STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195326	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Iberia Manor South	600 Bayard St New Iberia, LA 70560

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on observation, interview, and record review, the facility failed to ensure a resident's dignity by failing to provide a covering for a urinary catheter bag for 1 resident (#428) out of 35 sampled residents. Findings: Review of Resident #428's EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease and Heart Failure. On 07/21/2024 at 9:00 a.m., an interview and observation was made of Resident #428 with S12RNS (Register Nurse Supervisor). Resident #428's urinary catheter drainage bag was observed containing urine and there was no covering for the drainage bag. S12RNS confirmed that the catheter bag did not have a privacy cover. She was unsure of the policy on covering catheter drainage bags, but stated that she thought the bag should be covered. On 07/23/2024 at 11:42 a.m., an interview with S6Corp was conducted. She confirmed that a privacy cover should have been placed on Resident 428's urinary drainage bag.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 47123 Based on observation and interview, the facility failed to ensure the most recent survey results of the facility were posted in a place readily accessible to residents, family members, and legal representatives of residents. The facility's census was 80. Findings: On 07/21/2024 at 10:23 a.m., an observation was made of a clear plastic file holder mounted to the wall outside of the human resources office door near the facility's main entrance. A clear colored binder containing licensing surveys was observed inside the plastic file holder, and inside the binder were survey results and plan of corrections from the annual surveys and complaints conducted in 2018, 2019, 2020, and 2021. There was no evidence of the last three year's of annual or complaint surveys in the folder. On 07/23/2024 at 12:44 p.m., an interview was conducted with S1DON (Director of Nursing) and S11Adm (Administrator). They stated the results for the survey were posted at the entrance of the nursing home in a clear binder holder outside of the human resources office, but nowhere else. S11Adm confirmed the annual and complaint survey results from 2022 through 2024 were not in the binder holder, and should have been posted in a place readily accessible to residents, family members, or legal representatives.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176 Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment by failing to ensure clean bed linen was provided to 1 (#23) out of 2 (#23 and #33) residents investigated for a clean, comfortable and homelike environment. The final sample size was 35 residents. Findings: On 07/22/2024, a review of the facility's policy titled, Homelike Environment with a last reviewed date of 07/08/2024, read in part .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .e. clean bed and bath linens that are in good condition. Review of Resident #23's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Cerebral Infarction, Muscle Weakness, Unspecified Lack of Coordination and Need for Assistance with Personal Care. On 07/21/2024 at 11:04 a.m., an observation was made of Resident #23's bedroom. Resident #23 was sitting on his bed. The resident's pillow case was observed with a large red and brown stain. On 07/22/2024 at 9:02 a.m., a second observation was made of Resident #23's bedroom. Resident #23 was standing next to his bed. The resident's bed was made, and the large red and brown stain observed yesterday remained on the resident's pillow case. On 07/22/2024 at 9:05 a.m. an interview and observation of Resident #23's bedroom was conducted with S16LPN (Licensed Practical Nurse). She confirmed that Resident #23's bed was made and confirmed the stain on the pillow case. S16LPN confirmed bed linens should be clean, and the pillowcase should have been changed when the bed was made.

