STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325131	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Trails Rehabilitation Suites	1610 Renaissance Blvd NE Albuquerque, NM 87107

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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 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** 41988 Based on record review and interview, the facility failed to ensure staff revised the care plan for 3 (R #45, #60 and #320) of 2 (R #45, #60 and #320) residents reviewed when staff failed to: 1. Update the care plan to include Activities of Daily Living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) care for R #45 and #60. 2. Update the care plan to include activity preferences for R #60. 3. Inform the Power of Attorney (POA) of changes in care plan to include new behaviors for R #320 These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R #45: A. Record review of R #45's face sheet revealed R #45 was admitted into the facility on [DATE]. B. Record review of R #45's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 05/17/24, revealed R #45 required partial to moderate assistance, in which the helper did less than half the effort. Helper lifted, held, or supported trunk or limbs but provided less than half the effort for most ADL tasks. C. Record review of R #45's care plan, dated 07/10/24, revealed R #45's ADL care requirements were not documented in the care plan. D. On 07/18/24 at 5:44 pm during an interview with the Director of Nursing (DON), she stated staff should have care planned R #45's ADL care requirements, but they did not. R #60: E. Record review of R #60's face sheet revealed R #60 was admitted into the facility on [DATE]. (continued on next page)

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of R #60's MDS, dated [DATE], revealed R #60 required substantial and maximal assistance, in which the helper did more than half the effort. Helper lifted or held trunk or limbs and provided more than half the effort. R #60 was dependent, in which the helper did all the effort. Resident did none of the effort to complete the activity. R #60 required the assistance of two or more helpers for the resident to complete the activity for most ADL tasks. G. Record review of R #60's care plan, dated 07/10/24, revealed R #60's ADL requirements and activity preferences were not care planned. H. On 07/18/24 at 5:19 pm during an interview with the Activities Director (AD), she confirmed R #60's activity preferences were not care planned and should have been. I. On 07/18/24 at 5:45 pm during an interview with the DON, she stated R #60's ADL care requirements should have been care planned and were not. 47091 R #320: J. Record review of R #320's face sheet revealed R #320 was admitted to facility on 12/27/22 with the following diagnoses: - Type 2 diabetes mellitus (a condition that results from the body's inability to process sugar as fuel resulting in high sugar levels). - Muscle wasting and atrophy (the wasting or thinning of muscle mass). - Chronic Kidney Disease (a gradual loss of kidney function that can cause fluid, electrolyte and waste buildup in your body). - A mental health diagnosis was not noted upon admission. K. Record review of R #320's care plan, dated 09/28/23, revealed the category Behavioral Symptoms was added to the initial care plan on 04/03/24 and included R #320 was having mood and behavior needs, as evidenced by periods of difficulty adjusting to long term care (LTC). The resident refused care at times, such as being changed or use of Purewick [name of] external catheter. L. On 07/18/24 at 4:38 pm during interview with POA, she stated it was discussed, during R #320's care plan conference on 05/24/24, why staff failed to notify the family of any changes in R #320's care plan, to include any new or escalated behaviors. POA stated the facility staff informed her they did not know why the family was not informed. M. On 07/18/24 at 4:54 pm during interview with DON, she stated that according to the initial care plan (09/28/23), staff should have notified R #320's POA of changes made to the care plan, to include any new behavioral symptoms and interventions. The DON stated staff did not notify the family when they made changes to R #320's care plan.

