STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325076	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Anthony Healthcare and Rehabilitation Center	1400 West 21st Street Clovis, NM 88101

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to update the resident's medical chart and to ensure the resident's current advance directive and New Mexico Orders for Scope of Treatment (MOST) form (a document which provides an individual's wishes for emergency and lifesaving care) matched the order in the electronic health record (EHR) for 1 (R #7) of 2 (R #1 and R #7) residents reviewed for advance directives when staff failed to update the resident's code status. This deficient practice is likely to result in confusion, delay, and residents not having their wishes honored if a life-threatening event occurred. The findings are: A. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE]. B. Record review of R #7's physician orders dated [DATE], revealed R #7 chose a do not resuscitate (DNR; does not want to have CPR attempted on them if their heart or breathing stops) for her advanced directive code status. C. Record review of R #7's current advance directive and the MOST form signed on [DATE] revealed R #7 is a Full Code (attempt CPR or cardiopulmonary resuscitation) for her advanced directive code status. D. On [DATE] at 12:20 pm during an interview with the Director of Nursing (DON), she stated R # 7's code status should be Full Code and not DNR, confirming the inaccuracy.

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

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 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. Based on observation and interviews, the facility failed to provide a comfortable and homelike environment by: 1. Not repairing the peeling and chipped paint, 2. Not repainting areas of repair to match the rest of the wall, 3. Handrails in the 200-hall appeared worn and needed repair/refinishing, 4. Using an overhead paging system to announce phone calls for staff members and to call staff members to the office. These deficient practices could affect everyone that lives in the 200-hall as identified by the Daily Census provided by the Administrator (ADM) on 05/28/25 and will likely cause residents to feel like they are not living in a comfortable home-like environment and make them feel they are not valued. The findings are: A. On 05/29/25 at 9:36 am a random observation of the facility revealed the following: 1. Peeling and chipped paint on the walls throughout the 200-hall. 2. A section of the wall, close to the therapy entrance, approximately two feet wide and one foot tall, where it appears an object once hung on the wall is not repainted to match the rest of the wall. 3. Handrails in the 200-hall appeared worn out and needed repair/refinishing. B. On 05/28/25, random observations of the facility revealed the following announcements using the overhead paging system: 1. 2:53 pm: a staff member had a call on line one. 2. 3:00 pm: a staff member was called to the office. C. On 05/29/25, random observations of the facility revealed the following announcements using the overhead paging system: 1. 9:55 am: maintenance was called to the office 2. 10:00 am: a staff member had a call on line one. 3. 10:17 am: a staff member had a call on line one. 4. 11:21 am: maintenance was called to the office. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. 11:27 am: a staff member had a call on line one. D. On 05/29/25 at 1:15 pm, during an interview with the Administrator (ADM), she confirmed the facility is not providing an environment that is as comfortable and homelike as she would like.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interview, the facility failed to conduct an in-dept investigation, correct the grievance allegations, and notify residents of the outcome of their grievances. These deficient practices have the potential to affect all 62 residents (residents were identified using the census provided by the Administrator on 05/28/25) residing in the facility. If the facility is not investigating, correcting, and notifying residents of their grievance allegations then residents are likely to feel unheard and unimportant. The findings are: A. On 05/28/25 at 10:45 am during an interview with R #1, he stated that he has filed several grievances with the facility regarding the food and has never received an outcome. B. On 05/28/25 at 11:15 am during an interview with R #2, he stated that he has filed several grievances with the facility regarding several issues and has never received an outcome. C. On 05/28/25 at 1:40 pm during an interview with R #6, she stated that she has filed a couple grievances with the facility regarding food and showers and has never received an outcome. D. Record review of the facility's Grievance/Concern policy dated 06/01/22 revealed facility staff are to document all grievances and provide a response to the resident. E. On 05/28/25 at 2:43 pm during an interview with the Administrator (ADM), she stated that she is not able to provide evidence of grievances, the investigations, correction of the allegation or communicating outcomes to residents because the previous Social Services Director took the Grievance binder. The ADM stated that as of 05/01/25 a new binder was started.