STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunplex Sub-Acute Center	6520 Sunscope Drive Ocean Springs, MS 39564

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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. 43283 Based on observations, record review, resident and staff interviews, and facility policy review, the facility failed to treat residents in a dignified manner, as evidenced by not providing meals consecutively to all residents who were seated at the same table for three (3) of 20 residents observed during a dining room observation. Findings include: Record review of the facility's policy Resident Rights dated November 23, 2016, revealed . It is the policy of this facility to promote and protect the rights of residents residing in this facility. Procedure . 2. This facility will make every effort to assist the resident in exercising his/her rights and to assure that the resident is always treated with .dignity . 6. Policies governing resident rights are outlined in a separate chapter of this manual entitled Resident Rights . (a) Resident rights. The resident has a right to a dignified existence . (1) A facility must treat each resident with respect and dignity and care for each resident is a manner and in an environment that promotes .enhancement of his or her quality of life, recognizing each resident's individually . On 7/15/24 at 12:00 PM, observed 20 residents sitting in the dining room waiting for lunch with three (3) staff members also in the dining room. During an interview with Licensed Practical Nurse (LPN) #4, she explained the kitchen staff are having problems in the kitchen and residents are still waiting for lunch. Lunch is usually served around noon, but it is a little late today. At 12:10 PM on 07/15/24, the tray cart came out of the kitchen to be served. Observed two (2) LPNs and one (1) Certified Nurse Aide (CNA) in the dining room and they began passing out trays. Resident #10 was in the dining room sitting at the table on the first row facing the kitchen with another resident. The resident sitting with Resident #10 was served his tray at 12:18 PM, no tray was available for Resident #10, so staff requested his tray and continued to pass out the trays to other residents at other tables. At 12:20 PM on 07/15/24, during an interview with LPN #4, she explained all residents are to be served at the same time at the same table, she asked kitchen staff for Resident #10's tray again and other residents' trays also. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:25 PM on 07/15/24, during an interview with Resident #10, he explained he had been in the dining room since 11:30 AM and he always eats lunch in the dining room. He feels everyone at a table should be served at the same time and he was here way before the other resident at his table. At 12:26 PM on 07/15/24, Resident #10 still had not gotten his lunch tray and the other resident at his table was through eating and left the dining room. At 12:27 PM on 07/15/24, three (3) lunch trays remained on the cart. LPN #4 explained those trays were not being passed out because those trays are for resident's sitting at the table with resident's whose trays are not on the cart. LPN #4 requested residents' trays from the kitchen staff again. Resident #10 received his lunch tray at this time. At 12:30 PM on 07/15/24, Resident #27 complained that she had not received her lunch tray and her tablemate had been served her tray. LPN #4 explained to the resident, she had asked the kitchen staff for her tray. At 12:33 PM on 07/15/24, Resident #27 received her tray. Staff explained to the resident that her lunch tray had been put on the hall cart. At 12:35 PM on 07/15/24, during an interview with Resident #27, she explained she always eats in the dining room and has been in the dining room since 11:30 AM. She understands the residents that need to be fed should get their food first, but she would like to get her food when her tablemate gets hers. At 12:36 PM 07/15/24, two (2) residents still did not have their trays. At 12:41 PM on 07/15/24, Resident #160 asked the staff where her tray was. LPN #4 explained to her she has requested her tray from the kitchen staff already and is waiting on her tray. Resident #160 complained she is going to miss her smoke break because she has not eaten her lunch yet. At 12:45 PM on 07/15/24, during an interview with Resident #160, she reported she has been in the dining room since 11:30 AM and she always eats in the dining room with her roommate. Her roommate was served her tray at this time, due to staff being afraid the food would be cold due to no cover on the plate. LPN #4 asked for Resident #160's lunch tray four (4) more times before the tray was delivered to the resident at 12:53 PM. During an interview with Certified Nursing Assistant (CNA) #1 at 12:55 PM on 07/15/24, she explained she had to ask several times for residents' trays and confirmed not all residents were served at the same time and that is a dignity concern for the residents. At 1:00 PM on 07/15/24, during an interview with LPN #5, she confirmed the three (3) residents who were not served at the same time as their tablemate, each resident eats in the dining room daily. The kitchen staff was informed before the trays came out of all the residents in the dining room. She is not sure how the trays for lunch are delivered to the dining room or floor or which one is served first. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/15/24 at 1:30 PM, during an interview with the Dietary Manager, she explained the dining room is served first, then TCU (Transition Care Unit) 1, then [NAME] 1, then TCU 2, and then [NAME] 2. She explained the nursing staff working in the dining room will notify kitchen staff the residents to be served in the dining room. Sometimes some residents will come in after the names are given and then their trays may be a little later than the others. She expects all residents to be served at the same time and be respected in a dignified manner. On 07/17/24 at 2:10 PM, during an interview with the Director of Nursing and the Administrator, they both verbalized all residents are to be served at the same time in the dining room before moving on to the next table. Not serving residents at the same table is a dignity issue. They both expect all residents' rights to be respected and each resident to be treated in a dignified manner. Resident #10 A record review of Resident #10's Admission Record revealed the facility admitted the resident on 04/03/24, with the diagnosis of Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side. A record review of Resident #10's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/24 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated the resident was cognitively intact. Resident #27 A record review of Resident #27's Admission Record revealed the facility admitted the resident on 05/04/24 with the diagnosis of Chronic Obstructive Pulmonary Disease, Unspecified. A record review of Resident #27's Annual MDS, with an ARD of 05/08/24 revealed a BIMS Summary Score of 13, which indicated the resident was cognitively intact. Resident #160 A record review of Resident #160's Admission Record revealed the facility admitted the resident on 11/06/23, with the diagnosis of Paraplegia, Unspecified. A record review of Resident #160's Annual MDS, with an ARD of 05/08/24 revealed a Staff Assessment for Mental Status revealed there were no issues with the resident's short and long-term memory and was coded for modified independence indicating some difficulty in new situations only.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 43283 Based on observations, record reviews, resident and staff interviews, and the facility's policy, the facility failed to honor residents' request for an alternative menu as listed on the alternative menu for two (2) of two (2) residents sampled for choices. Resident #18 and #53 Findings include: A review of the facility's policy Resident Rights dated November 23, 2016, revealed, . It is the policy of this facility to promote and protect the rights of residents residing in this facility. Procedure . 2. This facility will make every effort to assist the resident in exercising his/her rights and to assure that the resident is always treated with respect, kindness, and dignity . 6. Policies governing resident rights are outlined in a separate chapter of this manual entitled Resident Rights . (a) Resident rights. The resident has a right to a dignified existence, self-determination . (1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality . when preparing foods and meals, a facility must take into consideration residents' needs and preferences . A review of the facility's policy Menu Alternatives dated 07/09/2018 revealed, . An alternative meat or entree and vegetable should be provided at every meal in the event of personal food preferences or refusals . Procedure: 1. Always available entrees, sandwiches, soups, salads, and desserts planned by the resident help increase resident satisfaction . On 07/15/24 at 12:00 PM, during an observation of a bulletin board just as you enter the dining room revealed a posting of the facility's Alternative Meals typed document which indicated If for any reason you do not like what is on the main menu, you may choose an item from the alternate list below: . Hamburger and French fries . Also observed posted was a document titled Alternative Weekly Menu which revealed, We are dedicated to ensuring that we give great customer service to all of our patrons. To ensure this we ask that all special requests be made in the department 2 to 4 hours prior to the start of the meal service . Resident #53 On 07/14/24 at 11:27 AM, during an interview with Resident #53, he explained that he had complained about the facility not honoring the alternative menu choices for months. He had asked for an alternative hamburger and fries, but the staff reported it is not allowed due to the last time it was offered all the residents ate mostly hamburgers and fries and would not eat the meal on the menu. He reported he was planning to start a petition this week for the residents' wanting hamburgers and fries as an alternative meal, as listed on the bulletin board. Residents were going to sign the form and he was going to present it to the management. He stated knew that he must follow the proper procedures to solve the problem. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/15/24 at 1:30 PM, during an interview with Resident #53, he explained the alternative menu posted in the dining room has hamburgers and fries as an option. The resident explained the that the menu has been up on the bulletin board in the dining room since he has been admitted in January. He explained that today he asked for an alternative and got soup and a sandwich. On 07/15/24 at 2:30 PM, during an interview with Licensed Practical Nurse (LPN) #6, she explained Resident #53 had complained about the food since being admitted . He does ask for an alternative meal almost daily. LPN #6 was not sure about hamburgers and fries. At 9:30 AM on 07/16/24, during an interview with the Dietary Manager (DM), she explained she had been aware residents were not happy about the menu and tries to meet with the resident council frequently regarding any concerns and goes over the menus. She explained the previous Administrator made the decision to no longer offer hamburgers and fries as the alternative menu, due to the residents asking for a lot of hamburgers. The DM explained that the removal of the hamburgers and fries from the alternative menu was related to budget concerns. The previous Administrator had decided to offer hamburger and fries on the weekly menu once a week instead and offer an entree that consists of hamburger such as sloppy joes once a week. She confirmed the old alternative menu was never taken down and it was never explained to the residents in the Resident Council about hamburgers not being offered as an alternative meal. On 07/16/24 at 10:45 AM, during an interview with Certified Nurse Aide (CNA) #5, she explained Resident #53 does complain about the food including the menu and the alternative choices. Resident #53 does not like the menu most days and always asks for an alternative. He has asked for hamburgers and fries many times but has been told by the kitchen staff he cannot get hamburgers. CNA #5 explained other residents ask for hamburgers and been told no they cannot have one. She explained the facility used to make hamburgers and fries for the alternative meal but was not sure the reason why they stopped. She and other staff members have had a hard time getting kitchen staff to cooperate with alternative meals. At 3:34 PM on 07/16/24, during an interview with CNA #6, she explained Resident #53 does ask for alternative meals regularly. She explained the kitchen used to offer burgers and fries as an alternative meal, but the residents have not been able to get them. Instead, the residents can get soup and sandwiches. A record review of Resident #53's Admission Record revealed the facility admitted the resident on 01/24/24, with the diagnosis of Bilateral Primary Osteoarthritis of Knee. A record review of Resident #53's Order Summary Report, with active orders as of 07/17/24 revealed orders for Regular diet, Regular texture, and Regular consistency. A record review of Resident #53's Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/18/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact. Resident #18 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/15/24 at 11:10 AM, during an interview with Resident #18, he reported he would like to get hamburgers again like he used to get if he didn't like the menu. He explained the facility used to let him order hamburgers and fries if he didn't like the menu, but the kitchen stopped fixing hamburgers and fries. He reported he does not always like the menu and asks for something else. Resident #18 was oriented to self and place. On 07/16/24 at 11:10 AM, Resident #18 reported he was told by the kitchen today that he could not get hamburgers and fries for lunch. At 11:15 AM on 07/16/24, during an interview with the facility's Cook, she confirmed she told Resident #18 he could not get hamburgers and fries for lunch today and that the DM would have to be addressed on the issue. A record review of Resident #18's Admission Record revealed the facility admitted the resident on 01/24/23 with diagnoses that included Unspecified Dementia Unspecified Severity Without Behavioral Disturbance. A record review of Resident #18's Order Summary Report with active orders as of 07/17/24, revealed orders for Renal diet, Regular texture, and Regular consistency. A record review of the Quarterly MDS for Resident #18, with ARD of 04/10/24 revealed a BIMS score of 06, which indicated that the resident had severe cognitive impairment. On 07/17/24 at 8:30 AM, during an interview with the DM, she confirmed she was informed of the incident with Resident #18 on 07/16/24, regarding hamburgers and fries. The DM stated that she had spoken to the dietary staff and that any resident can get hamburgers and fries when requested. On 07/17/24 at 10:50 AM, during a phone interview with the facility's Registered Dietitian, she explained she was not aware residents were complaining about the menus. On 07/17/24 at 02:10 PM, during an interview with the new Administrator, she explained she has only been at the facility for three weeks and was not aware the previous Administrator had taken away hamburgers and fries as an alternative food item and had not informed the residents of the change. She stated that she expects the kitchen staff to honor residents' choices and that the alternative menu be followed.