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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** 39826 Based on record reviews and interviews, the facility failed to ensure the PASARR (Preadmission Screening and Resident Review) Level 1 screening was completed accurately for 2 (#1, #43) out of 2 (#1, #43) residents investigated for PASARR in a final sample of 35 residents. Findings: Resident #43 Review of Resident #43's electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Bipolar Disorder, End Stage Renal Disease, Dependent on Renal Dialysis, and Essential Hypertension. Further review of her record contained a Level 1 Preadmission Screening and Resident Review, (PASARR) without any diagnosis checked to indicate she had any of the serious mental health diagnoses. Further review of Resident #43's record revealed no evidence the provider had submitted a corrected PASARR request to the appropriate state-designated authority with the diagnosis of Bipolar Disorder. On 07/21/2024 at 8:29 a.m., an interview was conducted with S10AAdm (Acting Administrator). She reviewed Resident #43's Level I Pre-admission screening dated 06/05/2024 and confirmed Section III question #1 had no diagnoses checked. Further review of the list of her diagnoses revealed a diagnosis of Bipolar Disorder unspecified in which S10AAdm confirmed Resident #43 had a qualifying diagnosis which required further review for a Level II PASARR. On 07/23/2024 at 09:45 a.m., during an interview, S1Director of Nursing (DON) stated Resident #43's Level 1 PASARR was submitted by the hospital before she was admitted confirming that staff from the nursing home failed to review the Level 1 for accuracy. On 07/23/24 at 12:28 p.m., S6Corp (Corporate Nurse) stated she reviewed all of the admission documents for Resident #43. She confirmed a request for review had been submitted to the state designated authority. 47123 Resident #1 Review of Resident #1's EMR revealed he was admitted to the facility on [DATE] and was diagnosed with Schizophrenia on 01/22/2018. Further review of Resident #1's EMR (electronic medical record) revealed a Level 1 PASARR screening dated 05/07/2018 that was completed at another facility. Section 3 titled Mental Illness, was checked yes, and only Major Depression Disorder was checked. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/22/2024 at 1:13p.m., an interview was conducted with S6Corp. She stated Resident #1 was diagnosed with Schizophrenia on 01/22/2018. S6Corp confirmed the Level 1 PASARR screening was not answered correctly because Schizophrenia was not checked. She confirmed no other PASARRs were found and was unable to confirm a corrected submission was sent.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47123 Based on record reviews and interviews, the facility failed to develop and implement a comprehensive person-centered plan of care for each resident as evidenced by: 1. failing to follow the plan of care to address Resident #33's elevated blood sugar; and 2. failing to ensure Resident #1 had enabler bars attached to the bed as ordered. Findings: 1. Resident #33. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnosis included, but were not limited to, Type 2 Diabetes Mellitus. Review of the resident's physician's orders dated revealed an order for Humulin R inject as per sliding scale 60-150 mg/dL (milligram per deciliter): 0 units, 151-200 mg/dL: 2 units, 201-250 mg/dL: 4 units, 251-300 mg/dL: 6 units, 301-350 mg/dL: 8 units, 351-400 mg/dL: 10 units, 401 mg/dL: 12 units, recheck blood sugar in 2 hours if still greater than 400 call the physician. Review of the resident's June 2024 MAR (Medication Administration Record) revealed on 06/27/2024 Resident # 33 had a blood glucose level of 404 mg/dl, Humulin R was not given, nor was there a recheck. On 07/22/2024 at 3:06 p.m., an interview and record review conducted with S1DON (Director of Nursing). She reviewed Resident #33's medical record and confirmed Resident #33 on 06/27/2024 had a blood sugar of 404mg/dl. S1DON further stated the Resident should have received 12 units and had a recheck in two hours. S1DON reviewed the chart and stated there was no documentation of the Resident receiving the 12 units of Humulin R, a recheck of the blood sugar in 2 hours, or refusal from the Resident. She stated the nurse should have followed the orders. 2. Resident #1. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnosis included, but were not limited to, Functional Quadriplegia. Review of Resident #1's July 2024 care plan revealed he had ADL (Activities Daily of Living) self-care performance deficit R/T (related to) quadriplegia . Enabler bars bilaterally to aide in turning and positioning. On 07/21/2024 at 11:09 a.m., an observation was conducted of Resident #1's room, which did not reveal enabler bars attached to his bed. On 07/22/2024 at 11:32 a.m., another observation was conducted of the Resident #1's room. He had no enabler bars attached to his bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/22/2024 at 12:24 p.m., an interview and observation was conducted with S9LPN (Licensed Practical Nurse). After his observation he confirmed in Resident #1's room, the resident did not have any enablers bar attached to his bed. S9LPN further stated the resident needed enabler bars because to assist the resident in performing bed mobility and with turning during care.