STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325065	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Vida Buena Healthcare	2301 Collins Drive Las Vegas, NM 87701

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 46064 Based on interview and record review, the facility failed to provide reasonable accommodations of resident needs and preferences for 1 (R #12) of 1 (R #12) residents. If the facility is not honoring resident preferences then residents are not able to make choices about aspects of their lives which are important to them. This deficient practice is likely to result in the resident's life style, personal choices, needs, and preference not being met. The findings are: A. On 06/10/24 at 11:55 AM during an interview with R #12, she stated the residents get up when staff come in and get them ready. R #12 stated she would like to get up at 9:00 am, but staff get her up at about 6:00 am. B. Record review of R #12's Admission Activity Assessment, dated 12/02/2021, revealed the resident preferred to get up at 9:00 am. C. On 06/12/24 at 11:24 AM during an interview with the Administrator, she stated residents should be accommodated to get up and go to bed when they wanted. She stated it was their choice. D. On 06/13/24 at 10:39 AM during an interview with Certified Nursing Assistant (CNA) #1, he stated R #12 asked to get up later than the time they go to get her up. He further stated staff encouraged the resident to get up when they went in. E. On 06/13/24 at 12:27 PM during interview with the Director of Nursing, she stated the expectation was for staff to follow resident preferences.

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 34439 Based on interview and record review, the facility failed to notify 2 (R #4 and #44) of 2 (R #4 and #44) residents when their balance was within or approached $200.00 of the maximum amount a Medicaid recipient could have in cash assets. If the facility is not notifying resident or residents' responsible parties when they are approaching the maximum amount then residents are likely to lose their eligibility of Medicaid benefits. A. Record review of the facility's Resident Statement Landscape (residents personal funds account) revealed R #4 and R #44 were above the eligible maximum amount. B. On 06/14/24 at 9:55 am during an interview with the facility Business Office Manager (BOM), he stated R #4's and R #44's accounts were above the maximum cash assets allowed amount for Medicaid recipients. He further stated the facility sent the residents' families a quarterly statement in April 2024, and they should have been aware the residents were approaching the maximum amount. He stated he did not send the families any other notifications, but the facility should notify the families when accounts were approaching the maximum amount. He also stated he should communicate with the Social Services Director (SSD) to let her know, so she could assist the residents in spending down their accounts. The BOM stated he did not do that. C. On 06/14/24 at 10:27 am during an interview with the SSD, she stated she was not aware R #4 was at or approaching the maximum allowed cash asset amount. The SSD stated staff did not tell her that either resident reached or was approaching the allowed amount.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50207 Based on observation and interviews the facility failed to provide a homelike environment for all 17 residents that ate their meals in the small dining room when staff failed to remove resident meals from the serving trays after they served the residents their meals. Residents were identified by the resident matrix provided by the Administrator on 06/10/24 and the seating chart for the small dining room provided by the Administrator on 06/12/24. This deficient practice could likely cause residents to feel depressed and anxious that they are not living in a comfortable home-like environment. The findings are: A. On 06/12/24 at 12:08 pm during an observation of the lunch meal in the small dining room, staff served the residents their lunch and left the food on the serving trays. Further observation revealed residents ate their meals with their plates, utensils, and cups still on the serving trays. B. On 06/12/24 at 12:13 pm during an interview with the Director of Nursing (DON), she stated They [residents that ate their meals in the small dining room] have always been served on trays. The DON stated that serving residents on trays is not homelike. C. On 06/12/24 at 12:16 pm during an interview with the Administrator (ADM), she stated she was not sure why staff served the residents in the small dining room their meals on serving trays. She stated, they just always do that and stated that it did not provide a homelike environment. D. On 06/12/24 at 12:21 pm during an interview with the Regional Director of Operations (RDO), he stated he preferred staff remove the trays but would not answer as to whether this practice provided a homelike environment.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064 Based on record review and interview, the facility failed to complete a Minimum Data Set (MDS; a collection of health data that reflects a resident's functional capabilities) assessment for 1 (R #3) of 1 (R #3) residents reviewed for significant change resident assessments. This deficient practice could likely result in resident needs not being identified or treated, resulting in residents receiving less than optimal care. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE]. B. Record review of R #3's physician orders, dated 03/12/24, revealed an order to discontinue hospice services. C. Record review of R #3's Electronic Health Record (EHR) revealed staff did not complete a significant change MDS assessment for R #3 when she discharged from hospice services. D. On 06/14/24 at 9:50 am during an interview with the MDS Coordinator (MDSC), she stated staff should have completed a significant change MDS assessment for R #3 when she discharged from hospice services in March 2024, but they did not.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207 Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 3 (R #75, R #78, and R #386) of 3 (R #75, R #78, and R #386) residents reviewed for baseline care plans. This deficient practice could likely result in a decline in the residents' conditions due to staff not being aware of the residents' needs. The findings are: R #75 A. Record review of R #75's face sheet revealed he was admitted to the facility on [DATE]. B. Record review of R #75's baseline care plan, dated 03/14/24, revealed an incomplete document. The sections for Nursing Services, Social Services, Rehabilitative Services, and Nutritional Services were blank. C. On 06/13/24 at 1:06 pm during an interview with the Director of Nursing (DON), she confirmed R #75's baseline care plan was incomplete. She stated it was her expectation staff fully complete the baseline care plans within the 48-hour deadline. R #78 D. Record review of R #78's face sheet revealed he was admitted to the facility on [DATE]. E. Record review of R #78's baseline care plan, dated 05/28/24, revealed an incomplete document. The sections for Nursing Services, Rehabilitative Services, and Nutritional Services were blank. F. On 06/13/24 at 12:59 pm during an interview with the Director of Nursing (DON), she confirmed R #78's baseline care plan was incomplete. She stated it was her expectation staff fully complete the baseline care plans within the 48-hour deadline. R #386 G. Record review of R #386's face sheet revealed she was admitted to the facility on [DATE]. H. Record review of R #386's baseline care plan, dated 06/03/24, revealed an incomplete document. The sections for Nursing Services, Rehabilitative Services, and Nutritional Services were blank. I. On 06/13/24 at 12:43 pm during an interview with the Director of Nursing (DON), she confirmed R #386's baseline care plan was incomplete. She stated it was her expectation staff fully complete the baseline care plans within the 48-hour deadline.

