STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425063	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - Greenwood	437 East Cambridge Street Greenwood, SC 29646

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on observation, interview, record review, and facility policy review, the facility failed to assess 1 of 8 residents reviewed during medication pass (Resident (R)122) for self-administration of medications. This failure led to medications being left at the bedside where they could be accessed by other residents or the resident not taking the medications. Findings include: Review of the facility's policy titled, Self-Administration of Medications, revised on 01/01/19, revealed In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer . If the resident desires to self-administer medications, an assessment is conducted by a member of the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility .When a member of the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medications of residents permitted to self-administer are stored in the central medication cart or medication room. The resident requests each dose from the medication nurse, who provides the medication to the resident in the unopened package for the resident to self-administer. The nurse then records such self-administration on the MAR [Medication Administration Record] by indicating administration on the medication administration record . Review of R122's Face Sheet located in the electronic medical record (EMR) under the Resident tab revealed R122 was admitted to the facility on [DATE] with a primary diagnosis of type two diabetes mellitus with diabetic peripheral angiopathy without gangrene. Review of R122's annual Minimum Data Set (MDS) located in the EMR under the Resident Assessment Instrument (RAI) tab with an Assessment Reference Date (ARD) of 02/22/24, revealed R122 had a Brief Interview for Mental Status (BIMS)score of 15 out of 15 which indicated R122 was cognitively intact. Review of R122's Care Plan located in the EMR under the RAI tab, did not include a care plan related to self-administration of medications. Review of R122's Evaluations located in the EMR under the Evaluations tab did not include an assessment/evaluation for self-administration of medications. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R122's Orders located under the Orders tab of the EMR revealed R122 did not have an order for self-administration of medications. Additionally, R122 had orders for beneflex AR (advanced relief) (digestion supplement) 650 mg (milligram) capsule to be given by mouth twice daily (06/16/23), neurovascular support vitamin 50 mg capsule to be given by mouth twice daily (06/16/23), preservision (vision supplement) ARED (age-related eye disease)-2 250-90-40-1 mg capsule to be given by mouth twice daily (03/27/23), and vision essentials gold (vision supplement) 40 mg capsule to be given by mouth twice daily (04/04/23). During an observation on 03/14/24 at 5:49 PM, R122 was sitting in her wheelchair in her bedroom. Licensed Practical Nurse (LPN)1 administered medications to R122 in a cup and left them sitting on her bedside table per the resident's request. During an interview on 03/14/24 at 5:49 PM, LPN1 confirmed she went into R122's room to administer medications, the resident requested the medications be left on her bedside table until she finished her meal. LPN1 stated she normally did not leave the medications at bedside but because the resident asked, she did so and stated she was planning on going back to confirm the resident took her medications. When LPN1 was asked how she would know if the resident actually took her medications without visualizing, she stated she would take the resident's word for it. LPN1 was not familiar with self-administration of medications assessment and was not sure if R122 had one. During an interview on 03/15/24 at 2:53 PM, the Director of Nursing (DON) stated her expectation regarding medication administration was to follow the facility policy that included observing the resident taking their medications, and not leaving them at the bedside. If residents wished to self-administer medications, they would need self-administration of medication assessment and a lock box in the resident's room. The DON confirmed that R122 did not have a self-administration of medication assessment and that no residents in the facility currently self-administered medications.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review, interview, and Resident Assessment Instrument (RAI) manual review, the facility failed to follow the RAI's transmittal requirements, which indicated that within 14 days after a facility completed a resident's assessment, a facility must electronically transmit encoded, accurate, and complete Minimum Data Set (MDS) data to the Center for Medicare & Medicaid Services (CMS) System for 4 of 4 residents (Resident (R)22, R34, R67, and R35) of 28 sampled residents. Specifically, it has been over 120 days since the facility transmitted the 4 residents MDS to the CMS System. Findings include: Review of the RAI 3.0 manual section 5.2, dated 10/19, revealed Timeliness Criteria indicated .Transmitting Data: Submission files are transmitted to the Quality Improvement and Enhancement System (QIES) Assessment Submission And Processing (ASAP) system using the CMS wide area network. Providers must transmit all sections of the MDS 3.0 .Transmission requirements apply to all MDS 3.0 records used to meet both federal . requirements . Assessment Transmission .All other MDS assessments must be submitted within 14 days of the MDS Completion Date . 