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on observation, interviews and record reviews, the facility failed to ensure the nursing staff demonstrated specific competencies and skill sets necessary to provide care to meet the residents' needs safely to attain or maintain the highest practicable physical well-being for 1 (#428) of 35 sampled residents. This was evidenced by S18LPN (Licensed Practical Nurse) leaving Resident #428's medication at the bedside. Findings: On 07/08/2024, a review of the facility's policy titled, Medication Administration, with a review date of July 8, 2024, revealed in part .27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Resident #428 was admitted to the facility on [DATE], with diagnoses that included Chronic Kidney Disease and Heart Failure. Review of the resident's BIMS (Brief Interview for Mental Status) performed on 07/18/2024 revealed a score of 15, indicating that the resident's cognition was intact. On 07/21/2024 at 08:40 a.m., an observation was made of Resident #428. A medicine cup with seven pills was observed on her over-bed table. Resident #428 stated that the nurse left the medications with her so that she could take them after her she ate breakfast. On 07/21/2024 at 11:25 a.m., an interview and observation was conducted with S12RNS (RN Supervisor). Resident #428's medicine cup remained on her over-bed table with no pills observed in it. Resident #428 stated that she had just administered her own medications. S12RNS stated that she was unaware of the facility's policy on self-administration of medications, but believed the nurse should watch the residents take their medications. On 07/23/2024 at 11:43 a.m., an interview with S1DON (Director of Nursing) stated that Resident #428 should have had a physician's order to administer her own medications. S1DON stated that she would have also had to be evaluated by the facility, to determine if she was competent to administer her own medications. She confirmed that Resident #428 did not have a physician order or evaluation to administer her own medication and should not have administered her own medications. She confirmed that nurse should not have left Resident #428's medications at the bedside. On 07/23/2024 at 03:00 p.m., an interview with S11Adm (Administrator) was conducted. S11Adm reported that S18LPN was the nurse responsible for administering Resident #428's medications on 07/21/2024 at 8:40 a.m.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 39319 Based on observation and interview, the facility failed to post daily nursing staffing that included the facility name, date, census, and the total number and actual hours worked by staff responsible for resident care in a prominent place readily accessible to residents and visitors. Findings: On 07/22/2024 at 3:30 p.m., an observation was made throughout the entire facility, and there was no evidence that the daily nursing staffing was posted. On 07/22/2024 at 4:00 p.m., an interview was conducted with S6Corp (Corporate Nurse) who confirmed that the census should be posted daily. She stated that staff had been posting it on Hall B. At that time, an observation was conducted with S6Corp on Hall B. A white dry-eraser board was observed located under the TV against the back wall. A closer observation revealed that the board did not contain any information. S6Corp stated that the board should have the census, the number of staff, and the total number and actual hours worked. She also confirmed that the board was not and should have been in an area where it was visible for all residents and visitors.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49784 Based on interviews and record reviews, the facility failed to provide pharmaceutical services that were in order and accounted for the drug record reconciliation of all controlled drugs during shift changes for 1(Medicine Cart 1) MC1 of 3 Medicine carts reviewed during their annual survey. This deficient practice had the potential to affect the 80 residents residing in the facility. On 07/23/2024, a review of the facility's policy titled, Controlled Substances, with a review date of July 8, 2024, revealed in part .4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. On 07/22/2024 at 09:09 a.m., an interview and review of the July 2024 Controlled Drugs-Count Record for MC1 was conducted with S19LPN (Licensed Practice Nurse) and S20ADON (Assistant Director of Nursing). Both S19LPN and S20ADON stated that the off going nurse for each shift should have reconciled the narcotics in each medicine cart with the oncoming nurse. Both S19LPN and S20ADON confirmed that there was no signature present for the off going nurse to indicate that the narcotics in MC1 were reconciled for the 7:00 a.m. -3:00 p.m. shift on 07/22/2024. Both S19LPN and S20ADON confirmed that there should be a signature for both the oncoming and the off going nurses that reconcile narcotics each shift, and the off going nurse's signature was missing for the 7:00 a.m. -3:00 p.m. shift on 07/22/2024. 