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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** 50207 Based on observations, interviews, and record reviews, the facility failed to develop a comprehensive care plan for 3 (R #58, R #78, and R #386) of 3 (R #58, R #78, and R #386) residents reviewed for care plans. This deficient practice could likely result in residents not receiving the care and treatment needed due to staff being unaware of the needs of residents. The findings are: R #58 A. Record review of R #58's face sheet revealed she was admitted to the facility on [DATE]. B. On 06/12/24 at 11:24 am during an observation, R #58 wore a nasal cannula (a thin, flexible tube that goes around the head and into the nose that supplies additional oxygen) connected to the oxygen concentrator (a device that supplies additional oxygen) while in her room. C. Record review of R #58's physician orders revealed an order, dated 01/26/24, for oxygen via nasal cannula continuously at 2 liters (L). D. Record review of R #58's care plan, dated 02/19/24 revealed the care plan did not include R #58's order and use of oxygen. E. On 06/13/24 at 12:54 pm during an interview with the Director of Nursing (DON), she confirmed R #58 utilized oxygen, and her care plan did not include the use of oxygen. The DON stated it was her expectation for staff to include oxygen use in care plans if relevant. R #78 F. Record review of R #78's face sheet revealed he was admitted to the facility on [DATE]. G. Record review of R #78's physician orders revealed an order, dated 06/03/24, for a house shake (a nutritional drink that provides additional calories) twice daily. H. Record review of R #78's care plan, dated 05/28/24 revealed the care plan did not include R #78's order for a house shake. I. On 06/13/24 at 12:59 pm during an interview with the DON, she confirmed R #78 received house shakes daily, and his care plan did not include the house shakes. The DON stated it was her expectation for staff to include nutritional supplements in care plans. R #386 J. Record review of R #386's face sheet revealed she was admitted to the facility on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. Record review of R #386's physician orders revealed an order, dated 06/04/24, for treatment for skin tears on left outer forearm and right forearm. Clean with normal saline solution, pat dry, and leave open to air or cover with dry dressing if draining. Monitor for signs or symptoms of infection. L. Record review of R #386's care plan, dated 06/11/24 revealed the care plan did not include R #386's diagnosis and treatment of the skin tears. M. On 06/13/24 at 12:43 pm during an interview with the DON, she confirmed R #386 had skin tears, and her care plan did not include her treatment. The DON stated it was her expectation for staff to include skin tears and treatment in the care plans.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for baths and showers by the facility staff for 2 (R #'s 15 and 31) of 2 (R #'s 15 and 31) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: R #15: A. Record review of R #15's face sheet revealed R #15 was admitted into the facility on [DATE]. B. Record review of R #15's care plan, dated 02/19/24, revealed the following: - Focus: R #15 was at risk for skin breakdown due to bowel and bladder incontinence and decreased mobility. - Interventions: Shower per schedule. C. Record review of the facility's shower schedule revealed R #15 was scheduled to receive a shower every Tuesday, Thursday, and Sunday. D. Record review of R #15's ADL tracking form in her Electronic Health Record (EHR), dated 05/01/24 through 05/31/24, revealed staff offered R #15 three showers out of 13 opportunities. E. Record review of R #15's shower sheets, dated 05/01/24 through 05/31/24, revealed staff offered R #15 eight showers out of 13 opportunities. F. Record review of R #15's ADL tracking form in her EHR, dated 06/01/24 through 06/14/24, revealed staff did not document any showers given or refused. G. Record review of R #15's shower sheets, dated 06/01/24 through 06/14/24, revealed staff did not document any shower sheets for R #15. H. On 06/10/24 at 2:19 pm during an interview with R #15, she stated she was supposed to receive three showers a week, but she did not receive three showers a week most of the time. R #15 also stated she did not feel good when she was not offered a shower as scheduled. I. On 06/13/24 at 10:55 am during an interview with Certified Nursing Assistant (CNA) #1, he stated R #15 liked to take a shower three times a week and did not know of any time R #15 had refused a shower. J. On 06/13/24 at 11:28 am during an interview with CNA #6, she stated R #15 should be offered a shower at least three times a week, and CNAs were to document each shower they offered in the resident's EHR and shower sheets. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. On 06/13/24 at 12:32 pm during an interview with Registered Nurse (RN) #2, she confirmed R #15 should be offered at least three showers a week, and the CNAs were to document the showers they offered in the resident's EHR and shower sheets. L. On 06/14/24 at 11:09 am during an interview with the Director of Nursing (DON), she stated staff should have offered R #15 at least three showers a week, and that did not occur. R #31: M. Record review of R #31's face sheet revealed R #31 was admitted into the facility on [DATE]. N. Record review of R #31's care plan, dated 05/30/24, revealed the following: - Focus: R #31 was at risk for further decline in ADLs due to cognitive impairments. He had an intellectual disability and may need reminders to complete ADL tasks. - Interventions: Assist resident with shower. O. Record review of the facility's shower schedule revealed R #31 was scheduled to be showered on Tuesday, Thursday, and Saturday. P. Record review of R #31's ADL tracking form in his EHR, dated 05/01/24 through 05/31/24, revealed staff offered R #31 three showers out of 13 opportunities and staff did not document any refusals. Q. Record review of R #31's shower sheets, dated 05/01/24 through 05/31/24, revealed staff did not provide any shower sheets for R #31 during that time frame. R. Record review of R #31's ADL tracking form in his EHR, dated 06/01/24 through 06/14/24, revealed staff did not document any showers. S. Record review of R #31's shower sheets, dated 06/01/24 through 06/14/24, revealed staff did not provide any shower sheets for R #31 during that time frame. T. On 06/11/24 at 9:47 am during an observation and interview with R #31, he had greasy hair had dirty nails and a faint odor of urine. R #31 stated staff did not offer him showers three times a week. U. On 06/13/24 at 10:58 am during an interview with CNA #1, he stated R #31 should be offered at least three showers a week. V. On 06/14/24 at 11:12 am during an interview with the DON, she stated staff should have offered R #31 at least three showers a week, and that did not occur.

