STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285260	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chimney Rock Villa	106 East 13th Street Bayard, NE 69334

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49766 Licensure Reference 175 NAC 12-006.05(S) Based on observations, interviews, and record review; the facility failed to provide care for residents in a manner that enhanced dignity and respect during meal services by ensuring staff did not stand over residents while assisting them to eat and by conducting social conversations with other staff rather than conversing with the residents they were assisting for 8 (Residents 8, 18, 20, 22, 23, 26, 29, and 31) of 8 sampled residents. The facility census was 31. Findings are: A record review of the facility's policy Assistance with Meals with a last revised date of March 2022 revealed Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a) staff is preferred to sit with residents; b) keeping interactions with other staff to a minimum while assisting residents with meals . A. A continuous observation on 7/8/2024 from 12:13 PM to 12:30 PM revealed Nurse Aide (NA) - A was sitting at a table with Residents 8 and 31. NA-B was sitting at a table with Residents 18, 22, and 23. NA-C was standing near the table with Residents 20, 26, and 29. NA-A, NA-B, and NA-C were heard having a personal conversation about the upcoming carnival while across the dining room from each other. The NAs did not include any residents in this conversation. An observation on 7/8/2024 at 12:39 PM revealed Nurse Aide (NA) - A was sitting at a table with Residents 8 and 31. NA-B was sitting at a table with Resident 18, 22 and 23. NA-C was standing near the table with Residents 20, 26, and 29. NA-A, NA-B, and NA-C were heard having a personal conversation about jewelry while across the dining room from each other. The NAs did not include any residents in this conversation. B. A continuous observation on 7/8/2024 at 12:47 PM to 12:55 revealed NA-C was standing while assisting Residents 20, 26, and 29 with eating their meals. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 7/8/2024 at 12:55 PM with NA-C confirmed the personal conversations during mealtime did not include the residents. The interview with NA-C also confirmed NA-C should have been sitting when assisting residents with eating. An interview on 7/8/2024 at 3:00 PM with the Director of Nursing (DON) confirmed their expectations during meal service included that staff were to be interacting with residents and not other staff and staff should have been seated while assisting residents with eating.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09(B) Based on record review and interview, the facility failed to accurately assess 1 (Resident 17) of 12 sampled resident's nutritional status on their admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning). The facility census was 31. The Findings Are: A record review of facility policy Certifying Accuracy of the Resident Assessment with revision date of November 2019, revealed that the information captured on the assessment should reflect the status of the resident during the observation period for that assessment. A record review of Resident 17's Admission MDS dated [DATE], revealed in Section K that the resident had had a Loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a prescribed weight loss program. Section K also revealed that the resident was on a mechanically altered diet. A record review of Resident 17's Consultation Notes dated 6/17/24, revealed documentation from Resident 17's medical provider which stated that the resident's weight on 6/17/24 was 116.7 kilograms (KG) and that the resident was on a regular diet. A record review of website unitconverters.net, revealed that 116.7 KG was equivalent to 257.3 pounds. A record review of Resident 17's admission History & Physical dated 6/17/24, revealed no evidence that Resident 17 had experienced any weight loss over the prior 6 months. A record review of Resident 17's current physician's orders revealed that the resident had an order for a Control Carbohydrate Diet that was to be regular texture and regular/thin consistency. This order had a start date of 6/20/24. An interview on 7/10/24 at 10:56 AM with the Dietary Manager (DM) confirmed that the DM had completed Section K of Resident 17's admission MDS andthe MDS should not have reflected that the resident had a significant weight loss or that the resident was receiving a mechanically altered diet as neither was accurate for Resident 17.