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview, the facility failed to have evidence that all allegations of abuse, neglect, exploitation or mistreatment were thoroughly investigated to prevent further incidents from occurring. This deficient practice could likely affect all 62 residents residing in the facility according to the census provided by the Administrator (ADM) on 05/28/25. If the facility is not thoroughly investigating and maintaining evidence of the investigations then residents are at a higher risk of being abused, neglected, exploited, or mistreated. The findings are: A. On 05/28/25 at 2:43 pm during an interview with the Administrator, she stated that she does not have evidence of any investigations conducted since 01/01/25 due to the previous Social Services Director taking the Reportable Binder (a binder the facility uses to keep all documentation and evidence of investigations) when she left. The ADM confirmed that she had to start a new binder as of 05/01/25.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interviews and record reviews, the facility failed to ensure the comprehensive care plan was accurate for 2 (R #1 and R #7) of 2 (R #1 and R #7) residents reviewed for care plan accuracy. This deficient practice could likely result in staff not understanding and implementing the most appropriate interventions and treatments for the residents. The findings are: R #1 A. Record review of R #1's admission record revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Spinal Stenosis, cervical region (narrowing of one or more spaces within the spinal canal), 2. Type 2 diabetes mellitus with hyperglycemia (blood sugar levels rise significantly), 3. Depression, unspecified, 4. Chronic diastolic (congestive) heart failure. B. Record review of R #1's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 10/18/24, revealed a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact. C. Record review of R #1's care plan dated 12/05/24 revealed that R #1 has an advance directive of (do not resuscitate) DNR; lifesaving measures are not desired) code status in place. D. Record review of R #1's New Mexico Orders for Scope and Treatment (MOST) form dated 07/30/24 revealed that R #1 has an advance directive of attempt resuscitation code status in place. E. On 05/29/25 at 12:20 pm during an interview with the Director of Nursing (DON), she confirmed that the facility failed to revise the care plan for R #1 after returning from the hospital. R #7 F. Record review of R #7's admission record revealed R #7 was originally admitted to the facility on [DATE] with the following diagnoses: 1. Acute respiratory failure with Hypoxia (not enough oxygen or too much carbon dioxide in the body), 2. Essential hypertension (HTN; high blood pressure), 3. Diverticulosis of Intestine, Part Unspecified, without perforation (inflammation/infection of somewhere in the intestine, without a hole in the intestine), or without Abscess without Bleeding, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Type 2 Diabetes Mellitus without Complications (too much sugar in the blood) 5. Muscle Weakness. G. Record review of R #7's care plan, dated 12/04/24, revealed the following: 1. Intervention for R #7 to have the choice between bed baths or showers twice per week. 2. Bathing Preference Sheet was updated to bathing once a week. 3. The facility failed to revise the care plan to reflect the change in bathing and showering. H. Record review of R #7's MOST form dated 02/28/25 revealed R #7 has an attempt resuscitation code status in place. I. Record review of R #7's care plan dated 02/28/25 revealed R #7 has a do not resuscitate code status in place. J. On 05/29/25 at 12:20 pm during an interview with the DON, she confirmed R #7 should have had a care plan for refusals of care and she does not. The DON confirmed that R #7's care plan should have been revised to match the most current MOST form, and it was not.

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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. Based on 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 for 1 (R #7) of 1 (R #7) dependent resident sampled for ADLs. If the facility is not assisting the residents to bathe or shower, then residents are likely to feel unimportant, dirty and could develop further or worsening health issues. The findings are: A. Record review of R #7's Document Survey Report (documentation showing ADL support/care completed), dated 11/28/24 through 04/28/25 revealed the following: 1. On 12/30/24 R #7 received a bed bath. 2. On 01/11/25 R #7 received a bed bath. 3. On 01/19/25 R #7 received a bed bath. 4. On 01/26/25 R #7 received a bed bath. 5. On 02/02/25 R #7 received a bed bath. 6. On 02/08/25 R #7 received a bed bath. 7. On 02/15/25 R #7 received a bed bath. 8. On 03/03/25 R #7 received a bed bath. 9. On 03/10/25 R #7 received a bed bath. B. On 05/29/25 at 12:20 pm during an interview with the Director of Nursing(DON), it was confirmed the facility failed to provide bathing services.