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47091 Based on record review and interview, the facility failed to ensure residents received care consistent with professional standards to promote the healing of pressure ulcers (a localized wound caused by prolonged pressure to an area above a prominent bone) for 1 (R #21) of 1 (R #21) resident reviewed when staff: 1. Delayed in implementing new interventions/treatment (antibiotic) when the wound started to deteriorate. 2. Failed to accurately document presence of wound on skin checks/showers sheets and wound staging on reports. 3. Failed to notify provider of changes in the wound. 4. Delayed in getting R #21 an appointment at the Wound Clinic for treatment (seen 21 days after order). These deficient practices likely resulted in the wound significantly worsening for R #21, exposing bone and osteomyelitis (bone infection). The findings are: A. Record review of R #21's face sheet, dated 06/12/24, indicated R #21 was admitted to the facility on [DATE]. B. Record review of R #21's medical record revealed R #21 was admitted with the following diagnoses: 1. Type 2 diabetes mellitus (a condition results from insufficient production of insulin, causing high blood sugar). 2. Unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life). 3. Hypertension [high blood pressure in the arteries (vessels that carry blood from the heart to the rest of the body.)] 4. Contractures (a shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) of the left and right knees and the left and right hip. 5. Muscle weakness (reduction in the power exerted by muscles resulting in an inability to perform a given task on first attempt). C. Record review of R #21's care plan, dated 08/23/19, revealed the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- R #21 was at risk for skin breakdown (a condition where the skin is damaged or injured) due to bowel and bladder incontinence and decreased mobility. - Interventions: - Daily skin checks. Document results in resident's record. Notify nurse on duty if there is any type of skin break down. - Weekly skin checks. Document results on skin sheet. Notify Medical Doctor (MD) if there is any type of skin break down noted. - Assist and encourage resident to change position every two hours while in bed. - R #21 had wounds: - On 05/22/23: Redness to coccyx (tail bone located at the end of the spine). - On 01/12/24: Re-open area to coccyx. (Wound was facility acquired) - On 05/14/24: Stage 2 (partial thickness loss of skin presenting as a shallow, open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister). Interventions: Cleanse wound to coccyx with wound cleanser (an anatomic solution used to rinse or irrigate wounds), apply calazime cream (a skin protectant paste that contains zinc oxide), and cover with dry dressing until healed. D. Record review of R #21's Weekly Pressure Injury Trending Reports revealed the following: - Date of report: 05/15/24. - Wound Type: Pressure Injury. - Wound Location: Coccyx. Acquired in house (developed in the facility). - Date wound identified: 05/12/24. - Stage: 2. - Wound Measurements (Week 2): 2.4 cm length x 1.4 cm width x 0.5 cm depth. - Treatment: Barrier cream (a topical formulation used in industrial applications and as a cosmetic to place a physical barrier between the skin and contaminants that may irritate the skin) with dry dressing (dry absorbent bandage). - Date of Report: 05/22/24. - Wound Type: Pressure Injury. - Wound Location: Coccyx. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- Wound Status: Unchanged. - Stage: 2. - Measurements (Week 3): 2.5 cm length x 1.5 cm width x 0.5 cm depth. - Treatment: Unchanged. E. Record review of R #21's Weekly Wound Progress note, dated 05/22/24, revealed R #21 had one wound on her coccyx. Staff documented the wound was a skin tear (a type of injury where the skin is torn from the body) with odor present. The wound had 100 percent (%) red and black granulation tissue (a type of connective tissue that forms on the surface of a wound during the healing process) present, and the wound measured 2.5 centimeters (cm) in length by (x) 1.5 cm in width x 0.5 cm in depth. F. Record review of R #21's Physician Orders revealed the following: - Order, dated 05/21/24, referral to Wound Clinic for unstageable pressure injury to coccyx. - Order, dated 05/21/24, Pro-Stat oral liquid (concentrated liquid protein). Give 30 milliliters (ml) by mouth two times daily. - Order, dated 05/22/24, zinc oral tablet (supplement taken by mouth to support the immune system), 50 milligrams (mg). Give one tablet by mouth once daily. G. Record review of R #21's progress notes revealed staff documented the following: - On 05/15/24, resident had new pressure sore to coccyx. It was healing well with red granulation tissue. Was cleaned and dressed as ordered. Resident tolerated well. - On 05/19/24, wound to coccyx tunneled (through layers of the skin) with a strong foul odor. Blood and wound drainage on dressing. Informed Director of Nursing (DON). Wound treatment done as ordered. - On 05/21/24, wound to coccyx with foul odor. Will notify Wound Care Nurse (WCRN) this morning. - On 05/21/24, resident complained of pain to coccyx. Cleaned area and gave as needed (PRN) pain medication. Will continue to monitor throughout the shift. - On 05/22/24, wound to coccyx continued with foul odor. - On 05/22/24, resident had a new pressure sore to coccyx. It was healing well with red granulation tissue but does have a foul odor. Was cleaned and dressed as ordered. Resident tolerated well. Wound clinic referral made. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	H. Record review of R #21's Physicians Note, dated 05/27/24, revealed the resident's wound was worsening, and the resident waited for an appointment at the Wound Care Center. Wound had slough (a type of necrotic tissue that accumulates on the surface of a wound) per photos. Physician recommended change wound dressing to Santyl (name of ointment; removes dead tissue from wounds so they can start to heal). I. Record review of R #21's Weekly Pressure Injury Trending Reports revealed the following: - Date of Report: 05/28/24. - Wound Type: Pressure Injury. - Wound Location: Coccyx. - Wound Status: Unchanged. - Stage: 2. - Measurements (Week 4): 6.0 cm length x 4.0 cm width x 4.9 cm depth. - Treatment: Unchanged. - Date of Report: 06/04/24. - Wound Type: Pressure Injury. - Wound Location: Coccyx. - Wound Status: Unchanged. - Stage: 2. - Measurements (Week 5): 6.0 cm length x 4.2 cm width x 4.5 cm depth. - Treatment: Unchanged . J. Record review of R #21's shower sheets revealed staff documented the following: - 05/01/24: No new conditions. - 05/08/24: No new conditions. - 05/10/24: Skin check (staff observed skin for any abnormalities including wounds or signs of breakdown). - 05/15/24: No new conditions. - 05/17/24: Open area reported with coccyx area circled on shower sheet. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Some	- 05/22/24: No new skin conditions. - 05/31/24: No new skin conditions. K. Record review of R #21's Physician Orders revealed the following: - Order, dated 05/28/24, wound culture (a small sample of a substance from patient's body to test for bacteria) with sensitivity (test that determines what antibiotic can kill a certain bacteria). Diagnosis: Worsening wound to coccyx with foul odor. - Order, dated 06/02/24, cleanse wound to coccyx with wound cleanser and pat dry. Apply Santyl to slough, pack with a wet to dry dressing, apply barrier cream to edges of wound, cover with a dry dressing, change daily and as needed (PRN). - Order, dated 06/02/24, reposition resident from right side to left side while in bed. Avoid placing resident on coccyx to promote healing. - Order, dated 06/03/24, refer to hospice for wound to coccyx and decline in condition. - Order, dated 06/10/24, Santyl external ointment, 250 unit/gram (g). - Order, dated 06/11/24, stage 4 [a full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar (dark dead tissue) may be present on some parts of the wound bed] sacral pressure ulcer with exposed bone. Bone sent for culture (cx; a sample taken from the body used to diagnose infection) at wound care. Patient referred to emergency room (ER) for surgical consult, IV antibiotics, case management consult for discussion of goals of care, and possible palliative care consult. L. Record review of R #21's progress notes revealed staff documented the following: - On 05/28/24, spoke with Nurse Practitioner (NP) and received order for Bactrim DS (medication used to treat bacterial infection) twice a day (BID) for 10 days. Pending appointment with wound clinic. Wound care provided daily and as needed. Daughter/Power of Attorney (POA; the authority to act for another person) notified of antibiotic therapy (ABT; taking an antibiotic to resolve infection) and wound. The daughter to visit this evening. Doctor (Dr.) visited yesterday and was updated on wound. He gave an order for hospice evaluation. Will speak with daughter and plan further care. - On 05/29/24, resident had pressure sore to coccyx. It was healing well with red granulation tissue, slough, and eschar. The wound had a foul odor. Was cleaned and dressed as ordered. Resident tolerated well. Wound clinic referral made. - On 05/29/24, resident continued on ABT for wound. Adverse effects were not noted. Wound culture results still pending and awaiting wound clinic appointment date at this time. - On 05/30/24, wound to coccyx continued with foul odor. Continued on Bactrim DS without adverse side effects. - On 05/30/24, resident tolerated wound care well. A discharge present on wound dressing and a foul odor. Resident on antibiotics for wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- On 06/01/24, resident tolerated wound care well. Drainage and odor present to wound. Resident was on antibiotics. - On 06/02/24, wound treatment done to coccyx. Resident tolerated well, without complaints of pain or discomfort. Dressing had drainage and odor noted. - On 06/02/24, resident remained on antibiotics for wound to coccyx. Resident on Bactrim DS BID for 10 days. Wound culture sent to hospital on 5/28/24. - On 06/05/24, resident continued on antibiotic treatment for wound. Adverse effects were not noted. Wound culture results still pending. Wound clinic appointment on 6/11/24. - On 06/07/24, resident was alert and without pain or discomfort. Wound care completed, and resident tolerated well. Drainage to bandage and odor present. On antibiotic for wound. - On 06/08/24, resident tolerated wound care well. Drainage to bandage present. Odor present. Resident on antibiotics for wound. - On 06/11/24, resident had an appointment with the hospital wound clinic this morning at 7:45 am. Transported via facility van and accompanied by staff. Daughter met resident at appointment. Wound clinic staff spoke with daughters about hospice/palliative care versus aggressive treatment. Daughters wanted to send resident to the ER for further evaluation and management of wound. Per note from wound clinic, bone sent for culture wound care. Resident referred to the ER for surgical consult and intravenous (IV; inserted in the vein) antibiotics. Case management consult for discussion of goals of care and possible palliative care consult. M. Record review of R #21's Electronic Health Record (EHR) revealed a note from the hospital wound clinic, dated 06/11/24. Stage 4 sacral (tailbone) pressure ulcer with exposed bone. Bone sent for culture and wound care. Patient referred to ER for surgical consult and IV antibiotics. N. On 06/12/24 at 2:02 pm during interview with the Wound Care Nurse (WCRN), she stated she first saw the R #21's stage 2 pressure injury to coccyx on 05/22/24, and it had a foul odor, and the Family Nurse Practitioner (FNP) saw the wound the same day. She stated she expected antibiotic therapy to be ordered on [05/22/24]. The WCRN stated she sent a wound culture to the hospital, but she was not sure if it came back. WCRN stated that there was a period of time when she was pulled to work the floor and wasn't able to update wound reports and review the wounds. WCRN also stated she would have expected the provider to order the ABT when foul smell was identified. O. On 06/13/24 at 10:43 am during an interview with Certified Nurse Aide (CNA) #1, he stated he was aware R #21 had a pressure injury to her coccyx, and it had a foul odor. He was aware of the odor from the wound, because he assisted the nurses with positioning the resident for bandage changes. CNA #1 stated skin checks were done on all residents on 05/10/24. He stated CNAs checked for and documented any new skin conditions. He stated the CNAs alerted the nurse when they found a skin issue, and they documented it on the shower sheet. He stated the CNAs always reported any discoloration, anything that looked out of the normal, a mole, and dry skin. CNA #1 stated they did skin checks at random times. He stated if the nurses found a pressure wound on someone in an area, then they checked the other residents in the area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	P. On 06/13/24 at 11:31 am during an interview with CNA #6, she stated the CNAs documented everything they saw during a shower on each resident's shower sheet. Q. On 06/13/24 at 12:41 pm during an interview with the DON and the Regional Nurse Coordinator (RNC), they stated it was expected staff would take action sooner to assess the wound and inform the provider of condition of wound. After reviewing the progress note entered on 05/19/24, the DON confirmed it was her expectation that the nurse report changes to the