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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 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 for 2 (R #'s 45 and 60) of 2 (R #'s 45 and 60) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: R #45: A. Record review of R #45's face sheet revealed R #45 was admitted into the facility on [DATE]. B. Record review of R #45's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 05/17/24, revealed R #45 required partial/ moderate assistance, in which the helper did less than half the effort. Helper lifted, held, or supported the resident's trunk or limbs, but provided less than half the effort for most ADL tasks. C. Record review of R #45's physician orders, dated 05/13/24, revealed R #45 was to be offered/receive a bath or shower on Wednesdays and Sundays. D. Record review of R #45's Point of Care (POC) Response (ADL tracker located in Electronic Health Record- EHR), dated 06/01/24 through 06/30/24, revealed staff offered/gave R #45 two baths/showers out of nine opportunities. E. Record review of R #45's shower sheets, dated 06/01/24 through 06/30/24, revealed staff offered/gave R #45 five baths/showers out of nine opportunities. F. Record review of R #45's POC Response, dated 07/01/24 through 07/18/24, revealed staff offered/gave R #45 three baths/showers out of five opportunities. G. Record review of R #45's shower sheets, dated 07/01/24 through 07/18/24, revealed staff offered/gave R #45 three baths/showers out of five opportunities. H. On 07/16/24 at 11:10 am during an observation and interview, R #45 had disheveled hair. R #45 stated she was mostly offered one shower a week, because nursing staff told her they were short staffed. R #45 also stated she felt yucky when she was not offered/given at least two baths or showers a week. I. On 07/18/24 at 11:00 am during an interview with Certified Nursing Assistant (CNA) #1, she stated R #45 liked her baths/showers and did not refuse often. CNA #1 confirmed staff did not always offer R #45 at least two baths/showers a week, but they should. J. On 07/18/24 at 1:09 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated staff should offer/give R #45 at least two baths/showers a week. (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 7/18/24 at 5:48 pm during an interview with the Director of Nursing (DON), she stated staff should offer/give residents baths/showers per the resident's bath/shower schedule. The DON stated staff did not offer/give R #45 enough baths or showers, and they should have. R #60: L. Record review of R #60's face sheet revealed R #60 was admitted into the facility on [DATE]. M. Record review of R #60's MDS, dated [DATE], revealed R #60 required substantial/maximal assistance, in which the helper did more than half the effort. The helper lifted or held the resident's trunk or limbs and provided more than half the effort, and the resident was dependent fo the helper to do all the effort. Resident did none of the effort to complete the activity and required the assistance of two or more helpers for the resident to complete the activity for most ADL tasks. N. Record review of R #60's physician orders, dated 05/21/24, revealed R #60 was to be offered/receive a bath/shower on Mondays and Fridays. Order was discontinued on 06/19/24. O. Record review of R #60's physician orders, dated 06/21/24, revealed R #60 was to be offered/receive a bath/shower on Wednesdays and Sundays. P. Record review of R #60's POC Response, dated 06/01/24 through 06/30/24, revealed staff offered/gave R #60 two baths/showers out of eight opportunities. Q. Record review of R #60's shower sheets, dated 06/01/24 through 06/30/24, revealed staff offered/gave R #60 six baths/showers out of eight opportunities. R. Record review of R #60's POC Response, dated 07/01/24 through 07/18/24, revealed staff offered/gave R #60 three baths/showers out of five opportunities. S. Record review of R #60's shower sheets, dated 07/01/24 through 07/18/24, revealed staff offered/gave R #60 three baths/showers out of five opportunities. T. On 07/15/24 at 3:54 pm during an interview with R #60, she stated she should be offered/given two baths/showers a week. She stated that did not always happen, because the CNAs tell her they were too busy. R #60 also stated not having at least two baths/showers a week made her feel dirty. U. On 07/18/24 at 11:04 am during an interview with CNA #1, she stated staff should offer/give R #60 at least two baths/showers a week. CNA #1 stated R #60 liked getting showers and did not refuse them often. V. On 07/18/24 at 1:06 pm during an interview with LPN #1, she stated R #60 did not refuse showers often. She stated if R #60 refused showers then R #60 will take a bed bath. W. On 7/18/24 at 5:50 pm during an interview, the DON stated staff did not offer/give R #60 enough baths/showers, and they should have.

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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 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. 41988 Based on observation, record review, and interview, the facility failed to ensure staff did not leave medications on the resident's bedside table. These deficient practices had the potential to impact the health of all residents on the 400 hall, and could likely result in residents taking a medication that is not intended for them or taking more than the dose prescribed. The findings are: A. On 07/18/24 at 12:03 PM, during an observation of R #28's room, there were a total of 12 pills. Six pills were oblong shaped pills engraved with LS703 (Ranolazine; used to treat chest pain), four yellow oval pills engraved with AN038 (Mucus Relief DM dextromethorphan 30 mg / guaifenesin 600 mg)], two beige oval pills engraved with MP9 [Pantoprazole Sodium Delayed Release 40 mg (used to treat acid reflux)] on R #28's bedside table. H. On 07/18/24 at 12:03 PM during an interview with R #28, he stated he did not know what the pills were or how long they were on bedside table. B. Record review of R #28's Physician order, dated 07/01/24, revealed the following: - An order for ranolazine ER, 500 milligrams (mg) tablet, every 12 hours. Pharmacy Directions: Take one tablet by mouth twice a day. Hold for dizziness. - An order for Mucinex DM bi-layer, 600 mg - 30 mg, every 12 hours. Pharmacy Directions: Take one tablet by mouth twice a day. Break in half and give with applesauce. - An order