD of 11/12/2024, revealed a BIMS score of 4. Resident had severe cognitive impairment. Resident had impairment on both sides for upper and lower extremities. Resident was dependent for eating, oral hygiene, toileting, showering/bathing; lower/upper body dressing and personal hygiene. Review of Resident #44's physician's order with a start date of 11/06/2024, read in part NPO diet, NPO texture, NPO consistency. Review of Resident #44's Care Plan revealed in part The resident requires tube feeding, NPO. Interventions to include: *****NPO**. Review of Resident #44's Tasks revealed a Kardex that read in part . Level of Staff assistance during care: Resident is nothing by mouth for swallowing. Eating/Nutrition: *****NPO**. Observation of Resident #44 on 01/13/2025 at 10:28 a.m. revealed Resident #44 in bed; Grey water pitcher with a straw noted on Resident #44's bedside table. Interview with S10 LPN on 01/13/2025 at 10:36 a.m. revealed that if Resident #44 requested anything by mouth; she would explain to Resident #44 that she was NPO. Interview with S9 CNA on 01/13/2025 at 10:41 a.m. revealed S9 CNA provided Resident #44 with small swallows of water when she goes in to check on Resident #44. S9 CNA stated that the water pitcher in Resident 44's room is used for sips of water. S9 CNA stated that she would ask the nurse if a resident was not able to have anything by mouth. Observation and Interview with S10 LPN on 01/13/2025 at 2:29 p.m. revealed that S9 CNA was aware that she should not have been giving Resident #44 anything by mouth to include water. S10 LPN stated that she was unsure of why the grey pitcher with a straw was in Resident #44's room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with S2 DON on 01/13/2025 at 2:50 p.m. confirmed that Resident #44 should not have been given sips of water since she was NPO and that there should not have been a water pitcher with a straw on her bedside table. S2 DON also stated that CNA's are aware of resident status by checking the Kiosk.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44844 Based on observation, record review and interview, the facility failed to ensure services were provided to meet professional standards of practice for 1 (Resident #46) of 29 sampled residents. The facility failed to ensure medications were administered safely and timely by leaving Resident #46's medications at her bedside. Findings: Review of the facility's policy titled Medication Administration dated 07/08/2024 revealed in part .Medications are administered in a safe and timely manner, and as prescribed. Review of Resident #46's medical record revealed an admitted [DATE] with diagnoses that included in part . Bilateral Primary Osteoarthritis, Morbid (severe) Obesity, Bipolar Disorder, Obstructive Sleep Apnea, Unspecified Myalgia, Repeated Falls, Chest Pain and Edema. Review of Resident #46's Quarterly MDS with an ARD of 10/22/2024 revealed a BIMS score of 15 which indicated intact cognition. The MDS revealed Resident #46 required supervision for: Bed mobility, Transfer, Eating and Toilet use. Review of Resident #46's care plan with a target date of 04/09/2025 revealed the resident has frequent health complaints with interventions that included administer medications as ordered. Observation and interview on 01/12/2025 at 9:41 a.m. revealed Resident #46 lying in bed. Resident #46 noted to have a cup of medicine sitting on her bed side table. Resident #46 revealed the medications in the cup were her morning medications that the nurse had left for her to take. Resident #46 revealed she had fallen back asleep before she could take her medications. Observation and interview on 01/12/2025 at 9:48 a.m. with S8 LPN in Resident #46's room confirmed the medications left on Resident #46's bed side table in a medicine cup were her morning medications. S8 LPN confirmed she did not ensure Resident #46 had swallowed her medications before she left Resident #4's room, but she should have. Review of Resident #46's January 2025 Medication Administration Record with S8 LPN revealed the following medications were left at Resident #46's bedside: 1. Cranberry Oral Tablet 450 MG PO-8:00 a.m. 2. Effexor XR 75 MG (antidepressant) PO-8:00 a.m. 3. Ezetimibe 10 MG (cholesterol lowering) PO-8:00 a.m. 4. Loratadine 10 MG (antihistamine) PO-8:00 a.m. 5. Eliquis 2.5 MG (anticoagulant) PO-8:00 a.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Lasix 40 MG (diuretic) PO-8:00 a.m. 7. Lyrica 100 MG (anticonvulsant) PO-8:00 a.m. 8. Preservision AREDS 2 Capsules (vitamin and mineral) PO-8:00 a.m. Interview on 01/13/2025 at 10:25 a.m. with S2 DON confirmed it was the expectation of nurses and nursing standards, that nurses ensure residents swallow their medications and not leave them at the resident's bedside.