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48181 Based on interviews, record reviews and facility policy review the facility failed to ensure a grievance of cold food by Resident Council members was resolved four (4) of six (6) months of Resident Council meetings reviewed. Findings included: A review of the facility's policy Grievances and/or Concerns dated November 23, 2016, revealed, .After receiving a .grievance the facility will actively seek a resolution and keep the resident appropriately apprised of its progress toward resolution. As necessary the facility will take action to prevent further occurrence during the investigation . A review of six (6) months of Resident Council Minutes revealed the residents have documented grievances of cold food for (4) of (6) months (01/31/24, 03/22/24. 04/29/24, and 05/24/24). On 07/14/24 at 1:30 PM, during a Resident Council Meeting, while reviewing previous concerns voiced by the Council regarding cold food, Residents #49, #5, #3, #39, #44, and #36 reported the food continued to be cold. On 07/16/24 at 3:00 PM, an interview with the Dietary Manager (DM) acknowledged receiving notice of the Resident Council report when she attended the meetings or from the Activities Director. The DM also acknowledged the Resident Council reports of cold food. The DM stated in January she had a meeting with the Director of Nursing (DON) regarding the speed of tray delivery to the rooms. The DM stated the DON had additional staff go to the floor to assist with trays. The DM stated this resolved the issue. The DM reported that about three (3) months ago she noticed one burner on the steam table was malfunctioning. The DM stated she made a report to the Maintenance Department on 03/18/24. The DM stated she also informed the past Administrator of the problems with the steamer. The DM confirmed when the current Administrator arrived at the facility she informed her at the June Quality Assurance (QA) meeting. The DM reported during the maintenance inspection, it was realized that a second burner was out. The DM stated the Maintenance Director ordered a part to fix the steam table, but the part was not able to be used due to the steam table wires being burned out. The DM reported there has not been any follow-up from the Maintenance Department. On 07/16/24 at 3:15 PM, in an interview with the Maintenance Director (MD), he acknowledged the DM reported the malfunctioning steam table to his department on 03/18/24 by way of a Maintenance Request Form. The MD stated he informed the previous Administrator of the malfunctioning steam table within a day or two of receiving the work order. The MD reported the Administrator ordered an element for the steam table to be repaired. The MD stated when the element arrived, he attempted the repair, but the steam table component was dry rotted. The MD stated by the time the part came in and he tried to fix the steam table, the Administrator was no longer working for the facility. The MD reported he would try to have a technician come to fix the steam table. The MD acknowledged that he did not have an established appointment for a technician to come to the facility to fix the steam table because he just called the technician yesterday and has not heard back from them. The MD confirmed he has not made any earlier attempts to contact a technician. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/24 at 3:30 PM, an interview with the DON she acknowledged the meeting with the DM in January to have Certified Nursing Assistants (CNAs) more active with passing out trays. The DON confirmed this intervention was effective. On 07/17/24 at 9:41 AM, an interview with the Administrator revealed she was never made aware of the malfunctioning steam table. The Administrator reported finding out the steam table did not fully work on Monday 07/14/24 from the Regional Director of Operations, as she was not present at the facility. The Administrator stated she received records of the Resident Council meeting minutes from the Activities Director as soon as they are finished. The Administrator revealed a service technician was scheduled to come to the facility this week.