for pantoprazole SOD 40 MG. One tablet by mouth twice a day. C. Record review of R #28's Medication Administration Review (MAR), dated 07/01/24, revealed the following: - Staff administered Ranolazine (LS703) every day from 07/01/24 through 07/17/24. - Staff administered Mucinex DM (dextromethorphan-guaifenesin; MP9) every day from 07/01/24 through 07/17/24. - Staff administered pantoprazole SOD, 40 mg tablet every day from 07/01/24 through 07/17/24. I. On 07/18/24 at 12:06 PM during an interview with Registered Nurse (RN) #3, she confirmed all the medication pills were on R #28's bedside table. She stated the Certified Medication Aide (CMA) left the medication there. The RN stated there should not be any medications left on the bedside table, and CMA #2 should know better than to do that. J. On 07/18/24 at 3:20 PM during an interview with Director of Nursing (DON), she stated staff should never leave any medications on resident's bedside tables. She stated the nurses and CMAs should always watch residents take all medications during medication administration and before the CMAs leave the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. On 7/22/24 at 4:11 PM during an interview with CMA #1, she stated staff should not leave any medications at a resident's bedside table. She stated staff were supposed to watch the residents take all their medications.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38450 Based on observation, interviews, and record review, the facility failed to ensure staff followed nutritionally calculated recipes for pureed diets. Failure to follow recipes that have been approved by the Registered Dietician (RD) has the potential for food not to meet the nutritional requirements of the residents. This failure had the potential to affect all six residents who ate pureed meals. The findings are: A. Observation on 07/15/24 at 10:52 am revealed the [NAME] placed one premeasured bag of vegetables into the food processor bowl. She added an unmeasured amount of a chicken flavored powder. The [NAME] pureed the mixture until smooth and placed it in the warmer for lunch service. B. On 7/15/24 at 10:54 am, during an interview, the [NAME] stated she prepared pureed meals for six residents. She stated she did not know the measurement of the vegetables, because they came in a pre-measured bag. She stated she added one bag of vegetables. The [NAME] stated she did not have a recipe for the pureed vegetables, and she did not know how much chicken flavored powder she added to the mixture. C. Record review of the recipe for seasoned broccoli and cauliflower, undated, revealed the following: - Measure half cup (c) of cooked broccoli and 1 tablespoons (tb) broth or melted butter for each serving needed into the food processor. - Process until smooth. - Add food thickener if needed to bring to mashed potato consistency. D. Observation on 07/15/24 at 11:10 am revealed the [NAME] placed six chicken breasts into the food processor bowl. She added two ladles of gravy. The [NAME] pureed the mixture until smooth and placed it in the warmer for lunch service. E. On 07/15/24 at 11:12 am, during an interview, the [NAME] stated she did not know how much gravy she added to the chicken. She stated she guessed it was about two cups of gravy. F. Record Review of the recipe for crispy oven baked chicken, undated, revealed the following: - Measure one cooked breast and two tb broth or water for each portion needed. - Using food processor, blend until smooth. G. Observation on 07/15/24 at 12:00 pm, the Dietary Manager (DM) placed six pieces of Texas toast into the food processor bowl. He added two and a half ladles of gravy. The DM pureed the mixture until smooth. The DM added an unmeasured amount of water to the mixture and continued to puree to the desired consistency. The DM placed the mixture on the steam table. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 07/18/24 at 10:20 am, during an interview with the Administrator (ADM), the DM, the Director of Nursing (DON), and the Regional Nurse Consultant (RNC), they stated the DM was responsible for the oversights of the kitchen and nourishment kitchens, to include the preparation of pureed foods. The DM stated the facility has a Registered Dietician (RD) who reviews the menus and recipes for nutritional values. The RD reviewed the menu for the current week and signed off on them. The DM stated it was expected staff would follow the recipes. He stated staff should inform him if there are change to the recipes so he can contact the RD for approval. The DM stated staff did not tell him they made any change to the recipes for the current week. The DM stated he did not follow the recipe for the Texas toast, because he did not know there was a recipe for it. He also stated he was in a time crunch and wanted to get the bread served to the residents in a timely manner. I. On 07/25/24 at 2:52 pm, during an interview with the RD, she stated the new menus and recipes come out every six months, and she reviews them. She stated RD stated she reviews resident charts and weights, and she can also make food substitutions for the menus, as needed. The RD stated it was expected the dietary staff would follow the recipes, because they are provided for each food item.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 47031 Based on observation, record review, and interview, the facility failed to provide assistance devices for 1 (R #13) of 1 (R #13) residents reviewed during random observation. This deficient practice are likely to result in residents being unable to perform activities of daily living which could likely result in consuming less food. The findings are: A. Record review of R #13's Annual Nutritional Assessment, dated 04/23/2024 and completed by the Registered Dietitian, revealed a recommendation for sippy cup (a plastic cup with two handles). B. Record review of R #13's physician orders, dated 04/01/24, revealed an order for a sippy cup with all meals. C. Record review of R #13's meal ticket, dated 07/18/24, revealed a note for a sippy cup. D. On 07/18/24 at 12:00 PM am during lunch observation, staff served R #13 his lunch meal plate without a sippy cup. Further observation revealed R #13 ate lunch and did not have a sippy cup. E. On 07/18/24 at 12:03 PM during an interview, Licensed Practical Nurse (LPN) #1 stated she never saw a sippy cup. She confirmed there was not a sippy cup with R #13's meal.