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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** Based on observation, record review, and interview, the facility failed to keep residents free from accidents for 2 (R #5 and R #7) of 2 (R #5 and R #7) residents reviewed for accidents when staff failed to: 1. Put interventions in place to reduce the risk of falls for R #5. 2. Implement appropriate post-fall interventions (ensure the health and safety of residents after a fall by completing actions such as neurochecks) for R #5 and R #7. These deficient practices could likely result in residents getting injured during falls or injuries going unnoticed after a fall. The findings are: R #5 A. Record review of R #5's admission record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement), 2. Major depressive disorder (depression; a mood disorder that causes a persistent feeling of sadness and loss of interest), severe with psychotic symptoms, 3. Reduced mobility and muscle weakness, 4. Delusional disorders. B. Record review of R #5's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 04/12/25, revealed the following: 1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 07, severe impairment. 2. R #5 requires substantial or maximal assistance to complete transfer activities. 3. R #5 has had falls since being admitted to the facility. C. On 05/28/25 at 10:25 am, an observation of R #5's room, R #5 laid on her left side, covered with a sheet and blanket. R #5's bed was in a high position; the top of the mattress was approximately three feet from the floor. There was no fall mat in place. D. On 05/29/25 at 11:13 am, during an interview with R #5's guardian (a person that has legal authority to make decisions on behalf of another person), she confirmed that she was notified of a fall R #5 had on 04/13/25. R #5's guardian stated that she has asked the facility to keep her bed in a lower position and to put a fall mat in place but neither of these has happened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record review of R #5's care plan initiated on 01/24/24 revealed R #5 is at risk for falls. The need for R #5's bed to be in a low position and a fall mat in place is not included in the plan. F. Record review of R #5's electronic health record (EHR) revealed no evidence that staff completed a neurocheck (a brief neurological assessment performed by staff repeatedly to monitor a resident's neurological status) with R #5 after the unwitnessed fall she had on 04/13/25. G. On 05/29/25 at 11:20 am, during an interview with the Director of Nursing (DON), she stated that all residents who are at risk for falls should have a fall mat in place and their bed should be kept in the lowest position. The DON confirmed neither of these interventions are in place for R #5 and stated they should be. The DON stated that neurochecks should have been done with R #5 but were not. R #7 H. Record review of R #7's admission record revealed that she was admitted to the facility on [DATE] with the following diagnoses: 1. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement), 2. Cerebral Infarction (an area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain), 3. Delirium due to known physiological condition, 4. Major depressive disorder (depression; a mood disorder that causes a persistent feeling of sadness and loss of interest). I. Record review of R #7's quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 05, severe impairment and has had falls since admission. J. Record review of R #7's progress notes revealed the following: 1. R #7 had a fall on 02/22/25, no other documentation to show the cause of the fall or what occurred during the fall was located. 2. R #7 had a fall on 04/07/25, no other documentation to show the cause of the fall or what occurred during the fall was located. K. Record review of R #7's care plan dated 05/06/25, revealed R #7 is at risk for falls and facility staff are to observe for any changes in medical status, pain status, mental status and medication side effects that may contribute to cognitive loss or confusion and can lead to increase fall risk. L. On 05/29/25 at 11:20 am, during an interview with the DON, she confirmed that the cause of the falls or what occurred during the fall was not documented adequately so she could not say what the cause of the fall was or if the falls could have been prevented. The DON confirmed that neurochecks should have been completed following each fall and was not done completely.