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51082 Based on interview and record review the facility failed to document a Discharge Summary when a resident was discharged from the facility for 1 (#71) out of 1 residents reviewed for discharge. The total sample size was 29. Findings: Review of the facility's policy titled Transfer or Discharge Documentation and Notice with a review date of 01/2023 read in part . When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Record Review of Resident #71's Electronic Health Record (EHR) revealed an admitted [DATE] and a discharge date of [DATE]. Resident #71 had diagnoses that included in part .Displaced Comminuted Fracture of Shaft of Right Femur; Subsequent encounter for Closed Fracture with routine healing; Muscle Weakness; Primary Osteoarthritis other specified site; Unilateral Primary Osteoarthritis, Right Knee; Cognitive Communication Deficit; Age-Related Osteoporosis without current pathological fracture; Anxiety Disorder. Record Review of Resident #71's Discharge MDS with an ARD of 12/10/2024 revealed a discharge date of [DATE]. Record Review of Resident #71's departmental progress notes read in part . 12/10/2024 4:50 pm General Nurses Note: Resident accepted by facility . S2 DON notified, notified Resident #71's responsible party (RP), and Physician . awaiting pick up from ambulance service. 12/10/2024 6:25 p.m. General Nurses Note: Resident #71 left out of facility via ambulance, Resident #71 left in stable condition via stretcher. Gave report to LPN, and notified Resident #71's RP and S2 DON of resident departure from facility. 12/10/2024 8:23 p.m. Social Services Note: Resident #71 discharged . Record Review of Resident #71's EHR and paper medical record revealed no documentation of a discharge summary completed. Interview on 01/14/2025 at 2:42 p.m. with S2 DON accompanied with S3 Corporate RN confirmed a discharge summary should have been completed for Resident #71, but was not.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47004 Based on record review and interview, the facility failed to complete an annual performance review of every certified nurse aide (CNA) at least once every 12 months for 4 (S11 CNA, S12 CNA, S13 CNA, and S14 CNA) of 5 (S11 CNA, S12 CNA, S13 CNA, S14 CNA, and S15 CNA) CNA personnel records reviewed. Findings: Review of CNA personnel records revealed the following: S11 CNA- date of hire was on 09/15/2023. Further review failed to reveal evidence that an annual performance review had been completed and/or signed off by department head in the past 12 months. S12 CNA-date of hire was on 11/21/2023. Further review failed to reveal evidence that an annual performance review had been completed and/or signed off by department head in the past 12 months. S13 CNA-date of hire was on 02/01/2023. Further review failed to reveal evidence that an annual performance review had been completed and/or signed off by department head in the past 12 months. S14 CNA-date of hire was on 04/26/2023. Further review failed to reveal evidence that an annual performance review had been completed and/or signed off by department head in the past 12 months. Interview on 01/14/2025 at 12:00 p.m. with S1 Administrator revealed all employees should have yearly performance evaluations completed. Telephone interview on 01/14/2025 at 12:06 p.m. with S4 Corporate HR confirmed all employees should have performance evaluations completed yearly. Interview on 01/14/2025 at 2:12 p.m. with S1 Administrator confirmed the performance evaluations were not completed for S11 CNA, S12 CNA, S13 CNA, and S14 CNA as required, but should have been.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 47004 Based on observation and interview the facility failed to post nurse staffing information on a daily basis that included the resident census, and total number and actual hours worked by RNs, LPNs and CNA staff directly responsible for resident care per shift. The facility census was 70. Findings: Observation on 01/12/2025 at 8:40 a.m. revealed a form for daily staffing dated 01/10/2025 was posted on a bulletin board near the nurse's station. Complete daily staffing information including census, and total number and actual hours worked by nursing staff were not posted for 01/10/2025, 01/11/2025, and 01/12/2025. Observation on 01/12/2025 at 9:06 a.m. revealed the posted daily staffing forms remained not updated for 01/10/2025, 01/11/2025, and 01/12/2025. Interview with S16 RN and S17 LPN at time of observation revealed they were unsure who was responsible for completing and posting the daily staffing hours over the weekend. S16 RN and S17 LPN confirmed the facility had not posted daily nurse staffing information on a daily basis, but should have. Interview on 01/12/2025 at 9:33 a.m. with S1 Administrator confirmed nurse staff information including daily required and provided hours should have been posted daily over the weekend, but had not.