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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** 38450 Based on observation, interviews, and record review, the facility failed to maintain the kitchen in a sanitary manner when staff failed to: - Maintain the ice machine in a manner to prevent contamination and foodborne illness, - Perform hand hygiene and to change gloves as often as necessary to avoid cross contamination, - Protect clean dishes and plastic ware to prevent contamination, - [NAME] and serve pureed food at the appropriate temperatures to prevent the growth of foodborne pathogens and illnesses, - Allow dishes to air dry completely before use or storage, - Keep staff food separated from resident food, - Utilize hair restraints and beard guards in a manner which restrained all hair while in the kitchen, - Properly store open food with labels and dates to prevent cross contamination and outdated usage, - Store scoops for bulk bins in a manner to prevent cross contamination, - Use the sanitizing solution according to manufacturer's instructions, - Wash, rinse, and sanitize the food preparation sink between uses to prevent cross-contamination and the growth of food-borne pathogens, - Maintain the kitchen environment in a clean and sanitary manner, - Report the presence of ants in the nourishment kitchen to the appropriate staff. These failures had the potential to result in cross contamination, the growth of foodborne pathogens, and foodborne illnesses. This failure had the potential to affect all residents who ate food from the kitchens. The findings are: Maintenance of Ice Machines A. Observation on 07/15/24 at 12:33 pm revealed an ice machine located in the beverage area of the main kitchen. Further observation revealed the ice machine drainpipes contained a black substance and clear slime built up on the bottom 1/4 inch () of two drain pipes. Observation also revealed staff used the ice machine for resident lunch service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. On 07/16/24 at 10:14 am during an interview with the Maintenance Director (MD), the Dietary Manager (DM), and the Assistant Dietary Manager (ADM), they stated the dietary staff and the maintenance staff are responsible for maintaining the ice machines throughout the facility. The DM stated the dietary staff cleans the ice machine weekly to include wiping it down; and the MD services the ice machine every three months. The DM stated they were issue with the drain on 05/06/24, and the machine was not draining properly. The DM stated the MD had more knowledge regarding the drainage issue. The MD stated he took the ice machine apart on 05/06/24, but it did not have any drainage issues. He stated he was not aware of the black substance on the drainpipe. The MD stated the black substance should not be on the drainpipe, because it could backup into the machine and contaminate the ice. C. Observation on 07/16/24 at 2:15 pm, revealed an ice machine located in the Nourishment Room located near the 300 hallway. Further observation revealed a water bottle blocked the air gap between the ice machine's drainpipes and the floor drain. Observation also revealed a black substance, a white substance, and a black slime covered the bottom 1 of both drainpipes. D. Observation on 07/16/24 at 3:43 pm revealed an ice machine located in the Nourishment located on the 200 hallway. Further observation revealed a black substance and a white substance covered the bottom 1 of both drainpipes. E. On 07/18/24 at 10:20 am, during an interview with the DM, the Administrator (ADMIN), the Director of Nursing (DON), and the Regional Nurse Consultant (RNC), they stated they stated the DM was responsible for the oversights of the kitchen and nourishment kitchens. The DM stated the Nourishment kitchens are satellite kitchens used for snacks and ice for the residents. The DM stated he checked the rooms daily, and other staff went into the rooms often. The DM stated it was expected the staff would alert him to any concerns in the Nourishment kitchens. He stated the dietary staff clean the ice machines weekly, and the MD was responsible to service the ice machine every three months. The ADMIN, DON, and RNC were not aware the ice machines contained a growth of black and white substances with slime. The ADMIN stated the substances should not be on the ice machine drainpipes, because it is an infection control issue. Handwashing and Glove Use (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. Observation on 07/15/24 at 10:12 am revealed Dietary Aide (DA) #3 wore gloves and chopped cooked eggs for residents' salads. The DA took the chopping board into the dishwashing area, touched the plastic wrap dispenser, and wrapped the bowls of salads. The DA did not remove her gloves and wash her hands after chopping cooked eggs and before touching other items. The DA did not wash her hands after touching the chopping board and before touching the plastic wrap and salad bowls. At 10:15 DA #3 continued to wrap bowls of salad and wore the same gloves from when she chopped the cooked eggs. The DA got a metal container from shelf, touched a visibly dirty food cart, and touched the ice scoop. The DA removed her gloves, but the DA did not perform handwashing. DA #3 wrote dates on the salads and touched the door handle of the walk-in refrigerator as she put the salad bowls in the refrigerator. At 10:20 am DA #3 put on gloves to make sandwiches. The DA touched bread slices, touched the lunch meat, and then touched more bread slices. At 10:31 am, the DA went to the storage shelf and touched multiple