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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** 49263 Licensure Reference Number 175 NAC 12-006.09(E) Based on record review and interview; facility staff failed to develop and implement a comprehensive person-centered Care Plan (CP) for 4 (Residents 7, 12, 17, and 27) of 12 sampled residents. The facility census was 31. The Findings Are: A.A record review of facility policy care plans (CP), Comprehensive Person-Centered with revision date of March 2022, revealed that the comprehensive, person-centered care plan should describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and should reflect currently recognized standards of practice for problem areas and conditions. B. A record review of Resident 7's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) dated 7/6/24, revealed in Section I that Resident 7 had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and in Section O that the resident required oxygen therapy. A record review of Resident 7's undated CP revealed no references to the resident's diagnosis of COPD or their need for oxygen therapy. An interview on 7/10/24 at 10:42 AM with the Director of Nursing (DON) confirmed that Resident 7 was to be on 2 liters per minute (LPM) of oxygen continuously and that Resident 7's CP did not reflect the resident's diagnosis of COPD or the resident's need for continuous oxygen. The DON confirmed that this diagnosis and intervention were something the DON would expect to be reflected in the care plan. C. A record review of Resident 17's Admission MDS dated [DATE] revealed in Section K that the resident's weight was 256 pounds, and their height was 65 inches. A record review of website CDC.gov, revealed that a weight of 256 pounds and a height of 65 inches indicated a Body Mass Index (BMI) of 42.6. A record review of Resident 17's undated CP revealed a care plan focus of I have a nutritional problem or potential nutritional problem related to current weight being 164 pounds with a BMI of 26.9. An interview on 7/10/24 at 10:56 AM with the Dietary Manager (DM) confirmed that the DM was responsible for the nutrition section of the CP and that the weight and BMI in Resident 17's CP were inaccurate for this resident. D. A record review of Resident 27's MDS dated [DATE] revealed in Section GG that the resident required substantial assistance with toilet use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 27's undated CP revealed no evidence of the level of assistance the resident needed with their toileting. An interview on 7/10/24 at 10:33 AM with the DON revealed that Resident 27's need for assistance with their Activities of Daily Living (ADLs) fluctuated based on their mood. The DON stated that at times the resident was independent with their toileting needs but at other times the resident required staff assistance, and that at night the staff typically had to change the resident's incontinence brief and provide perineal cares while the resident was in bed. The DON confirmed that Resident 27's care plan did not contain information regarding the resident's fluctuating need for assistance with their toileting and that the DON would expect this information to be on the resident's CP. 49766 E. A record review of an Admission Record indicated the facility admitted Resident 12 on 4/21/2023 with diagnoses of Epilepsy, attention and concentration deficit, stroke, Congestive Heart Failure, and Type 2 Diabetes Mellitus. A record review of Resident 12's quarterly MDS with an assessment date of 6/14/2024 indicated Resident 12 had a Brief Interview for Mental Status (BIMS) of 2/15, indicating Resident 12 had severe cognitive impairment. The MDS also indicated Resident 12 had a weight loss. A record review of Resident 12's undated CP revealed no focus care area for nutrition and had no interventions addressing the resident's weight loss. An interview on 7/10/2024 at 3:00 PM with the DON confirmed Resident 12's CP did not include a focus care area for nutrition or any interventions for addressing the resident's weight loss.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09(F)(iii) Based on record review and interviews, the facility failed to review and revise Resident 19's care plan to reflect their current nutritional interventions and Resident 20's Care Plan (CP) to accurately reflect the level of assistance needed with their Activities of Daily Living (ADLs). The sample size was 12 and the facility census was 31. The Findings Are: A. A record review of facility policy Care Plans, Comprehensive Person-Centered with revision date of March 2022, revealed that the comprehensive, person-centered care plan should describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and should reflect currently recognized standards of practice for problem areas and conditions. The policy also stated that assessments of residents were ongoing and care plans were to be revised as information about the residents and the residents' conditions changed. A record review of Resident 20's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning), dated 1/19/24, revealed in Section GG that the resident required partial staff assistance with their bed mobility, transfers, and toilet use and only supervision while eating. A record review of Resident 20's MDS dated [DATE], revealed in Section GG that the resident required set up assistance with bed mobility, partial staff assistance with eating, and substantial staff assistance with transfers and toilet use. A record review of Resident 20's Task documentation for toilet use revealed that the resident had routinely required extensive staff assistance over the prior 3 months. A record review of Resident 20's Task documentation for transfers revealed that the resident had required primarily extensive staff assistance over the prior 3 months. A record review of Resident 20's Task documentation for eating revealed that the resident had required set up assist or limited staff assistance, equally, over the prior 3 months. A record review of Resident 20's undated CP revealed that the resident had an ADL self-care performance deficit, but the care plan also stated that the resident was independent set up for oral care, bed mobility, grooming, dressing, bathing, eating, toileting, ambulation, locomotion, transferring, repositioning, and hygiene. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 7/10/24 at 10:25 AM with the DON confirmed that Resident 20's CP identified the resident was independent with set up for all ADLs and that based on Resident 20's MDS data from 1/19/24 and 5/30/24, the resident's CP interventions for ADL assistance were inaccurate and should have been revised in January of 2024. 49766 B. A record review of an Admission Record indicated the facility admitted Resident 19 on 5/24/2022 with diagnoses of Alzheimer's disease and Type 2 Diabetes Mellitus. A record review of a Dietary Note with a date of 6/14/2024 indicated that the resident had had a significant weight loss in one month and that an intervention had been put into place for the staff to offer meals to Resident 19 in their room if the staff was unable to wake the resident for a meal. A record review of Resident 19's undated CP revealed no evidence of the intervention to offer meals to the resident in their room if the staff was unable to wake the resident for a meal. An interview on 7/10/2024 at 3:00 PM with the DON confirmed the intervention for Resident 19 had not been included in the resident's CP and the CP should have been updated to reflect this intervention.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference 175 NAC 12-006.09 Based on record review and interviews, the facility failed to ensure a hypertension (high blood pressure) medication was administered in accordance with the Prescribers' orders for 1 (Resident 12) of 1 sampled resident. The facility census was 31. Findings are: A. A record review of facility policy Administering Medications with a revision date of April 2019 indicated medications were to be administered in accordance with prescriber orders. B. A record review of an Admission Record indicated the facility admitted Resident 12 to the facility on [DATE] with diagnoses of epilepsy, stroke, and hypertension. A record review of Resident 12's quarterly Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents), with an Assessment Reference Date of 6/14/2024 indicated Resident 12 had a Brief Interview for Mental Status (BIMS) of 2 , which indicated Resident 12 had severe cognitive impairment. A record review of Resident 12's Pharmacist Recommendation dated 3/21/23, indicated the pharmacist had recommended for vital signs parameters to be placed on Resident 12's Coreg (a medication for hypertension) order. It also indicated a prescriber response with a new order stating the medication was to be held if Resident 12's systolic blood pressure was less than 100 or their pulse was less than 60. A record review of Resident 12's Medication Administration Record with a date of May 2024 revealed that on 5/30/2024 Resident 12 had been administered Coreg with a blood pressure of 88/55, which was below the vital signs parameters set by the prescriber. A record review of Resident 12's Medication Administration Record with a date of June 2024 revealed Resident 12 had been administered Coreg on the following dates with the following pulses, which were below the vital signs parameters set by the prescriber: -6/9/2024 evening - pulse 58 -6/19/2024 evening - pulse 57 -6/26/2024 evening - pulse 56 -6/27/2024 morning - pulse 48 A record review of Resident 12's Medication Administration Record with a date of July 2024 revealed that on 7/7/2024 Resident 12 had been administered Coreg with a blood pressure of 98/66, which was below the vital signs parameters set by the prescriber. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 7/9/2024 at 3:26 PM with the Director of Nursing confirmed Resident 12's Coreg had been administered not in accordance with the physician's orders on 5/30/2024, 6/9/2024, 6/19/2024, 6/26/2024, 6/27/2024, and 7/7/2024.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49263 Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g) Based on observation, record review, and interviews the facility failed to ensure an order was in place for 1 (Resident 7) of 1 sampled resident's oxygen therapy, resulting in an insufficient oxygen flow rate. The facility census was 31. The Findings Are: A record review of Resident 7's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning), dated 7/6/24, revealed in Section C that the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated that the resident had moderately impaired cognition. The MDS also revealed in Section I that the resident had Chronic Obstructive Pulmonary Disease (COPD) and in Section O that the resident was receiving oxygen therapy. An observation on 7/8/24 at 3:00 PM revealed Resident 7 was entering their room, wearing the nasal cannula that was attached to the portable oxygen tank that was on their walker. Resident 7 sat down on their bed, took off the nasal cannula from their portable oxygen tank and put on the nasal cannula that was attached to their oxygen concentrator. Resident 7 then turned on the oxygen concentrator. Both the portable oxygen tank and the oxygen concentrator were set at 1.5 liters per minute (LPM). An interview on 7/8/24 at 3:00 PM with Resident 7 revealed Resident 7's oxygen was