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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. 51096 Based on observation, interview and record review the facility failed to meet the nutritional needs of Residents in accordance with established national guidelines. The facility failed to follow the menu in regards to recipe and portion size to ensure nutritional adequacy of the meal for 6 (#57, #41, #4, #1, #36 and #23) of 6 residents (#57, #41, #4, #1, #36 and #23), who received pureed diets. Review of the facility's recipe book located in the kitchen for pureed diets revealed in part . P/PU4 (coded for pureed foods-no lumps, require no chewing). Beef Meatballs f/Frz (fresh/frozen) w/mushroom gravy. [NAME] Method: Puree; Serving Utensil: #8 scoop; Serving Size: 1/2 Cup. Preparation Step: IDDSI (International Dysphagia Diet Standardization Initiative) Pureed foods: The number of portions served should equal the same number of portions pureed. Use Fork-Drip and Spoon-tilt test to ensure proper PU4 consistency is reached. Potato Mashed f (fresh)/ Inst (instant) Mix (Mashed Potatoes). Serving Utensil: #8 scoop; serving size: 1/2 cup. Ingredients: Water, Tap (Boiled) and Potato, Mashed Flake Dry. Preparation Step: Prepare mashed potatoes according to package instructions. 1.Observation of preparation of the pureed lunch meal, and interview of S18 [NAME] on 01/12/2025 at 10:35 a.m., revealed the following: The pureed meal preparation consisted of Meatballs, Mashed Potatoes and [NAME] Gravy. S18 [NAME] stated that she was told to just make it look like baby food. S18 [NAME] was observed to add an unmeasured amount of cold tap water from the sink, and an unmeasured amount of the meatballs, in the food processor. S18 [NAME] paused the food processor to check the consistency of the meatballs, and then added more meatballs. S18 [NAME] stated that she was unaware of the amount of meatballs that had been added. S18 [NAME] did not follow a recipe to prepare the food items, and stated that she was unaware of a recipe binder for pureed food preparation. S18 [NAME] stated that she was told to just make it look like baby food. S18 [NAME] stated that there were 6 residents who received a pureed diet. Observation of S18 [NAME] prepare the mashed potatoes revealed there were preparation instructions on the bag; however, S18 [NAME] added an unmeasured amount of instant mashed potatoes to boiling water until the potatoes reached the consistency she preferred and S18 [NAME] used the same process for preparing the brown gravy mix. Interview on 01/12/2025 at 10:50 a.m. with S7 Dietary Manager, confirmed that S18 [NAME] did not refer to the recipe for the P/PU4 diet prior to preparing the food, and confirmed that S18 [NAME] did not prepare the pureed items correctly. 2. Observation of the lunch meal service on 01/12/2025 at 12:10 p.m., revealed the P/PU4 diet of beef meatballs were not served with a #8 scoop (1/2 cup or 4 ounces). S18 [NAME] used a yellow scoop that measured 1 and 5/8 oz., served one meal tray that was to have 2oz of meat per the resident's meal card and changed to a green scoop that measured 2 and 2/3 oz. after S7 Dietary manager informed her of the incorrect utensil size. Interview on 01/12/2025 at 12:26 p.m. with S7 Dietary Manager confirmed that the pureed meal item was served using the incorrect serving size utensil, and that they should have used the utensil designated on the posted print out titled NSF Certified Dishers, that contained color coded utensil serving measurements.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51096 Based on observation and interview the facility failed to store and prepare food under sanitary conditions in accordance with professional standards of food service safety, as evidenced by failing to: 1. Properly store food items located in the facility's refrigerator, freezer, resident dining area, and kitchen area. 2.Store clean dishes in an area that would remain free of food debris. 3. Monitor and record the temperatures of a refrigerator that was used to store prepared meal items for residents, from [DATE] to current ([DATE]). 4.Test and document the dishwasher's sanitizing solution concentration for dinner dishes on [DATE] and [DATE], and breakfast dishes on [DATE]. 5.Ensure dietary staff wore proper hair covering. Findings: Review of the facility's policy dated ,d+[DATE], and titled Refrigerators and Freezers, read in part . Policy Statement: This facility will ensure safe refrigerator temperatures, and sanitation, and will observe food expiration guidelines. Policy Interpretation and Implementation: 2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. 4. Food Service Supervisors, or designated employees will check and record refrigerator and freezer temperatures daily with first opening, and at closing in the evening. 7. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. 