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 3 (R #2, R #3, and R #4) of 3 (R #2, R #3, and R #4) residents reviewed for respiratory care when staff failed to change the oxygen concentrator (a medical device that provides extra oxygen) tubing. If the facility fails to provide new, clean tubing for oxygen concentrators then residents are at risk of becoming ill. The findings are: R #2 A. Record review of R #2's admission record revealed R #2 was originally admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease (CODP; lung disease), 2. Quadriplegia (paralysis of all four limbs), 3. Type 2 diabetes mellitus (DM2; a condition results from insufficient production of insulin causing high blood sugar), 4. Morbid obesity (severely overweight). B. Record review of R #2's current medical orders revealed the following: 1. An order, dated 08/15/24, for oxygen at three liters using a nasal canula. 2. No order or recommendation was found for the care of medical equipment. C. On 05/28/25 at 11:15 am, an observation of R #2's room revealed an oxygen concentrator sat on the floor next to R #2's bed. R #2 was wearing a nasal canula and utilizing this concentrator to supply his additional oxygen. A bag with another resident's name on it was attached to the concentrator. There was no date indicating the date the oxygen concentrator tubing. D. On 05/28/25 at 11:43 am, during an interview with the Director of Nursing (DON), she confirmed the oxygen concentrator that R #2 is using had another resident's name on it and there was no date indicating when the oxygen concentrator tubing was changed. The DON stated that R #2 is supposed to be using this oxygen concentrator, she was not sure why another resident's name is on it. The DON stated that her expectation is for all residents that need oxygen to have an oxygen concentrator dedicated to their use and the oxygen concentrator tubing to be changed as ordered. R #3 E. Record review of R #3's admission record revealed R #3 was originally admitted to the facility on [DATE] with the following diagnoses: 1. Acute and chronic respiratory failure (not enough oxygen or too much carbon dioxide in the body), (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Essential hypertension (HTN; high blood pressure), 3. Chronic obstructive pulmonary disease (CODP; lung disease), 4. Morbid obesity (severely overweight), 5. Obstructive Sleep Apnea (sleep disorder that occurs when a person's breathing is interrupted during sleep). F. Record review of R #3's current medical orders revealed an order dated 06/09/24 for staff to change the oxygen concentrator tubing and place a label indicating the date it was changed weekly. G. On 05/28/25 at 11:20 am, during an observation of R #3's room, an oxygen concentrator was located next to R #3's bed. R #3 was wearing a nasal canula and using the oxygen concentrator to supply the additional oxygen she needs. There was no label indicating the date the concentrator tubing was changed. H. On 05/28/25 at 11:43 am, during an interview with the DON, she confirmed there was no label to indicate the date the oxygen tube on R #3's concentrator was changed. The DON stated her expectation is for all residents that utilize oxygen to have their tubing changed as ordered as labeled with the date it was completed. R #4 I. Record review of R #4's admission record revealed he was originally admitted to the facility on [DATE] with the following diagnoses: 1. Chronic congestive heart failure, 2. Chronic obstructive pulmonary disease (CODP; lung disease). J. Record review of R #4's current medical orders revealed an order dated 11/12/20 for staff to change the oxygen concentrator tubing weekly. K. On 05/28/25 at 11:25 am, a random observation of R #4's room revealed an oxygen concentrator next to his bed. R #4 was wearing a nasal canula and using this oxygen concentrator to supply the additional oxygen he needs. There was no label indicating the date the concentrator tubing was changed. L. On 05/28/25 at 11:43 am, during an interview with the DON, she confirmed there was no label to indicate the date the oxygen tube on R #4's concentrator was changed. The DON stated her expectation is for all residents that utilize oxygen to have their tubing changed as ordered as labeled with the date it was completed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to secure medications in a medication cart and a treatment cart for all 62 residents living in the facility (residents were identified by the census list provided by the Administrator on 05/28/25). This deficient practice could result in residents obtaining medication not prescribed to them resulting in adverse side effects. The findings are: A. On 05/28/25 at 1:45 pm, an observation of the facility revealed the medication cart was located by room [ROOM NUMBER] and was unlocked. B. On 05/28/25 at 1:46 pm, during an interview Licensed Practical Nurse (LPN) #1, she confirmed that the medication cart was unlocked. C. On 05/29/25 at 10:11 am, an observation of the facility revealed the treatment cart was in the 200 hall near the nurse's station and was unlocked. D. On 05/29/25 at 10:13 am, during an interview LPN #2, she confirmed that the medication cart was unlocked. E. On 05/29/25 at 11:20 am, during an interview with the Director of Nursing (DON), she stated that all medication carts should be locked when unattended.