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37415 Based on observation, interviews, and facility policy review, the facility failed to ensure an unattended medication cart was secured and locked for one (1) of three (3) medication carts observed. Findings include: A review of the facility's Hazardous Areas Devices and Equipment, reviewed 8/2023 revealed, All hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible . Identification of Hazards 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to the following: a. Equipment and devices that are left unattended or are malfunctioning . A review of the facility's Storage of Medications, dated 9/5/12 revealed, Medications and biologicals are stored safely, securely, and properly following manufacturers' recommendations are those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures . B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access . L. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are removed from stock, disposed of according to procedures for medication disposal . and reordered from the pharmacy . if a current order exists . During an observation of the medication cart on the 200 Hall on 7/14/24 at 9:00 AM, revealed an unlocked and unattended medication cart. There was an unopened 21 gauge x (by) 1 inch gauge needle lying on the top of the medication cart. Both drawers had more than twenty (20) unsecured pills lying in the bottom of the drawer. The unlocked drawers allowed access to anyone. On 7/14/24 at 9:02 AM, Licensed Practical Nurse (LPN) #1 was observed down the hallway administering medications to residents and was out of the view of the unlocked and unsecured medication cart. On 7/14/24 at 9:30 AM, in an observation and interview, Certified Nursing Aide (CNA) #1 pushed the unsecured medication cart into a shower room. CNA #1 revealed she pushed the cart into the shower room to help the nurse because she knew the medication cart should not be left unattended in the hallway. CNA #1 said she did not notice the needle on the top of the medication cart, nor was she aware the drawers of the cart contained various pills. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/14/24 at 9:45 AM, during an interview, LPN #1 confirmed the medication cart was left unlocked and unattended in the hallway by the nurse's station. LPN #1 said the medication cart had been stationed on the hall since Wednesday of this week because the locking mechanism had broken. The medications were switched over to another medication cart while she was off from work and when she returned to work on Friday, she had noticed the cart had been changed out. LPN #1 explained the cart had been sitting in the hallway since Friday. She stated she had not noticed a needle on top of the cart, and she was not aware there were loose pills in the drawers of the cart. LPN#1 stated a confused resident could have hurt themselves if they had gotten the needle or taken some of the pills in the drawers. She stated whoever changed out the medication cart should have removed all the medications and stored the cart properly. During an interview on 7/14/24 at 10:00 AM, the Director of Nursing (DON) explained the medication cart was changed out by the night shift because the cart was broken and would not lock. The DON said the night shift should have removed the needle and the medications out of the cart. The DON explained she had not noticed the cart on the hallway, and she expected the nurses to make sure medication carts are locked in the medication room when they are not being used. The DON confirmed a confused resident could have harmed themselves with the needle and taken the medication that was in the bottom of the drawers. During an interview on 7/14/24 at 12:34 PM, the Administrator explained she expected the nurses to keep medications and supplies in a secure medication room when the nurse was not using them. The Administrator said the medications should have been destroyed and the broken medication cart should have been taken out of the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43283 Based on observations, interviews, record reviews, test tray evaluation, and facility policy review, the facility failed to ensure the resident's food was at an appetizing temperature for one (1) of 16 sampled residents. (Resident #53). This has the potential to affect all residents receiving meals prepared by the facility's dietary department. Findings include: This tag is cross-referenced to tag F565: Based on observations, interviews, and record reviews, the facility failed to ensure a grievance of cold food by Resident Council members was resolved four (4) of six (6) months of Resident Council meetings reviewed. A review of the facility's policy titled Food Temperatures, dated 03/19/20 revealed, Food should be served at the proper temperature to ensure food safety and palatability. Procedure: . 