8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired, or past perish dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy dated ,d+[DATE], and titled Food Receiving and Storage read in part . Policy Statement: Food shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: 1. Food Services, or other designated staff, will maintain clean food storage areas at all times. 7. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). 12. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the food and nutrition services manager or designee, and documented according to state - specific requirements. c. Refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines. Review of the facility's policy dated ,d+[DATE], and titled Food Preparation and Service read in part . Policy Statement: Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: Food Preparation Area 6. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Review of the facility's policy dated ,d+[DATE], and titled Dry Storage read in part . 4. If a food is taken out of the original container (what the manufacturer placed the product in) it must be labeled and dated. 11. Bags of bread products should be closed and dated with the date that it was opened. 12. All bins for storage must be emptied and cleaned before new food can be added. After the bin has been cleaned and dried, it should be dated with the date that it is filled. Review of the facility's policy dated ,d+[DATE], and titled Sanitization read in part . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195310	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Many Healthcare and Rehabilitation Center	120 Natchitoches Hwy 6 East Many, LA 71449

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Statement: The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation: 1. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary . Review of the facility's policy dated ,d+[DATE], and titled Dishwashing Machine Use read in part . Policy Statement: Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. Policy Interpretation and Implementation: 5. A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution after filling the dishwashing machine, and once a week thereafter. Concentrations will be recorded in a facility approved log. Observation of refrigerated items, and interview with S18 [NAME] during the initial tour of the kitchen that began on [DATE] at 8:58 a.m., revealed 3 sticks of butter that had been removed from the packaging, and was not dated; 1 stick of butter opened, and undated; sausage links unsealed; a gallon size jar of Italian dressing open and undated; 1 pack of turkey sandwich meat, undated; a clear liquid substance in the bottom a silver container that contained the opened turkey sandwich meat and other unopened sandwich meats; and a bottle of liquid garlic opened and undated. Observation of the Freezer during the initial tour of the kitchen that began on [DATE] at 8:58 a.m., revealed 4 bags of frozen spinach that had been removed from the box and was undated; 6 bags of frozen red potatoes that had been removed from the box, and was undated; 7 packages of whipped topping that had been removed from the box and was undated; 1 bag of frozen chicken wings opened and undated; 1 package of Shrimp opened and undated; 1 box of frozen pie dough unsealed and undated with a Best By date of [DATE]; 1 box of frozen pie dough undated with a Best By date of [DATE]; 1 box of cookie dough unsealed and undated; 5 bags of frozen cauliflower that had been removed from the box and was undated; 6 bags of frozen vegetable blend that had been removed from the box and was undated. Observation in the kitchen area on [DATE] at 9:30 a.m. with S7 Dietary Manager revealed hamburger buns on the prep area table, opened and undated; pan lids located under the steam table, dirtied with food particles; a box of bananas stored under the kitchen mixer right next to a trash can; and an apple juice dispensing carton opened and uncovered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the resident dining area on [DATE] at 9:45 a.m., revealed a black refrigerator with no thermometer in the freezer area that held ice cream used for resident consumption, and prepared meal items in the refrigerated area to include puddings, and a red juice for today's lunch meal, with no temperature log observed at that time. Observation revealed 4 loaves of sandwich bread and 2 bags of rolls that were located on the shelving unit, and had been removed from the original container and was undated; a box of Kellogg's cereal that was opened, unsealed and undated. Interview with S7 Dietary Manager on [DATE] at 10:00 a.m. confirmed that in the refrigerator there were 3 sticks of butter that had been removed from the packaging, and were undated; 1 stick of butter that had been opened, and was undated; 1 package of sausage links were unsealed; a big jar of Italian dressing was opened and undated; 1 pack of turkey sandwich meat, was undated; and that there was a clear liquid substance in the bottom of the silver container that contained the undated turkey sandwich meat and other unopened sandwich meats; and that a bottle of liquid garlic was opened and undated. S7 Dietary Manager