provider and document how the wound was being treated. The DON stated the resident's record did not contain documentation on the progression of the wound. The DON stated sometimes a foul-smelling wound was a sign of an infection. She stated staff perform skin checks weekly as a skin assessment performed by the nurse. The DON stated staff fill out [document what we see] shower sheets according to the nurses' preference. She stated staff needed training on documenting on the progress of the wound and all actions taken in the resident's record. R. On 06/13/24 at 1:49 pm during an interview with the Family Nurse Practitioner (FNP), she stated the first time she saw R #21's wound it had a bad smell. She described the wound as necrotic (dead tissue). She stated she never saw the results from the wound culture she ordered on 05/28/24. The FNP stated if staff would have informed her of the change in R #21's wound then she would have suggested that R #21 go to the wound clinic sooner. She stated she expected the facility to call the 24 hour on-call provider to inform them of any change of condition so appropriate action could be taken. The FNP stated staff should have considered the changes in the resident's wound to be a change of condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, interview, and record review, the facility failed to ensure residents were free from accident hazards for 3 (R #15, #42, and #45) of 3 (R #15, #42, and #45) residents, when they failed to: 1. Use appropriate number of staff members to assist R #15 and R #45 while using a Hoyer lift (a patient lift or portable total body lift is a mobility tool designed to help individuals with mobility challenges). 2. Implement interventions to prevent falls after R #42 had repeated falls with injury. These deficient practices could likely result in residents being at risk of serious harm or injury. The findings are: Hoyer Lift Findings: A. Record review of the facility's Total Mechanical Lift (Hoyer lift) policy, dated June 2020, revealed at least two staff are to be present while resident is transferred with the mechanical lift. R #15: B. Record review of R #15's face sheet revealed R #15 was admitted into the facility on [DATE] with the following diagnoses: 1. Spastic quadriplegic cerebral palsy (stiff muscles and jerky movements that affects both legs and arms). 2. Muscle wasting and atrophy (loss of skeletal muscle mass). 3. Muscle weakness. 4. Need for assistance with personal care. C. Record review of R #15's care plan, dated 04/09/24, revealed the following: - Focus: R #15 had cerebral palsy. and needed extensive assistance for all her activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). - Interventions: Hoyer lift for all transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 06/13/24 at 2:53 pm during a unit observation, Certified Nursing Assistant (CNA) #3 entered R #15's room alone with a Hoyer lift. At 3:04 pm, CNA #3 left R #15's room alone with the Hoyer lift. E. On 06/13/24 at 3:04 pm during an interview with CNA #3, she confirmed she transferred R #15 alone with a Hoyer lift and should not have. R #45: F. Record review of R #45's face sheet revealed R #45 was admitted into the facility on [DATE] with the following diagnoses: 1. Muscle wasting and atrophy. 2. Unsteadiness on feet. 3. Muscle weakness. 4. Need for assistance with personal care. G. Record review of R #45's care plan, dated 03/19/24, revealed the following: - Focus: R #45 experienced some increased weakness and had several falls. - Interventions: Remind resident not to transfer or ambulate without assistance. H. On 06/10/24 at 3:51 pm during a unit observation, CNA #4 entered R #45's room alone with a Hoyer lift and exited from R #45's room alone with the hoyer lift. I. On 06/10/24 at 4:06 pm during an interview with CNA #4, she stated she was supposed to have another staff to help with Hoyer lifts. CNA #3 stated she transferred R #45 by herself with a Hoyer lift and should not have done so. J. On 06/14/24 at 11:17 am during an interview with the Director of Nursing (DON), she stated there should be two staff for a Hoyer lift transfer. The DON stated at least two CNAs should have been present when staff transferred R #15 and R #45 with a Hoyer lift. 47031 Fall Findings: R #42: K. Record review of R #42's medical record revealed R#42 was admitted on [DATE] with a diagnosis of unsteadiness on feet. L. Record review of R #42's nurses notes revealed the following: - On 05/06/2024 the resident had a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 05/11/2024 staff found the resident sitting on floor by door way and scooting on his bottom. M. Record review of R #42's care plan, dated 6/12/2024,revealed staff instructed to add anti-skid strips in the resident's bathroom. N. On 06/13/2024 at 9:08 am during an observation of R #42's room, there were not any anti-skid strips in his bathroom. O. On 06/14/2024 at 8:00 am during an interview with the Director of Nursing (DON), she stated R #42 should have anti-skid strips on the floor of his restroom. She stated the resident recently clogged his toilet, and maintenance staff removed the anti-skid strips to work on the resident's toilet.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47091 Based on observation, record review, and interview, the facility failed to meet professional standards of care related to the use of oxygen for 1 (R #21) of 1 (R #21) residents. This deficient practice is likely to cause resident to have upper respiratory infections if oxygen monitoring is not done. The findings are: A. Record review of R #21's face sheet, dated 06/12/24, indicated R #21 was admitted to the facility on [DATE]. B. Record review of R #21's medical record revealed R #21 was admitted with the following diagnoses: 1. Chronic obstructive pulmonary disease (COPD; a chronic inflammatory lung disease that causes obstructed airflow from the lungs.) 2. Dysphagia (difficulty swallowing.) 3. Dementia (a group of symptoms affecting memory, thinking and social abilities.) 4. Hypertension [high blood pressure in the arteries (vessels that carry blood from the heart to the rest of the body).] C. On 06/13/24 at 9:26 am during random observation, an oxygen (O2) concentrator (a device that concentrates the oxygen from a gas supply by selectively removing nitrogen to supply an oxygen enriched product gas stream) and nasal cannula (NC; a non-invasive device that delivers supplemental oxygen to residents through the nose) were at R #21's bedside. D. Record review of R #21's physicians orders revealed R #21 did not have a physicians order for oxygen therapy. E. On 06/13/24 at 9:26 am during an interview, Certified Nurse Aide (CNA) # 7 confirmed R #21 used O2. F. On 06/13/24 at 9:38 am during an interview, the Assistant Director of Nursing (ADON) stated R #21 used O2 therapy at night. G. On 06/13/24 at 9:41 am during an interview, Registered Nurse (RN) #2 stated she was unaware R #21 had an O2 concentrator in her room and confirmed she did not see a current physicians order for oxygen for the resident. H. On 06/13/24 at 9:45 am during an interview, the Director of Nursing (DON) reviewed R #21's physicians orders and stated she did not see an order for O2. She stated the resident should have one. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. On 06/13/24 at 10:50 am during an interview with CNA #1, he stated R #21 had a portable O2 concentrator when she sat in her wheelchair. CNA #1 stated the resident was on 2 liters of O2 per minute via her nasal cannula. He stated he checked the resident every two hours to obtain her oxygen reading.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207 Based on interviews and record review, the facility failed to effectively manage pain for 1 (R #386) of 1 (R #386) residents reviewed for pain when staff did not provide pain treatment. This deficient practice likely resulted in R #386 experiencing pain without sufficient relief. The findings are: A. Record review of R #386's face sheet revealed she was admitted to the facility on [DATE]. B. On 06/10/24 at 3:21 pm during an interview with R #386, her husband, and her daughter, R #386 stated she had pain related to hemorrhoids, and her daughter brought cream from home for her to use. R #386's daughter stated she asked the facility for hemorrhoid cream on 06/07/24, but they did not bring any. The daughter stated she brought some cream from home and helped her mom to apply the cream on her hemorrhoids. C. Record review of R #386's current physician orders revealed the record did not contain orders for any type of medication or treatment for hemorrhoids. D. Record review of R #386's progress and nursing notes revealed the record did not contain information regarding R #386's hemorrhoids or pain related to hemorrhoids. E. On 06/12/24 at 2:01 pm, during an interview with Certified Nurse Assistant (CNA) #2, she stated she knew R #386 has hemorrhoids, because she noticed blood when she helped the resident to the bathroom. CNA #2 stated she could not remember the date this occurred. CNA #2 stated she told a nurse, but she could not remember which one she told. F. On 06/12/24 at 2:07 pm, during an interview with Registered Nurse (RN) #1 she stated she was not aware R #386 had hemorrhoids or that she experienced pain. G. On 06/13/24 at 12:43 pm during an interview with the Director of Nursing (DON), she stated hemorrhoid cream should have been started when the hemorrhoids were identified. The DON stated if the hemorrhoids were not identified upon admission to the facility, then staff should have addressed it when R #386's daughter reported the issue to them.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure 1 (R #29) of 1 (R #29) residents reviewed for behavioral health concerns received necessary behavioral health care to meet their needs when staff failed to: 1. Ensure effective communication between the facility and psychiatric (psych) providers and provide consistent psychiatric services regarding R #29's psych service needs. 2. Document when facility Social Services Director (SSD) offered psych talk therapy to residents. These deficient practices are likely to result in the residents not receiving the behavioral or mental health care and assistance needed to improve mood and reduce depression and anxiety. The findings are: A. Record review of R #29's face sheet revealed R #29 was admitted into the facility on [DATE] with the following diagnoses: 1. Major depressive disorder (a mental disorder characterized by persistently depressed mood). 2. Anxiety. B. Record review of R #29's psychiatric individual therapy (talk therapy) notes, dated 12/29/21, revealed R #29 was discharged from talk therapy. Was discharged because was only seen for medication management. C. Record review of R #29's care plan, dated 04/17/24, revealed the following: - Focus: R #29 exhibited moods/behaviors as evidenced by agitation and lack of cooperation. - Interventions: Provide psychiatric services as needed. D. Record review of R #29's Electronic Health Record (EHR) revealed the following: 1. R #29 was not seen or offered talk therapy since she discharged for m talk therapy services on 12/29/21. 2. R #29 was only seen for psychotropic medication management by a psychiatric services provider. 3. R #29's EHR did not contain any indication she was offered talk therapy by SSD. E. On 06/11/24 at 8:53 am during an interview with R #29, she stated she was really depressed, but nobody listened to her. R #29 stated she received medication management from the psychiatric provider, but he only talked to her for a few minutes. R #29 stated she wanted longer talk therapy sessions. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 06/13/24 at 11:01 am during an interview with Certified Nursing Assistant (CNA) #1, he confirmed R #29 had depression. CNA #1 stated all staff members were aware of R #29's depression, and R #29 appeared to be sad often. G. On 06/13/24 at 11:32 am during an interview with CNA #6, she confirmed all staff were aware of R #29's depression. H. On 06/13/24 at 12:35 pm during an interview with Registered Nurse (RN) #2, she stated she and all other nurses were aware of R #29's depression. RN #2 stated she informed the SSD of R #29's depression sometime back. I. On 06/14/24 at 10:16 am during an interview with the Psych Service Provider (PSP), he stated R #29 had depression, but he only saw R #29 for her psychotropic medication management. The PSP also stated the facility should send a talk therapy referral for R #29 if that was something R #29 wanted. J. On 06/14/24 at 10:33 am during an interview with the SSD, she stated she did not send a talk therapy referral to the psych provider for R #29. The SSD also stated she did not document when she asked residents if they would like talk therapy services, but she should.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34439 Based on record review and interview, the facility failed to conduct a monthly Drug Regime Review for 1 (R #1) of 5 (R #1, R #29, R #37,R #45 and R #74) residents reviewed for unnecessary medications. This deficient practice is likely to result in irregularities not being communicated in a timely manner to the physician for review, evaluation, and possible intervention, which could result in delay of assessment or appropriate treatment. The findings are: A. Record review of R #1's physicians orders, dated 12/06/23, revealed duloxetine HCl (medication used for depression) delayed release sprinkle, 60 milligrams (mg). Give one capsule by mouth one time a day for depression. B. Record review of the facility's Medication Regime Review binder, dated from 01/01/24 through 06/12/24, revealed the binder did not contain R #1's documentation available for review. C. On 06/14/24 at 8:36 am during an interview with the Director of Nursing (DON), she stated. She gave the documents to medical records, and they could not locate the documents. She stated she was unable to locate any documents for the months of April 2024 and May 2024. She confirmed they were unable to provide the Medication Regime Review records for review. 46064