pans, looking for a container for the sandwiches. The DA returned the unused pans to the storage shelf. The DA did not remove gloves or hand wash after making sandwiches and before touching the pans. At 10:37 am, DA #3 touched cheese slices with same gloved hands. She placed the extra cheese into bags and touched the door handle of the walk-in refrigerator as she put the cheese away. The DA exited the walk-in refrigerator, removed her gloves, but she did not perform handwashing. The DA took the plastic wrap dispenser and covered the container of sandwiches. Further observation revealed the salads and sandwiches were used for residents' meal. G. On 07/15/24 at 10:43 am during an interview, the DM stated the policy for handwashing and glove use was for staff to hand wash before putting on gloves and after removing gloves. The DM stated staff should wear gloves when handling eggs. The DM stated staff should also perform handwashing whenever they go from a dirty task (touching dirty dishes, cleaning the kitchen, taking out trash, and similar) to a clean task (touching clean dishes, preparing food, and similar). He stated the dietary staff have been trained on handwashing and glove use in the kitchen. H. Observation on 07/15/24 at 10:30 am revealed DA #4 arrived in the kitchen and put on gloves. The DA touched various papers, pens, food preparation tables, and door handles. At 10:43 am, DA #4 touched two apples with the same gloved hands. The DA did not remove her gloves and perform hand washing after touching papers and pens and before touching the food preparation tables and the apples. Further observation revealed the apples were used for residents' meals and staff continued to prepare food on the food preparation table. I. Observation on 07/15/24 at 10:35 am revealed DA #2 put on gloves but did not wash her hands first. The DA touched clean silverware on the mouthpiece. She put the silverware into divided containers for resident use. The DA removed her gloves and went into the pantry where she touched food items. DA #2 did not perform hand washing after removing her gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	J. On 07/18/24 at 10:20 am, during an interview with the DM, the Administrator (ADMIN), the Director of Nursing (DON), and the Regional Nurse Consultant (RNC), they stated they stated the DM was responsible for the oversight of the kitchen. The DM stated he observed the dietary staff weekly and provided on-the-spot training as needed. He stated he provided more in-depth training at monthly in-service meetings for persistent issues. He stated it was expected staff follow the Food Code and CMS guidance for food safety. He stated he reviewed these expectations during his observations and in-services. The DM stated staff missed several opportunities for handwashing on 07/15/24. He stated staff should not treat their gloved hands as they do their bare hands. The DM stated he instructed his staff that gloves are there to prevent cross contamination, but they only prevented cross contamination if they are used once. He said staff should use their glove for a single activity, remove them, and hand wash before going to the next activity. Protection of Stored Plastic Ware and Dishes K. Observation on 07/15/24 at 9:31 am of the main kitchen revealed the following: - A container of plastic wear sat on bottom shelf of service table opened and not protected. Further observation revealed multiple staff walked past the container, pushed service carts, and pulled trash cans past the uncovered container. - A container of plastic lids on bottom shelf of a service table opened and not protected. Further observation revealed multiple staff walked past the container, pushed service carts, and pulled trash cans past the uncovered container. L. On 07/15/24 at 9:33 am during an interview, the DM stated it was expected staff would take what plastic ware they need from the container and put the lid back in place. He stated the cup lids are usually in a plastic sleeve, and he was not sure why they were out. He stated the plastic ware should be protected from cross contamination. M. On 07/15/24 at 9:50 am, observation of the dishwashing area revealed a box of resident cups with straws sat on the floor of the dishwashing area uncovered. Further observation revealed multiple staff in the dishwashing area washed and sprayed dishes which created an overspray, pulled trash cans, and pulled carts of dirty dishes past the uncovered box. N. Observation on 07/15/24 at 9:35 am, revealed a stack of metal pans stored inverted on bottom shelf of shelving. Further observation revealed the shelf was open metal type, and there was not a barrier between the floor and the inverted pans, which exposed the pans to contaminations from the floor to include mop water. Observation also revealed various bowls and containers stored upright on the shelves with the food surface exposed. O. On 07/15/24 at 9:37 am during an interview, the DM stated staff swept and mopped the kitchen floors everyday, to include under the shelving. He stated the pans should be protected from potential contaminates from the floor, to include dust from sweeping and splashes from mopping. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	P. Observation 07/15/24 at 9:38 am, of the dish washing area revealed a cart with clean divided plates (a plate with multiple sections). Further observation revealed the divided plates were stored upright with the food surface exposed and unprotected, as multiple staff in the dishwashing area washed and sprayed dishes which created an overspray, pulled trash cans, and pulled carts of dirty dishes past the uncovered plates. Q. On 07/15/24 at 9:40 am during an interview, the DM stated the cart should be located in the cooking area where staff will use them for meal service. He stated the clean dishes should not be stored unprotected in the dish washing area. R. On 07/18/24 at 10:20 am, during an interview with the DM, the Administrator (ADMIN), the Director of Nursing (DON), and the Regional Nurse Consultant (RNC), they stated the DM was responsible for the oversights of the kitchen and nourishment kitchens. They stated staff should store clean dishes in a safe manner. The DM stated staff should store clean dishes inverted with the food surface down so particles or drips did not end up on the food surface. He stated staff know have been trained on how to store clean dishes and plastic ware to prevent contamination. Pureed Food Temperatures S. Observation on 7/15/24 at 12:00 pm, the DM prepared pureed Texas toast for the residents' lunch service. The DM finished preparation and placed a container of pureed Texas toast on the steam table. The DM did not measure the temperature of the pureed toast before he placed it on the steam table. The [NAME] prepared a plate of food for one resident and placed a serving of the pureed toast on the resident's plate. The DA placed the plate on the food service cart. The DM measured the temperature of the pureed bread using the facility's calibrated thermometer. The bread measured 100 degrees ( ) Fahrenheit (F). The [NAME] told the DM to place the container of pureed bread in the steamer to bring it up to temperature. The DM asked the [NAME] if she used the pureed bread, and the [NAME] replied yes. The DM told the [NAME] to remove the resident's plate from the cart since the pureed bread was not the correct temperature. The [NAME] and the DAs did not remove the resident's plate from the cart, and the DA took the cart to the 300 hallway for lunch service to the resident. T. On 07/18/24 at 10:20 am, during an interview with the DM, the Administrator (ADMIN), the Director of Nursing (DON), and the Regional Nurse Consultant (RNC), they stated the DM was responsible for the oversights of the kitchen and nourishment kitchens. The DM stated the cooks were responsible monitor the temperatures of foods, and he reviewed the the temperature log books to ensure the cooks are taking the food temperatures after they cook them and before they serve them to the residents. The DM stated hot foods should be held at 140 F or higher on the steam table. He stated if the food is not that temperature then it is expected staff would reheat the food until it was the appropriate temperature. The DM stated the pureed Texas toast was not the correct temperature, and that was why he told the [NAME] to pull the plate off the cart. The DM stated he was not aware staff did not pull the plate. Air Dry Dishes U. Observation on 07/15/24 at 9:38 am of the dish washing area revealed clean bowls on the shelves in dishwashing area were wet stacked (visibly wet and stacked on top each other. Also called wet nested.) Observation also revealed staff used the wet stacked bowls for resident meal service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DD. On 07/15/24 at 9:43 am during an interview, the DM stated the staff drinks did not belong in the Servery refrigerator, because the refrigerator was for resident items only. He stated there was a shelf in his office where staff should put their drinks. EE. Observation on 07/15/2024 at 10:10 am revealed the can of Liquid Death, [NAME] Berry flavor was not in the Servery refrigerator. The can was opened and located on the shelf in the DM's office. FF. On 07/18/24 at 10:20 am, during an interview with the DM, the Administrator (ADMIN), the Director of Nursing (DON), and the Regional Nurse Consultant (RNC), they stated the DM was responsible for the oversights of the kitchen and nourishment kitchens. They stated staff should not put their personal food or drinks in the resident food refrigerators. They stated there was a refrigerator in the employee lounge that the staff could use instead. Hairnets and [NAME] Guards EE. Observation on 07/15/24 at 8:55 am revealed the following: - The DM wore a facemask, but the facemask did not cover all his facial hair. The DM had a goatee, and the DM's goatee hair stuck out the beard guard approximately 1 1/2. Further observation revealed the DM was around food and food related items during meal preparation. - DA #2 wore a hairnet, but the hairnet did not secure all the hair on her head. The DA had loose hair which measured approximately 1 to 2 in length and framed her face on the top and both sides. Further observation revealed the DA was around food and food related items during food preparation. FF. On 07/18/24 at 10:20 am, during an interview with the DM, the Administrator (ADMIN), the Director of Nursing (DON), and the Regional Nurse Consultant (RNC), they stated the DM was responsible for the oversights of the kitchen and nourishment kitchens. They stated hairnets and beard guards should cover all the hair. Unlabeled and Undated Food Items GG. Observation on 07/15/24 at 9:00 am, of the dry pantry revealed a bulk bin half full and not labeled. HH. During an interview on 07/15/24 at 9:02 am, the DM stated the bulk bin contained oatmeal, and the container should have a label to identify the contents of the bin. II. Observation on 07/15/24 at 9:13 am, of the walk-in refrigerator revealed the following: - Two packages of sliced meat not labeled and not in the original box. - Dill pickled relish, 1 gallon, opened and not