8. Palatability of foods determines appropriate temperatures at bedside or tableside food. Generally, hot food is palatable between 110 degrees Fahrenheit (F) and 120 degrees Fahrenheit (F) . On 07/14/24 at 11:24 AM, during an interview, Resident #53 complained the food had been served cold at times. On 07/14/24 at 11:25 AM, during an interview with Certified Nurse Aide (CNA) #7, she explained she had been at the facility since April 2024, and residents had complained about the food being cold. On 07/14/24 at 11:45 AM, during an interview with Dietary Department Cook/Staff #4, she revealed two (2) of the four (4) compartments on the steam table did not work. The cook reported she poured boiling water into one of the inoperable compartments to use it. The cook revealed the Maintenance Department had been informed that the steam table could not be repaired. The cook stated she was informed that the steam table would have to be replaced. On 07/15/24 at 11:35 AM, during an observation of the kitchen staff as they prepared trays, the staff were not covering plates as they prepared them. There were up to six (6) racks of trays on a cart with no lids on the plates. At 11:39 AM on 07/15/24, during an observation of the steam table food temperatures, the scalloped corn was 170 degrees, garlic pepper pork loin was 160 degrees, and zucchini, tomatoes, and mushrooms were 170 degrees. At 12:05 PM on 07/15/24, the first tray cart left the kitchen to go to the dining room. None of the dining room trays had a plate cover. At 1:14 PM on 07/15/24, the last open tray cart containing four (4) trays left the kitchen to go to the hall. (continued on next page)

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	255244	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunplex Sub-Acute Center	6520 Sunscope Drive Ocean Springs, MS 39564

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/15/24 at 1:18 PM, the test tray reached the State Agency (SA) in the conference room. The food temperatures revealed garlic pepper pork loin with gravy at 110 degrees, zucchini and tomatoes at 100 degrees, and corn at 110 degrees. The food was lukewarm to taste. The Dietary Manager confirmed the food was lukewarm and not at an appetizing temperature. At 2:05 PM on 07/15/24, during an interview, CNA #5 explained Resident #53 and other residents had complained about the food being cold for several months. On 07/17/24 at 10:50 AM, during a phone interview with the facility's Registered Dietitian, she explained she was not aware residents were complaining about the cold food. On 07/17/24 at 2:15 PM, during an interview, the Administrator explained she was made aware recently that the residents had been complaining about cold food and that the steam table was not working properly. She expected all food to be delivered to the residents at an appetizing temperature. A record review of the Admission Record of Resident #53 revealed the facility admitted the resident on 01/24/24, with diagnoses that included Bilateral Primary Osteoarthritis of Knee and Essential Hypertension. The significant change Minimum Data Set (MDS) for Resident #53, with an Assessment Reference Date (ARD) of 06/18/24, revealed a Brief Interview for Mental Status (MDS) score of 15, which indicated the resident was cognitively intact.

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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. 48181 Based on observation, staff interviews, and facility policy review, the facility failed to ensure spoiled food items were discarded, food items such as seasonings and spices were not open and exposed, and the food prep area was free from contamination for two (2) of two (2) kitchen observations. This has the potential to affect all residents receiving meals from the facility's dietary department. Findings included: A review of the facility's policy Food Storage, revised 07/11/2024, revealed, Fresh vegetables should be checked and sorted for ripeness .should be inspected for decay .dry products should be kept in tightly sealed containers . A review of the facility's policy Infection Prevention and Control, dated 10/6/2017, revealed, The goals of the infection prevention and control program are to: A. Decrease the risk of infection to residents and personnel . C. Identify and correct problems relating to infection prevention and control practices .D. Maintain compliance with state and federal regulations related to infection and prevention . On 07/14/24 at 9:07 AM, during an interview and observation of the kitchen with the Cook, there were three (3) green bell peppers that had soft, pliable spots and areas of white biological growth. There were 15 containers of seasonings that were not closed, and the seasonings were exposed. The [NAME] acknowledged the overly ripe bell peppers and the exposed seasonings. The [NAME] reported she was unaware the produce was over-ripe and reported she and the Dietary Manager (DM) were responsible for maintaining food quality in the kitchen. On 07/15/24 at 11:14 AM, during an observation, the [NAME] picked up a glove from the floor and placed it on a food prep table where pureed tomatoes and sandwiches were being prepared. On 07/15/24 at 11:16 AM, in an interview with the Cook, she acknowledged that she had picked up a glove off the floor and placed it on the food prep table. The cook stated she knew food was being prepared