07/23/2024 at 11:31 a.m., an interview and review of the July 2024 Controlled Drugs-Count Record for MC1 was conducted with S1DON (Director of Nursing). This review revealed missing signatures for the narcotic reconciliations below: 1. 07/20/2024 - oncoming nurse 3-11 2. 07/21/2024- off going nurse 7-3 3. 07/21/2024- oncoming nurse 3-11 4. 07/22/2024- off going nurse 7-3 S1DON reported that the nurses for these shifts, per facility policy, should have signed indicating that the narcotics were reconciled, and confirmed they had not.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on observation and interview, the facility failed to properly store drugs as evidenced by 1. Loose pills found in the bottom drawers of 1(MC2 (Medicine Cart 2) out of 3 medication carts reviewed. 2. Failure to label a multi-use vial found in 1(MS1) out of 2 medicine storage rooms reviewed This deficient practice had the potential to affect the 80 residents residing in the facility. Findings: On 07/23/2024, a review of the facility's policy titled, Storage of Medications, with a review date of 07/08/2024, revealed, in part, the following: Policy Statement: The facility stores all drugs and biologicals in a safe, secure and orderly manner .3. Nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. On 07/22/2024 at 9:57 a.m., an interview along with an observation of MS1 (Medication Storage room [ROOM NUMBER], 100 hall) was conducted with S22LPN (Licensed Practical Nurse). A multi-use vial of flu vaccine was observed open, with no labeled opening date of the vial. S22LPN verified that the flu vaccine vial should have been labeled with the date it was opened and it was not. On 07/22/2024 at 3:31 p.m. an interview along with an observation of MS1 (Medication Storage room [ROOM NUMBER], 100 hall) was conducted with S6Corp (Corporate Nurse) and S20ADON (Assistant Director of Nursing). They both confirmed the multi-use vial of flu vaccine was not labeled with the date it was opened and that it should have been. On 07/23/2024 at 11:03 a.m. an interview and observation of MC2 was made with S21LPN. Two round white pills were found at the bottom of the second medicine drawer and 1 white round pill was found on the bottom medicine drawer of MC2. S21LPN confirmed that these pills should not have been loose in the drawers.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 47965 Based on observation, and interviews, the facility failed to ensure that menus were followed for residents. This had the potential to affect a census of 80 residents. Findings: On 07/21/2024 at 12:05 p.m., an observation was made of the meal service during lunch. The residents were served Rice Pilaf, Glazed Ham, Baked beans, Pureed Ham, Chopped Ham, [NAME] Mashed Potatoes, Pork Chops with Gravy, Pureed [NAME] Beans, Dinner Rolls, and Lemon Cake. There was no pureed dinner rolls or cornbread available. Review of the facility's lunch menu revealed the residents should have received: Glazed Ham, Baked sweet potato, Braised cabbage, Cornbread, and Frosted cake. On 07/21/2024 at 1:10 p.m., an interview was conducted with S5Cook. She confirmed there was a difference in what was served from the scheduled menu. S5Cook also confirmed that she did not prepare and serve pureed bread for residents receiving pureed meals. S5Cook stated she should have checked the menu. On 07/22/2024 at 2:08 p.m., an interview was conducted with S8RD (Registered Dietician) who stated the kitchen staff should not change the menu on their own. S8RD stated there was a substitution list to ensure the residents' nutritional needs were met and confirmed the kitchen staff did not use the substitution list. She also stated that she is available by phone when she is not in the facility, but did not receive a call from the facility with any concerns regarding the menu.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965 Based on observation, record reviews, and interviews, the facility failed to ensure that recipes were followed for 4 of 4 (#11, #34, #45, and #55) residents who received pureed diets, by failing to follow a recipe for mashed potatoes. Findings: On 07/22/2024, a review of the facility's policy titled Therapeutic diets with a revision date of 06/12/2024, read in part, Policy Statement: Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care .Policy Interpretation and Implementation: 4. A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example .d. Altered consistency diet. A review of Resident #11's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, and Dysphagia Following Cerebral Infarction. A review of Resident #11's Physician's orders revealed an order for a Pureed diet written on 08/15/2023. A review of Resident #34's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, and Dysphagia Following Unspecified Cerebrovascular Disease. A review of Resident #34's Physician's orders revealed an order for a Pureed diet written on 09/13/2023. A review Resident #45's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included, but were not limited to Dysphagia Oropharyngeal Phase, and Moderate Protein Calorie Malnutrition. A review of Resident #45 Physician's orders revealed an order for a Regular diet, pureed texture written on 02/12/2024. A review Resident #55's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included, but were not limited to Dysphagia Following Other Cerebrovascular Disease, and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. A review of Resident #55 Physician's orders revealed an order for CC/RCS (Controlled Carbohydrate/Reduced Concentrated Sweets) Diet pureed written on 06/01/2023. (continued on next page)