dated. JJ. On 07/15/24 at 9:15 am during an interview, the DM stated it was expected staff would return the package of sliced meat to the original labeled box or staff would label the product. He stated it was expected staff would date the pickled relish container when it was opened. He stated they used stickers to identify food with the name of the food, the date it was opened, and use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	KK. Observation on 07/15/24 at 9:21 am of the walk-in freezer revealed one bag of Texas toast not labeled, undated, and not in the original box. LL. On 07/15/24 at 9:23 am during an interview, the DM stated it was expected staff would label and date food items when they put it away. MM. Observation on 07/15/24 at 9:40 am of the refrigerator located in the Servery off the main kitchen revealed a one gallon bag with cubed watermelon not labeled and undated NN. On 07/15/24 at 9:43 am during an interview, the DM stated he did not know what the watermelon was for, but it should be labeled and dated. OO. On 07/18/24 at 10:20 am, during an interview with the DM, the Administrator (ADMIN), the Director of Nursing (DON), and the Regional Nurse Consultant (RNC), they stated the DM was responsible for the oversights of the kitchen and nourishment kitchens. The DM stated all staff have received training on food storage, labeling and dating food items. He stated it was expected the staff would follow the training. The DM stated he checks the pantry, refrigerator, and freezers for unlabeled and undated food. Bulk Bin Scoop Storage PP. Observation on 07/15/24 at 9:00 am of the dry pantry revealed the following: - The scoop to the oatmeal bulk bin sat on top of the bin unprotected. Further observation revealed the top of the oatmeal bin covered with crumbs and debris. - The scoop to the sugar bulk bin sat on top of the bin unprotected. QQ. On 07/15/24 at 9:05 am during an interview, the DM stated he monitored the dry pantry everyday. He stated it was expected staff would place a barrier between the scoop and the container. He stated there should be a plastic baggie for the staff to put the scoop into instead of setting it on the container. The DM stated it was expected staff would place the scoop in the plastic baggie immediately after they used it. He stated the staff have been trained on scoop storage. Dishes Not Sanitized According to Manufacturer's Instructions RR. Record review of the facility's Manual Pot and Pan Wash Procedure sign, located above the three compartment sink, revealed the following: - Submerge in sanitizer sink for one minute or as specified by product label and local guidelines. - Turn upside down to air dry. Do not wipe dry. SS. Record review of the manufacturer's instructions for the sanitizing solution the dietary staff used in the three compartment sink, Oasis 146 Multi-Quat Sanitizer, revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Use sanitizer to sanitize pre-cleaned hard, non-porous surfaces of food processing equipment, dairy equipment, food utensils, dishes, silverware, glasses, sink tops, countertops, and other hard, non-porous surfaces. - Thoroughly wash or flush objects with a good detergent or compatible cleaner followed by a potable water rinse before application of the sanitizing solution. - Expose all surfaces to the sanitizing solution for a period of not less than one minute. - Allow equipment to drain thoroughly and air dry. TT. Observation on 07/15/24 at 10:39 am revealed, DA #1 washed dishes in the three-compartment sink. Two pans sat in the sanitizer sink, and one pan was half submerged in the sanitizing solution. The DA took the pans out of the water and sat them on the drain board. The DA dipped two cutting boards into the sanitizing solution and put them on the drain board. The DA did not submerge the pans or cutting boards in the sanitizing solution for one minute per the manufacturer's instructions. UU. Observation on 07/15/24 at 11:45 am revealed the DM removed a food processor bowl from the food preparation sink. The DM took the food processor bowl to the three compartment sink, rinsed the bowl with the cleaning solution, rinsed it under running water, and put it in the sanitizer solution for 30 seconds. The DM removed the food processor bowl from the sanitizer solution, shook the bowl, and laid it inverted (upside down) on the cutting board to dry. The DM performed handwashing and put on gloves. He picked up the food processor bowl, visibly wet and dripping, and set it on the food processor. The DM put six slices of bread into the food processor bowl. The DM removed the food processor lid from food preparation sink, rinsed it with the cleaning solution, rinsed it under running water, placed it in sanitizer solution for four to five seconds, and placed the lid inverted on cutting board. The DM removed his gloves, performed handwashing, shook the lid, and placed it on the food processing bowl. The DM did not submerge the food processor bowl or the lid in the sanitizing solution for one minute and allow the items to air dry completely per the manufacturer's instructions VV. On 07/18/24 at 10:20 am, during an interview with the DM, the Administrator (ADMIN), the Director of Nursing (DON), and the Regional Nurse Consultant (RNC), they stated the DM was responsible for the oversights of the kitchen and nourishment kitchens. They stated it was expected for staff submerge the dishes completely in the sanitizing solution for one minute per the manufacturer's instructions, or the dishes would not be sanitized correctly. Food Preparation Sink Not Sanitized After Rinsing Chicken WW. Record review of the manufacturer's instructions for the sanitizing solution the dietary staff used in the three compartment sink, Oasis 146 Multi-Quat Sanitizer, revealed the following: - Use sanitizer to sanitize pre-cleaned hard, non-porous surfaces of food processing equipment, dairy equipment, food utensils, dishes, silverware, glasses, sink tops, countertops, and other hard, non-porous surfaces. - Thoroughly wash or flush objects with a good detergent or compatible cleaner followed by a potable water rinse before application of the sanitizing solution. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	HHH. Observation on 07/16/24 at 9:55 am, revealed the microwave oven was visibly dirty on inside top with splatters and not in use. III. Observation on 07/16/24 at 10:04 am of the Servery locate [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325131	A. Building B. Wing	07/22/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47031 Based on observation, interview, and record review, the facility failed to follow proper infection control practices for 4 (R #'28, #45, #60, and #79) of 4 (R #28, #45, #60, and #79) residents identified during random observation when the facility failed to: 1. Ensure nasal cannulas [a device that delivers extra oxygen (O2) through a tube and into your nose] were labeled with the date when they were changed for R #28 and #79. 2. Ensure Continuous Positive Airway Pressure (CPAP; used to treat sleep apnea) equipment was stored appropriately for R#45 and #60. 3. Ensure R #60's nebulizer (device for producing a fine spray of liquid, used for example for inhaling a medicinal drug) was stored appropriately. This deficient practice could likely result in the spread of contagious and resistant illnesses to other residents. The findings are: Nasal Cannula Findings: R #28 A. Record review of R #28's physicians order, dated 06/02/23, revealed keep O2 cannula/mask/tubing and/or nebulizer mask/tubing bagged when not in use. B. On 07/16/24 at 12:49 PM, an observation of R #28's room revealed the following: 1. R #28 lay on the bed, and his O2 tubing laid on the floor of his room. 2. Staff did not label the nasal cannula with a date that indicated a date the nasal cannula was changed. C. On 07/16/24 at 12:51 PM, during an interview, Registered Nurse (RN) #3 confirmed the tubing was not dated. RN #1 stated there should be a date, and staff should change out nasal cannulas every shift. D. On 07/16/24 at 12:53 PM during an interview, Certified Nurse Assistant (CNA) #7 stated staff should label oxygen tubing with the date it was changed, and staff should change out the nasal cannulas every shift. R #79 E. On 07/16/24 at 11:33 AM, an observation of R # 79's room revealed the following: 1. R #79 had an oxygen concentrator (uses the air in the atmosphere, filters it, and produces air that is 90%-95% oxygen) in her room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The nasal cannula was attached to the oxygen concentrator in R #79's room, and the nasal cannula did not have a date on the tubing. 3. R #79 lay bed and wore the nasal cannula. 4. Staff did not label the nasal cannula with a date to indicate when staff changed the nasal cannula. F. On 07/16/24 at 11:44 AM, during an interview with CNA #7, she confirmed the following: 1. Nasal cannulas should be changed out every shift. 2. Staff should label the nasal cannula with a date to indicate when the nasal cannula was changed. 3. She was unable to determine when was the last time staff changed R #79's nasal cannula. G. On 07/16/24 at 11:50 AM, during an interview with RN #3, she stated it was expected for staff to change out nasal cannulas as ordered and label the nasal cannulas with the date they were changed. 41988 CPAP and Nebulizer Findings: R #45 H. Record review of R #45's face sheet revealed R #45 was admitted into the facility on [DATE]. I. On 07/16/24 at 11:12 am during an observation and interview, R #45's CPAP mask was not sealed and lay on her nightstand with other belongings. R #45 stated she wore her CPAP often. J. On 07/15/24 at 11:13 am during an interview with CNA #5, he stated R #45's CPAP mask should be stored in a sealed bag, but it was not. K. Record review of R #45's care plan, dated 07/17/24, revealed the following: 1. Problem: R #45 required the use of a CPAP while sleeping due to sleep apnea. 2. Approach: Replace all tubing weekly and as needed (PRN). CPAP mask may be washed with soapy water, rinsed, and allowed to dry. Do not dispose. Bag all equipment when not in use. L. On 07/18/24 at 1:03 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated R #45's CPAP mask should be stored in a bag when not in use. M. On 07/18/24 at 5:50 pm during an interview with the Director of Nursing (DON), she stated R #45's CPAP mask should have been stored appropriately, and it was not. R #60 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	N. Record review of R #60's face sheet revealed R #60 was admitted into the facility on [DATE]. O. On 07/15/24 at 3:58 pm during an observation and interview, R #60's CPAP mask and nebulizer lay on the nightstand, not sealed in a bag, and with other items. P. On 07/15/24 at 4:00 pm during an interview with CNA #6, she confirmed R #60's CPAP mask and nebulizer were not stored properly. Q. On 07/18/24 at 1:04 pm during an interview with LPN #1, she stated R #60's CPAP mask and nebulizer should be stored in a clean bag when not in use. R. On 07/18/24 at 5:51 pm during an interview with the DON, she stated R #60's CPAP mask and nebulizer should have been stored appropriately, and they were not.