on the table, but she did not want to place the glove back into the container with clean gloves. She confirmed the floor was considered dirty and the glove should have been discarded appropriately. On 07/15/24 at 1:24 PM, an interview with the DM revealed she was aware of the issues regarding spoiled peppers, exposed seasonings, and the [NAME] placing a glove on the food prep table from the floor. The DM stated it was the responsibility of the cook and herself to make sure spoiled foods were discarded. The DM reported whoever opened an item should make sure it was not left open, with the contents exposed. The DM stated she expected spoiled foods to be discarded and the seasonings to be closed. She also stated she expected items that were picked up off of the floor are discarded appropriately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/17/24 at 9:24 AM, an interview with the Administrator stated the issues in the kitchen should not have occurred. It was her expectation that items be stored and discarded appropriately.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 37415 Based on staff interviews and Certification and Survey Provider Enhanced Reports (Casper) reporting data review, the provider failed to ensure their Payroll Based Journal (PBJ) (information on the staffing hours for the appropriate care of the residents) had been corrected before submitting to the Centers for Medicare and Medicaid Services (CMS) for the second Quarter of the 2024 Fiscal Year (January 1, 2024 - March 31, 2024) for one (1) of four (4) quarters. Findings include: A review of the provider's [NAME] reporting data revealed the facility triggered excessively low weekend staffing and one star staffing rating for the second quarter of the 2024 fiscal year. A review of the facility's policy titled, Staffing Policy, reviewed 10/2022 revealed, . 4. Direct care staffing information per day (including agency and contract staff) is submitted to the Centers for Medicare and Medicaid Services (CMS) payroll-based journal system on the schedule specified by CMS but no less than once a quarter . During an interview on 7/17/24 at 9:00 AM, the Senior Director of Operations (SDO) explained she was responsible for sending staffing numbers to CMS. The SDO also said the staffing punches were pulled from Paylocity (online payroll software) and sent to CMS. The SDO also explained she notified the Administrator that the facility triggered for low weekend staffing. The SDO said she asked if there was anyone that was coded wrong which would cause the discrepancy. During an interview on 7/17/24 at 10:00 AM, the Business Office Manager (BOM) explained the facility failed to accurately code several employees when submitting the PBJ. The BOM said she attended a mini boot camp with the company on May 25, 2024. During this boot camp, it was brought to her attention that several employees who work for their facility do multiple jobs that have several different codes. If those individuals work the floor on weekends, those codes must be put in manually or the system would go back to their primary code. This would make the PBJ look like the staff did not work on those weekend days. The BOM stated when she came back to the facility, she did an audit and noted several days this occurred in the second quarter. The days this occurred were 2/17/24, 2/18/24, 3/9/24, 3/10/24, 3/30/24, and 3/31/24. A record review of the facility's Weekly Summary of Hours Report revealed Registered Nurse (RN) #1 worked 2/17/24, 3/9/24, and 3/10/24. The RN's primary position is Transitional Care Unit (TCU) Manager, which did not show that she was coded as a floor nurse for those days. Certified Nursing Assistant (CNA) #2 worked as a CNA on 3/2/24. Her primary position is Transportation Aide. CNA #3 worked as a CNA on 3/2/24. The CNA's primary position is Transportation Aide. Licensed Practical Nurse (LPN) #3 worked on 2/17/24, 2/18/24, and 3/10/24. This nurse's primary position is Medical Records. CNA #4 worked on 2/17/24, 2/18/24, 3/10/24, 3/30/24, and 3/31/24. The CNA's primary position is Dietary Aide. The Director of Nursing (DON) worked on 3/31/24. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/17/24 at 10:30 AM, the DON explained she was notified on 6/3/24 the facility triggered low staffing in the second quarter because of the inaccurate codes. The DON said she was told that the BOM as well as the DON would have to manually code staff that work weekends that do not normally provide direct care. During an interview on 7/17/24 at 12:30 PM, the Administrator confirmed the facility triggered for low weekend staffing and is a one-star facility. The Administrator stated she had only been the Administrator for three (3) weeks at this facility. The Administrator said she was informed that the facility had a problem with the right code being submitted to CMS if the staff works multiple positions. She was told the DON and BOM would manually place the correct codes in the system. The Administrator said she thinks this will fix the problem.