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	195326	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Iberia Manor South	600 Bayard St New Iberia, LA 70560

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/21/2024 at 10:34 a.m., an observation was conducted of S5Cook (Cook) as she prepared pureed potatoes for the residents' lunch. S5Cook poured the potato powder from a bag in a preparation bowl, then poured hot water which she collected in an aluminum pot from the faucet into the container with the potato powder. She placed the potato mixture in a blender and added more hot water from the aluminum pot. S5Cook did not use a measuring spoon or cup to measure the potato mixture or water. After blending the potato mixture she used a spoon to check the consistency. S5Cook was asked about her process for preparing the potatoes. She stated she had never measured the ingredients or had been given a recipe to use. S5Cook also stated she had never followed the recipe on the bag. An observation of the bag from which the potato powder was poured revealed recipes for 5, 10, and 20 four ounce servings. On 07/21/2024 at 3:45 p.m., an interview was conducted with S6Corp (Corporate Nurse) who stated that recipes were available for the cooks to use in the kitchen, and S5Cook should have used a recipe to prepare the pureed meal. On 07/22/2024 at 2:08 pm., an interview was conducted with S8RD (Registered Dietician). She stated a recipe book was printed to go with the menus three weeks ago, so the kitchen staff should have used a recipe to prepare the pureed meal. She further stated she is available by phone when she is not in the facility, and did not receive a call from the facility to address any concerns with the recipes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965 Based on observations, interview, and record review, the facility failed to store food in accordance with professional standards for food service and failed to ensure sanitary conditions were maintained in the kitchen by failing to: 1. Clean the kitchen fryer, fryer baskets, floor beside fryer and oven; 2. Label refrigerated foods and discard expired foods in the refrigerator; 3. Monitor refrigerator and freezer temperatures; 4. Monitor dishwasher temperature and chemicals; and 5. Ensure staff wore hair restraints in the kitchen. This deficient practice had the potential to affect the 80 residents who consumed food from the kitchen. Findings: On [DATE], a review of the facility's policy titled Sanitization with a revision date of ,d+[DATE], read in part, Policy Statement: The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation .1. All kitchens, kitchen areas and dining areas shall be kept clean .11 B. Fixed Equipment .1. Fixed equipment will be routinely cleaned and maintained .3. Food contact equipment will be cleaned and sanitized after every use. On [DATE], a review of the facility's policy titled Refrigerator and Freezer Storage read in part .3. If a food is taken out of the original container (what the manufacturer placed the product in) it must be labeled and dated. 4. All left over foods must be labeled and dated with the date in and the date out (date the food is to be discarded)-this date can be no more than 72 hours after it was put in the refrigerator .6. All expired foods must be removed from the refrigerator and freezer .9. If an item is opened, the food must be tightly sealed. It should be dated with the date that it was opened. If the product was removed from its original container, then the product should also have the name of the product . 1. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 8:32 a.m., a tour was conducted of the facility's kitchen with S5Cook (Cook) who stated that she was the cook in charge for the day shift. An observation was conducted of the fryer. The oil was observed to be brown with yellow crumbs, which looked like food coating floating on the corners of the fryer. Splatters of oil were noted on the floor beside the fryer, and the floor was darkened in that area. S5Cook confirmed the splatters on the floor as oil from the fryer. Two fryer baskets were observed to be coated with oil and were dirty with food residue. One of the baskets had two french fries in the bottom. S5Cook stated the fryer baskets and oil were last used for frying french fries on Friday ([DATE]) and confirmed that they had not been cleaned since then. An observation of the baking oven revealed the inside of its bilateral doors were dirty with caked on grease stains. S5Cook confirmed the oven doors were dirty and was unable to state when they were last cleaned. She stated that the fryer, oven, and floor should have been cleaned. 