to be set at 1.5 LPM and that the resident utilized supplemental oxygen continuously. A record review of Resident 7's current physician's orders as of 7/8/24 revealed no evidence of Resident 7 having an order for oxygen therapy. An interview on 7/10/24 at 10:42 AM with the DON confirmed that there was no order in Resident 7's Electronic Health Records (EHR) for the oxygen therapy and that the resident should have been on 2 LPM of oxygen continuously. An interview on 7/10/24 at 11:00 AM with the administrator confirmed that Resident 7 had recently seen a pulmonologist and that the pulmonologist had ordered was continue with 2 LPM of oxygen. The Administaror confirmed no order for the oxygen had been entered in the resident's EHR for staff to follow. A record review of facility policy Oxygen Administration, with revision date of October 2010, revealed that staff were to verify that there was a physician's order for the procedure and were to review the physician's order for oxygen administration. The policy also revealed that staff were to document the date and time the procedure was performed as well as the rate of oxygen flow.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 49766 Licensure Reference 175 NAC 12-006.09(H) Based on interviews and record reviews, the facility failed to ensure antibiotics had a stop date for 2 (Resident 1 and 19) of 5 sampled residents. The facility census was 31. Findings are: A. A record review of the facility's policy Antibiotic Stewardship - Orders for Antibiotics with a revision date of December 2016 revealed the following: - If an antibiotic is indicated, the order will include a stop date or number of days of therapy. - Appropriate indications for use of antibiotics include criteria met for clinical definition of active infection and pathogen susceptibility, based on culture and sensitivity, to antimicrobial. B. A record review of Center for Disease Control's (CDC) document The Core Elements of Antibiotic Stewardship for Nursing Homes APPENDIX A: Policy and Practice Actions to Improve Antibiotic Use revealed Surveys of antibiotic use have shown that (Urinary Tract Infection) UTI prophylaxis accounts for a significant proportion of antibiotic prescriptions. Very few studies support antibiotic use for UTI prophylaxis, especially in older adults, and many studies have shown this antibiotic exposure increases risk of side effects and resistant organisms. Therefore, efforts to educate providers on the potential harm of antibiotics for UTI prophylaxis could reduce unnecessary antibiotic exposure and improve resident outcomes.' A record review of an Admission Record indicated the facility admitted Resident 1 on 7/11/2019 with diagnoses of Multiple Sclerosis, obstructive and reflux uropathy, chronic kidney disease, and Urinary Tract Infection. A record review of Resident 1's quarterly Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents) with an Assessment Reference Date (ARD) of 4/12/2024 indicated Resident 1 had a Brief Interview for Mental Status (BIMS) of 15 indicating Resident 1 was cognitively intact. Resident 1's MDS also indicated Resident 1 was on an antibiotic. A record review of Resident 1's Order Summary revealed an order for Keflex (an antibiotic) with an order start date of 11/27/2023 and an indication of prophylaxis. The order did not include a stop date or treatment duration. An interview on 7/9/2024 at 2:56 PM with the Director of Nursing (DON) revealed the DON was aware Resident 1 was on a prophylactic antibiotic without a stop date or treatment duration. C. A record review of an Admission Record indicated the facility admitted Resident 19 on 5/24/2022 with diagnosis of Alzheimer's disease and age-related macular degeneration. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 19's significant change MDS with an ARD of 5/29/2024 indicated Resident 19 had a BIMS of 0 which indicated Resident 19 had severe cognitive impairment. A record review of Resident 19's Order Summary revealed an order for Neomycin-Polymyxin-Dexamethasone ophthalmic ointment (an antibiotic eyedrop) with a start date of 2/25/2024 and an indication of pink eye. The order did not have a stop date or a treatment duration. An interview on 7/9/2024 at 2:47 PM with the DON confirmed Resident 19's antibiotic eyedrop did not have a stop date or treatment duration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49766 Licensure Reference 175 NAC 12-006.10 Based on observations, interviews, and record reviews; the facility failed to ensure a medication that could not be crushed was not crushed for 1 (Resident 22) of 4 sampled residents. The facility census was 31. Findings are: A record review of facility policy Administering Medications with a last revised date of April 2019 revealed no guidance regarding the crushing of medications. A record review of Medical Professional Reference's Do not Crush or Chew List that was last updated on 6/5/2024, revealed potassium chloride was included on the list. It also revealed crushing extended-release medications can lead to large dose being released at once or alter the mechanism intended to protect the medication against stomach and mouth irritation. A record review of Resident 22's Order Summary revealed an order for potassium chloride extended release with directions to take 1 tablet by mouth every day. There was no guidance on the order regarding not crushing the medication. An observation on 7/10/2024 at 8:42 AM of Medication Aide (MA)-D revealed MA-D had crushed all of Resident 22's medications, including Resident 22's potassium chloride extended release. An interview on 7/10/2024 at 9:20 AM with MA-D confirmed MA-D was unaware potassium chloride extended release could not be crushed.