confirmed that in the freezer, there were 4 bags of frozen spinach that had been removed from the box and was undated; 6 bags of frozen red potatoes that had been removed from the box, and was undated; 7 packages of whipped topping that had been removed from the box and was undated; 1 bag of frozen chicken wings opened and undated; 1 package of Shrimp opened and undated; 1 box of frozen pie dough unsealed and undated with a Best By date of [DATE]; 1 box of frozen pie dough undated with a Best By date of [DATE]; 1 box of cookie dough unsealed and undated; 5 bags of frozen cauliflower that had been removed from the box and was undated; 6 bags of frozen vegetable blend that had been removed from the box and was undated. S7 Dietary Manager stated that the frozen pie dough should have been thrown out. S7 Dietary Manager confirmed that in the Dining area, there was no thermometer in the black refrigerator's freezer area, and that there were 4 loaves of sandwich bread and 2 bags of rolls that were located on the shelving unit, that had been removed from the original container and was undated; a box of Kellogg's cereal that was opened, unsealed and undated. Interview with S20 Kitchen Aide on [DATE] at 10:13 a.m., revealed that she was unaware of how or where to document the dishwasher's sanitizer solution concentration results, and had already used the dishwasher for the breakfast dishes without the sanitizer concentration being checked. Review of the ,d+[DATE] dishwasher's sanitizing solution concentration log, revealed that the dinner log had not been completed for [DATE] and [DATE], and the breakfast log had not been completed for [DATE]. Interview and review of the Kitchen's freezer/refrigerator logs with S7 Dietary Manager on [DATE] at 10:29 a.m., confirmed that the temperature log for the black refrigerator located in the dining area, had not been completed the entire month of ,d+[DATE], and from [DATE] to current ([DATE]), and it should have been. Observation of the lunch meal service on [DATE] at 12:10 p.m., which consisted of Corndogs, French fries and creamed corn, revealed hair was observed in the corndogs. S18 [NAME] who served the corn dogs wore a green bandana as a hair covering. S7 Dietary Manager observed the corn dogs at that time, and confirmed that hair was in the corn dogs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51096 Based on observation, record review, and interview the facility failed to maintain an effective infection prevention and control program and ensure staff practices were consistent with current infection control principles and practices to prevent possible cross contamination for 1 (#44) of 29 sampled residents by failing to use enhanced barrier precautions, when needed. Findings: Review on 01/14/2025 of the facility's policy and procedure dated 04/01/2024, and titled Enhanced Barrier Precautions read in part . Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Resident Activity/Assistance for Residents on EBP [NAME] Gloves and Gown Administer medications enterally: Yes Device care or use: central line, urinary catheter, feeding tube . Yes Any other high-contact activity that includes close bodily contact or coming into contact with the indwelling medical device Yes Review of Resident #44's clinical record revealed an admitted [DATE], with diagnoses which included dysphagia-oropharyngeal phase; hemiplegia and hemiparesis following cerebral infarction protein-calorie malnutrition; dysphasia following other cerebrovascular disease; dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; adult failure to thrive and age-related physical debility. Review of Resident #44's Quarterly MDS with an ARD of 11/12/2024, revealed a BIMS score of 4. Resident had severe cognitive impairment. Resident had impairment on both sides for upper and lower extremities. Resident was dependent for eating, oral hygiene, toileting, showering/bathing; lower/upper body dressing and personal hygiene. Review of Resident #44's Care Plan revealed in part The resident requires tube feeding; NPO. Interventions to include . Promote enhanced barrier precaution when providing care or having physical contact with resident. Observation of Resident #44 in room on 01/12/2025 at 2:57 p.m. revealed an Enhanced Barrier Precaution (EBP) sign on the outside of the room but no PPE noted on door or in room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #44 in bed on 01/13/2025 at 10:28 a.m. revealed an Enhanced Barrier Precaution sign by Resident #44's door but no PPE hanging on door or in Resident #44's room. Observation of Resident #44's Medication administration via PEG tube on 01/13/2025 at 1:59 p.m. revealed S10 LPN did not wear a gown while in contact with Resident #44's PEG tube. S10 LPN confirmed that she should have worn a gown while flushing and administering medications via Resident #44's PEG tube. Interview with S2 DON on 01/13/2025 at 2:50 p.m. confirmed that a gown and gloves should have been worn by S10 LPN while administering Resident #44's medication and flush via PEG tube.