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	325076	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Anthony Healthcare and Rehabilitation Center	1400 West 21st Street Clovis, NM 88101

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to serve food that is palatable, attractive, and at a safe and appetizing temperature. This deficient practice has the potential to affect all 62 residents' ability to eat and enjoy their meals, may decrease their quality of life, and could likely lose weight. The findings are: A. Record review of R #1's admission record revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Spinal Stenosis, cervical region, 2. Type 2 diabetes mellitus with hyperglycemia 3. Depression, unspecified, 4. Chronic diastolic (congestive) heart failure. B. Record review of R #1's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 10/18/24, revealed a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact. C. On 05/28/25 at 10:45 am, during an interview with R #1, he stated that the food does not taste good, food that is supposed to be hot is served cold, and the facility does not follow the menu. D. Record review of photos that R #1 has taken of meals that he was served and the meal ticket (a facility document that shows information related to a resident's diet recommendations, allergy status, and individual specific menu for that resident's meal) for the meals revealed the following: 1. A meal ticket dated 02/27/25 indicated the breakfast meal to be French toast, but the photo of the meal showed some type of Danish (a type of pastry). 2. A meal ticket dated 02/28/25 indicated oven browned potatoes were to be served with a beef chili and rice casserole but the photo showed potatoes were not served. 3. A meal ticket dated 03/01/25 indicated Toasted O's (dry cereal), scrambled eggs with ham, and wheat toast was to be served for breakfast but the photo showed oatmeal, scrambled eggs without ham, and a biscuit was served. 4. A meal ticket dated 03/01/25 indicated a dinner roll, pan fried potatoes, and herbed green beans were to be served with crunchy buttermilk chicken, but the photo of this meal showed a piece of bread, mixed vegetables, and mashed potatoes were served. 5. A meal ticket dated 03/03/25 indicated Toasted O's, a banana, and French toast was to be served for breakfast, but photo of this meal showed oatmeal, a pancake and eggs were served. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. A meal ticket dated 03/05/25 indicated Toasted O's and hash browns were to be served with scrambled eggs but the photo of the meal showed oatmeal, scrambled eggs and biscuit with gravy was served. 7. A meal ticket dated 03/05/25 indicated cranberry glazed chicken with a dinner roll, cinnamon apples, Brussel sprouts and stuffing was to be served but the photo of this meal shows what appears to be a casserole, with mixed vegetables, and mashed potatoes was served. 8. Meal ticket dated 03/08/25 indicated a chicken casserole and sliced carrots with a chocolate chip cookie was to be served but the photo of this meal shows what appears to be a casserole, a slice of bread and pinto beans was served. 9. A meal ticket dated 03/09/25 that indicated maple sage turkey was to be served with a dinner roll, homemade pumpkin pie, seasoned peas and cornbread dressing but the photo shows turkey was served with rice, mixed vegetables, a piece of bread, and an oatmeal pie cookie was served for lunch. 10. A meal ticket dated 03/09/25 that indicated beef barley soup, tossed salad, herb crusted chicken, a dinner roll and sliced pears was to be served but the photo of the meal shows spaghetti, a slice of bread, coleslaw and a cup of fruit was served. E. On 05/28/25 at 11:15 am, during an interview with R #2 he stated that the hot food is served cold and the food does not taste good. He stated that he has to buy his own food and keep it in his room, so he has something to eat when the food from the facility is inedible. F. On 05/28/25 at 12:15 pm, an observation of the lunch meal revealed the following: 1. Chicken on a room tray that was served to R #2 had an internal temperature of 109.3 degrees. 2. Pizza (alternative food offered) had an internal temperature of 112.6 degrees. G. On 05/28/25 at 12:15 pm, during an interview with Certified Nursing Assistant (CNA), #1, she confirmed the temperature of the chicken was 109.3 degrees and the temperature of the pizza was 112.6 degrees. H. On 05/28/25 at 12:33 pm during an interview with Dietary Aide (DA), she confirmed that the temperatures taken for the pizza and chicken were not appropriate temperatures for food to be served at.