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	325065	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Vida Buena Healthcare	2301 Collins Drive Las Vegas, NM 87701

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to monitor for the use of psychotropic medications (any medication that affects brain activity associated with mental processes and behavior) for 4 (R #'s 3, 11, 19, and 29) of 4 (R #'s 3, 11, 19, and 29) residents reviewed when staff failed to: 1. Attempt to gradually reduce the dose (lower dose/quantity of medication administered) for a psychotropic medication for R #3, #11, and #19. 2. Complete a psychotropic medication consent form prior to psychotropic medication use for R #29. These deficient practices are likely to result in residents being administered unnecessary medication or being over medicated. The findings are: R #3: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE]. B. Record review of R #3's physician orders, dated 09/11/23, revealed risperidone oral tablet, 4 milligrams (mg). Give one tablet by mouth two times a day for bipolar depression. C. Record review of R #3's pharmacist medication regimen review (MRR), dated 04/13/24, revealed a recommendation for gradual dose reduction attempt for risperidone, 4 mg. The facility provider did not acknowledged nor signed the MMR as required. D. Record review of R #3's Medication Administration Record (MAR), dated 04/01/24 through 04/30/24, revealed staff administered R #3 the risperidone 4 mg twice a day, every day for the month. E. Record review of R #3's MAR, dated 05/01/24 through 05/31/24, revealed staff administered R #3 the risperidone 4 mg twice a day, every day for the month. F. Record review of R #3's MAR, dated 06/01/24 through 06/14/24, revealed staff administered R #3 the risperidone 4 mg twice a day, every day for the time frame. R #11: G. Record review of R #11's face sheet revealed R #11 was admitted into the facility on [DATE]. H. Record review of R #11's physician orders, dated 01/30/24, revealed fluoxetine, 60 mg. Give 60 mg by mouth one time a day related to schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior.) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Record review of R #11's pharmacist MRR, dated 04/12/24, revealed a recommendation for gradual dose reduction attempt for fluoxetine, 60 mg. The facility provider did not acknowledged nor signed the MMR as required. J. Record review of R #11's MAR, dated 05/01/24 through 05/31/24, revealed staff administered R #11 the fluoxetine 60 mg once a day, every day for the month. K. Record review of R #11's MAR, dated 06/01/24 through 06/14/24, revealed staff administered R #11 the fluoxetine 60 mg once a day, every day for the time frame. R #19: L. Record review of R #19's face sheet revealed R #19 was admitted into the facility on [DATE]. M. Record review of R #19's physician orders, dated 01/30/24, revealed quetiapine fumarate (Seroquel), 25 mg. Give one tablet by mouth one time a day for behaviors. N. Record review of R #19's pharmacist MRR, dated 04/13/24, revealed a recommendation to discontinue Seroquel 25 mg. The facility provider did not acknowledged nor signed the MMR as required. O. Record review of R #19's MAR, dated 05/01/24 through 05/31/24, revealed staff administered R #19 the quitiapine 25 mg once a day, every day for the month. P. Record review of R #19's MAR dated 06/01/24 through 06/14/24 revealed staff administered R #19 the quitiapine 25 mg once a day, every day for the time frame. Q. On 06/14/24 at 8:36 am during an interview with the Director of Nursing (DON), she stated she did not know why the provider did not acknowledge R #3's, #11's, and #19's MRRs. The DON stated the pharmacists recommendations for R #3, #11, and #19 were not attempted, but they should have been. R #29: R. Record review of R #29's face sheet revealed R #19 was admitted into the facility on [DATE]. S. Record review of R #29's physician orders revealed the following: - An order, dated 11/22/23, for Abilify oral tablet, 15 mg (aripiprazole). Give one tablet by mouth at bedtime related to bipolar disorder (a serious mental illness characterized by extreme mood swings.) - An order, dated 04/09/24, for Cymbalta capsules delayed release (duloxetine). Give 30 mg by mouth one time a day related to pain. T. Record review of R #29's psychotropic medication consent forms, dated 06/10/24, revealed the aripiprazole and duloxetine consent forms were created and signed on 06/10/24 and not prior to the use of the medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	U. On 06/14/24 at 9:54 am during an interview with the Assistant Director of Nursing (ADON), he stated both psychotropic medication consent forms should have been completed and signed when the orders were first given, but were 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. 46064 Based on observation and interview the facility failed to: 1. Ensure all medications were stored properly and in the original, labeled packaging. 2. Ensure medical supplies in the medication storage room were not expired. These deficient practices were likely to negatively impact the health of all residents, if staff administered or used potentially compromised or contaminated medications and medical supplies due to inappropriate storage. The findings are: A. On 6/10/24 at 10:37 AM during an observation of the A-Wing facility medication cart, five loose pills were at the bottom of drawer two. B. On 6/10/24 at 10:50 AM, Certified Medical Assistant (CMA) #1 stated there were unidentified loose pills on the bottom of drawer two, and they should not have been. CMA #1 further stated that nursing staff is responsible for cleaning the carts and disposing any loose medications or expired medications. CMA #1 further stated that the pharmacy comes in and will go through the medication carts and dispose of expired medications. C. On 6/10/24 at 10:55 AM during observation of the A-Wing medication room, one and a half boxes of expired Sani Cloth wipes (disposable disinfection wipes used to clean medical equipment) were located in the medication storage room. The wipes expired on August, 2023. D. On 6/10/24 at 10:55 AM, RN #2 stated the wipes were expired and should be disposed. The nursing staff are responsibel of disposing expired medications as well as the pharmacy when they do monthly audits. ?