2. On [DATE] at 8:52 a.m., an observation was conducted of the storage refrigerator with S5Cook. The following items were observed: -One red pitcher and one clear pitcher containing liquid with no label to indicate content or date they were prepared. S5Cook stated they contained juice and should have been labeled with content and date and time prepared. -A metal storage container containing mixed beans out of its original container with a plastic covering with no date or time. S5Cook stated it should have been labeled with date and time. -A metal storage container with a metal lid containing a red paste with no label to indicate content or date and time it was placed in the storage container. S5Cook stated the content was tomato paste and should have been labeled with content date and time. -A container labeled Mousse dated [DATE], one labeled fruit dated [DATE], and another labeled butter scotch which was dated [DATE]. S5Cook stated that the foods should have been discarded because they had been in the refrigerator over 72 hours. A pack of cheese slices with use by date of [DATE], and a bag of parmesan cheese with expiration date of [DATE]. S5Cook stated the items were expired and should have been discarded. 3. A review of the Refrigerator and Freezer Temperature Logs revealed no refrigerator or freezer temperatures documented for [DATE]. S5Cook confirmed the missing temperatures and stated they should have been recorded. 4. A review of the Dishwasher Temperature/Sanitizer Logs revealed no monitoring of temperature and chemicals documented for [DATE]. S5Cook confirmed the missing data and stated they should have been checked and documented on the sheet. 5. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:16 a.m., S17ACT (Activity Coordinator) was observed in the kitchen with no hair covering. She confirmed she did not have a hair covering and stated that she came to help and should have put on a hair net. S5Cook confirmed S17ACT was in the kitchen without hair covering and stated all staff knew they should cover their hair before entering the kitchen.

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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. 41419 Based on observation, interview, and records reviewed the facility failed to maintain an effective infection control and prevention program and implement accepted infection control practices to help prevent and control the spread of an infectious communicable disease, COVID-19, as evidenced by staff: 1. Failing to remove Personal Protective Equipment (PPE) prior to exiting a positive COVID-19 room and perform hand hygiene upon removing PPE; and 2. Failing to ensure housekeeping staff used gloves and performed hand hygiene while handling a dirty mop. Findings: On 07/22/2024, a review of the facility's policy titled Infection Prevention and Control Program with a revision date of 01/01/2024, read in part, Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of communicable diseases and infections .Policy Interpretation and Implementation .11. Prevention of Infection a. important facets of infection prevention include: 3. educating staff and ensuring that they adhere to proper techniques and procedures. 1. On 07/21/2024 at 3:30 p.m., an observation was conducted on Hall A. S13CNA (Certified Nursing Assistant) was observed exiting Resident #178's room who was positive for COVID-19. Further observation revealed S13CNA removing the blue plastic disposable isolation gown as she walked down Hallway A. S13CNA discarded the blue plastic gown in a room, and did not sanitize her hands after throwing the isolation gown in the trash can. S13CNA was observed entering the nurse's station. On 07/21/2024 at 3:31 p.m., an interview was conducted with S12RNS (Registered Nurse Supervisor), who was sitting in the nurses station. She confirmed that PPE had to be removed prior to exiting an isolation room. On 07/21/2024 at 3:32 p.m., an interview was conducted with S13CNA and S12RNS. S13CNA was asked if she was aware that PPE was to be removed prior to leaving an isolation room, and she replied I know all that! as she walked away. S12RNS stated Well if she knew all that, why did she do it?! S12RNS stated S13CNA should have removed the PPE prior to leaving the isolation room, and should have sanitized her hands upon discarding the isolation gown. 47965 2. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/22/2024 at 7:43 a.m., an observation and interview was conducted with S3HSK (Housekeeper) as she mopped the floor on Hall W. S3HSK removed the used mop pad from the mop with her bare hands, wrapped it up in her hand, and placed it in a bag on her cart. She then proceeded to push her cart down the hall without performing hand hygiene. S3HSK confirmed that she did not use gloves to remove the dirty mop pad, and did not perform hand hygiene after handling the mop. She stated she should have worn gloves to handle the dirty mop pad and performed hand hygiene afterwards. On 07/22/2024 at 7:44 a.m., an interview was conducted with S2HSKSup (Housekeeping Supervisor). She confirmed that handling the soiled mop pad with bare hands and not performing hand hygiene was not good infection control practice, and S3HSK should have known better. On 07/22/2024 at 10:12 a.m., an interview was conducted with S4IP (Infection Preventionist). She stated that S3HSK handling of the dirty mop with her bare hands and not performing hand hygiene afterwards was against the facility's infection control procedures.