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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** 49766 Licensure Reference 175 NAC ,d+[DATE].11(D) Licensure Reference 175 NAC ,d+[DATE].11(E) Licensure Reference 175 NAC ,d+[DATE].18(B) Based on observations, interviews, and record review; the facility failed to ensure food products were disposed of or used before expirations dates, failed to ensure foods were not stored on the floor of the freezer in according to manufacturer's recommendations, failed to ensure the steam table food temperatures were held at safe temperatures and implement hand hygiene after the changing of gloves in order to prevent the potential for foodborne illness. This had the potential to affect all resident who resided within the facility. The facility census was 31. Findings are: A. A record review of the facility's policy Food Storage with a date of ,d+[DATE] revealed food should not be stored on the floor. B. Record review of 2017 Nebraska Food Code, under section ,d+[DATE].17 revealed food should be clearly marked to indicate the date or day by which food should be consumed or discarded. C. An observation on [DATE] at 6:59 AM of the initial kitchen tour revealed the following: -In the dry food storage area: -A package of lime gelatin with an opened date of [DATE] and without a use by date. -A box of tomato juice that was ,d+[DATE] used with an opened-on date of [DATE]. The box stated, refrigerate after opening. -In the walk-in refrigerator: -[NAME] Cottage Cheese container that was ,d+[DATE] empty that had expired on [DATE]. -Seven 12-packs of Dannon yogurt that had expired on [DATE]. -A ,d+[DATE] stick of butter wrapped in saran wrap with no opened-on date. -In the walk-in freezer: -A brown box containing food being stored on the floor. -A sign on the freezer door had stated there can be nothing on the floor of this freezer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285260	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chimney Rock Villa	106 East 13th Street Bayard, NE 69334

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on [DATE] at 8:28 AM with Dietary Aide (DA) - E confirmed these items were expired, tomato juice should have been refrigerated upon opening, and no items should be on the floor. DA-E was unsure of how long dry storage foods should be disposed of after opening but thought maybe 30 days. D. A record review of 2017 Nebraska Food Code, under section ,d+[DATE],272.01. revealed that hot foods should be held at or above a temperature of 135 degrees Fahrenheit. An interview on [DATE] at 12:08 PM with Cook-F revealed Cook-F believed temperatures on the steam table for meat should remain 180 degrees or higher and vegetables around 200 degrees. An observation on [DATE] at 12:50 PM of Cook-F revealed the final temperatures of food served on the steam table included the following: -Ground Chicken: 129.3 degrees Fahrenheit -Mashed Potatoes: 132.6 degrees Fahrenheit -Ground Beef: 124.7 degrees Fahrenheit An interview on [DATE] at 12:50 PM with Cook-F confirmed the steamtable temperatures were accurate as recorded and should have been hotter. E. A record review of a facility policy Handwashing/Hand Hygiene with a last revised date of [DATE], revealed hand hygiene is indicated immediately before touching a resident, after touching a resident, after touching a resident's environment, and immediately after glove removal. An observation on [DATE] at 12:28 PM revealed Cook-F serving food. Cook-F had removed a glove from one hand and applied and new one without the benefit of hand hygiene prior to the application of the new glove. An observation on [DATE] at 12:33 PM revealed Cook-F serving food. Cook-F had removed a glove from one hand and applied and new one without the benefit of hand hygiene prior to the application of the new glove. An observation on [DATE] at 12:37 PM revealed Cook-F serving food. Cook-F had removed a glove from one hand and applied and new one without the benefit of hand hygiene prior to the application of the new glove. An observation on [DATE] at 12:47 PM revealed Nurse Aide (NA) - C assisting Resident 26 with eating. NA-C then began assisting Resident 20 with eating. NA-C did not perform hand hygiene in between assisting each resident. An observation on [DATE] at 12:48 PM revealed NA-C had assisted Resident 20 with taking a bite of food. NA-C then assisted Resident 26 with taking a drink, touching Resident 26's straw with NA-C's hand without the benefit of hand hygiene prior to touching Resident 26's straw. NA-C then assisted Resident 29 with taking a bite of food, without the benefit of hand hygiene prior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on [DATE] at 12:51 PM revealed NA-C had assisted Resident 29 with unlocking their wheelchair and with repositioning Resident 29 in their wheelchair. NA-C then provided a bite of food to Resident 20 and then to Resident 26 without the benefit of hand hygiene in between the residents. An observation on [DATE] at 12:54 PM revealed NA-C had been assisting Resident 26 with eating. NA-C then went to Resident 20 and provided Resident 20 a bite of food without the benefit of hand hygiene in between assisting each resident. An interview on [DATE] at 12:55 with NA-C confirmed NA-C did not perform hand hygiene between assisting each resident and that they were aware they should have performed hand hygiene between each resident.