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 41988 Based on record review, interview, and observation, the facility failed to provide sufficient support staff to carry out the functions of food and nutrition services at the facility. This deficient practice is likely to result in the residents' dietary needs not being met, recieving food that is not stored approriately (open to air, not labeled and dated) and longer waits for meal service for all 80 residents residing at the facility. Reference F0809 and F0812

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to provide food that accommodated resident preferences for 1 (R #15) of 1 (R #15) residents observed for food preferences. This deficient practice is likely to result in weight loss due to the resident not eating or an allergic reaction to the food being served to the resident. The findings are: A. Record review of R #15's face sheet revealed R #15 was admitted into the facility on [DATE]. B. Record review of R #15's care plan, dated 05/03/24, revealed the following: - Focus: Diet: Regular type. Regular with chopped meat. - Interventions: Use adaptive feeding equipment - Red foam built-up utensils, lip plate, and mug with spouted lid (sippy-cup) at all meals for improved self-feeding ability. Provide diet as ordered and honor food preferences. No beans. C. Record review of R #15's meal ticket, undated, revealed No beans. D. On 06/10/24 at 2:17 pm during an interview with R #15, she stated she had limited choices on meals to eat, and the kitchen constantly sent her food she did not like. E. On 06/12/24 at 12:33 pm during a lunch observation, staff served R #15 pasta with red sauce, beans, and enchiladas. R #15 stated, I don't want those [beans]. F. On 06/12/24 at 12:34 pm during an interview with Certified Nursing Assistant (CNA) #5, she confirmed R #15 was served beans and should not have been. G. On 06/12/24 at 12:37 pm during an interview with Dietary Aide (DA) #1, she stated R #15's meal ticket says the staff should not serve the resident beans, but they did. H. On 06/13/24 at 3:57 pm during an interview with the Dietary Manager (DM), she stated staff should not serve R #15 beans, because it says no beans on her meal ticket.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 41988 Based on observation, record review, and interview, the facility failed to deliver meals consistently and timely for all 80 residents in the facility. This deficient practice could potentially lead to frustration and hunger. The findings are: A. Record review of the facility meal times in the dining room revealed the following: 1. Breakfast: 8:05 am. 2. Lunch: 12:05 pm. 3. Dinner: 5:05 pm B. On 06/10/24, a lunch observation revealed the following: - At 12:24 pm, the main dining room was filled with residents, and lunch was not served. - At 12:57 pm, staff began to serve lunch. C. On 06/10/24 at 12:40 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated staff were supposed to serve lunch in the dining room at 12:05 pm, but it was late. LPN #1 also stated staff have served meals late ever since the facility did not have a Dietary Manager (DM). D. On 06/10/24 at 2:19 pm during an interview with R #15, she stated staff often delivered the meals late in the main dining room. R #15 stated other residents were upset when meals are late. E. On 06/10/24 at 3:20 pm during an interview with R #386, she stated staff often serve meals later than the posted meal times. F. On 06/11/24 at 8:24 am, a meal observation in the main dining room revealed staff began to serve breakfast. G. On 06/11/24 at 12:21 pm, a meal observation in the dining room revealed staff began to serve lunch. H. On 06/11/24 at 3:12 pm during an interview with the Registered Dietitian (RD), she confirmed staff served the meals later than they should. The RD stated they were trying to work on staff serving meals on time.

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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** 41988 Based on observation and interview, the facility failed to ensure food was stored, prepared, distributed, and served to residents in accordance with professional standards of food service safety when staff failed to: 1. Ensure all food items in the kitchen were labeled, dated, and stored properly. 2. Ensure refrigerated and frozen food was put away after a delivery and not left out for an extended period of time. 3. Ensure the kitchen walls, floors, and freezer floor were clean from dirt, grime, and unknown liquid. These deficient practices are likely to affect all 80 residents identified on the resident census list provided by the Administrator on 06/10/24. If the facility does not follow food safety guidelines, then they are likely to expose residents to food borne illnesses. The findings are: Food Storage Findings: A. On 06/10/24 at 10:39 am, an initial kitchen observation revealed the following: 1. One plastic tub of russet potatoes was not labeled or dated and stored in the dry storage. 2. One plastic tub of four white onions and approximately 30 red onions was not labeled or dated and stored in the kitchen prep area. 3. One large cardboard box of red apples with approximately 30 to 40 apples was not labeled or dated and stored in the kitchen prep area. B. On 06/10/24 at 10:56 am during an interview with Dietary Aide (DA) #1, she confirmed all findings and stated all food should be labeled and dated. C. On 06/10/24 at 12:36 pm, a kitchen follow-up observation revealed the following: 1. One box of 75, 4 ounce (oz) cartons of [NAME] Ready Care Strawberry shakes was on a prep table and not on ice or in a refrigerator. 2. Two boxes of 15, 2 pound (lb) cartons of Papetti's Breakfast Blend Scrambled Egg Mix was on prep table and not on ice or in a refrigerator or freezer. 3. One box of 46.44 lb boneless pork butts was on prep table and not on ice or in a refrigerator or freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. One 13.5 lb box Wheat Garlic Breadsticks made with whole grain was on the prep table and not on ice or in the freezer. D. On 06/10/24 at 1:11 pm during an interview with DA #1, she confirmed the findings. She stated the items were still not in the refrigerator or freezer after the delivery earlier in the morning, but they should have been. DA #1 also stated they began to serve lunch and did not have enough staff to put the food away first. E. On 06/13/24 at 3:26 pm, a kitchen follow-up observation revealed one 10 lb box of Double Red Provisions 100 percent (%) pure ground beef patties was open to air and stored in the freezer. F. On 06/13/24 at 3:28 pm during an interview with the Dietary Manager (DM), she confirmed the findings. She stated all food should be stored appropriately and put away immediately after a food delivery and the beef patties should be covered and not left open to air. Kitchen Cleanliness Findings: G. On 06/10/24 at 10:53 am during an initial kitchen observation, the overall facility kitchen was dirty with dirt/grease/grime on the floors, walls and baseboards. H. On 06/10/24 at 10:56 am during an interview with DA #1, she confirmed the findings and stated they were shorthanded with staff and not cleaning like they should. I. On 06/13/24 at 3:28 pm during a kitchen follow-up observation, the freezer floor was sticky and had brown liquid present upon entrance. J. On 06/13/24 at 3:30 pm during an interview with the DM, she confirmed the freezer floor finding and stated the floor should be clean and free from unknown liquid. The DM also confirmed the kitchen was still dirty and should be cleaned.