1. Review of R22's Resident Face Sheet of the electronic medical record (EMR) located under the Resident tab, indicated the resident was admitted to the facility on [DATE] and was discharged on [DATE]. Review of R22's discharge MDS of the EMR located under the RAI tab, dated 11/05/23, indicated the resident was discharged . The facility failed to ensure a Registered Nurse (RN) signed and then transmitted the assessment to the CMS system. 2. Review of R34's Resident Face Sheet of the EMR located under the Resident tab, indicated the resident was admitted to the facility on [DATE]. Review of R34's annual MDS of the EMR located under the RAI tab, dated 12/21/23, indicated the facility failed to ensure an RN signed and then transmitted the assessment to the CMS system. 3. Review of R67's Resident Face Sheet of the EMR located under the Resident tab, indicated the resident was admitted to the facility on [DATE]. Review of R67's annual MDS of the EMR located under the RAI tab, dated 01/08/24, indicated Nurse Manager/MDS Coordinator (NM3/MDSC2) signed the MDS assessment on 03/08/24 and the assessment was transmitted on 03/08/24, therefore the transmission was late to the CMS system. 4. Review of R35's Resident Face Sheet of the EMR located under the Resident tab, indicated the resident was admitted to the facility on [DATE]. Review of R35's quarterly MDS of the EMR located under the RAI tab, dated 12/27/23, revealed it had not been transmitted by the facility. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/15/24 at 11:12 AM, the Nurse Manager/MDS Coordinator (NM4/MDSC1) confirmed R22, R34, R67, and R35 were not transmitted timely to the CMS System. NM4/MDSC1 stated she batched and submitted MDS data daily and these assessments were missed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 25225 Based on observation, interview, record review, and facility policy review, the facility failed to develop comprehensive care plans related to indwelling urinary catheters and/or the use of Tubigrip stockings (compression stockings used to help manage edema) for 2 of 28 sampled residents (Resident (R)63 and R1). Findings include: Review of the facility's policy titled, Patient Care Plans, dated 11/23, revealed . New problems are handled as they arise and are to be added to the current care plan even if the change in condition is not considered significant enough for a complete revision . 1. Review of R63's Face Sheet, located under the Resident tab of the electronic medical record (EMR), revealed R63 was admitted to the facility on [DATE] with diagnoses which included but was not limited to: iron deficiency anemia, chronic diastolic (congestive) heart failure, and unspecified atrial fibrillation. Review of R63's Orders, dated 08/24/23 and located under the Resident tab of the EMR, revealed a physician's order for an indwelling urinary catheter due to a neurogenic bladder. Review of R63's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/16/24 and located under the RAI (Resident Assessment Instrument) tab of the EMR, revealed R63 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The assessment recorded R63 as having an indwelling urinary catheter. During an observation and interview on 03/13/24 at 11:14 AM, R63 was observed to have an indwelling urinary catheter. R63 stated he had received the catheter during August 2023. Review of R63's comprehensive Care Plan located under the RAI tab of the EMR, revealed no focus, goal, or interventions related to R63's use of an indwelling urinary catheter. During an interview on 03/14/24 at 4:04 PM, the Director of Nursing (DON) confirmed R63 received the indwelling urinary catheter on 08/24/23. The DON confirmed that an indwelling urinary catheter was pertinent information that should have been included on the care plan. During an interview on 03/15/24 at 11:11 AM, MDS Coordinator (MDSC)1 confirmed she was the MDSC for R63. MDSC1 stated information for a resident's care plan was obtained from the residents, family members, the chart, history, hospital admissions, and other sources. MDSC1 confirmed R63's care plan did not address his use of an indwelling urinary catheter. MDSC1 stated, I don't have an answer. MDSC1 confirmed the indwelling urinary catheter should have been included in the care plan. 2. Review of R1's Face Sheet located in the EMR under the Resident tab, revealed he was admitted to the facility on [DATE] with a primary diagnosis of atrial fibrillation and co-morbidities including venous insufficiency. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's admission MDS located in the EMR under the RAI with an ARD of 02/07/24, revealed R1 had a BIMS of 15 out of 15 which indicated R1 was cognitively intact. Additionally, R1 was on diuretic medications. Review of R1's Orders located in the EMR under the Orders tab of the EMR revealed an order dated 02/20/24 for Tubigrips (compression garment worn to reduce swelling) to bilateral lower extremities to be applied upon getting out of bed in the morning, to be worn during the day, and removed at bedtime. Review of R1's Care Plan located in the EMR under the RAI tab, reviewed on 02/22/24, did not include use of Tubigrips for swelling. During an interview on 03/14/24 at 3:36 PM, the DON stated that the purpose of Tubigrips was for lower extremity edema, clot prevention, and usually ordered for residents that were immobile. The DON confirmed that R1's care plan did not include Tubigrips but should have been. 40824

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on observation, record review, interviews, and facility policy review, the facility failed to ensure the resident care plan was revised to accurately reflect 1 of 28 sampled residents (Resident (R)72) current plan of care. In addition, the facility failed to ensure 1 of 28 sampled residents (R125) was invited to her quarterly care conference. Findings include: Review of the facility's policy titled, Updating and Revisiting Care Plans, dated 11/23, indicated .Routine Reviews and Updates: Care plans are to be updated as needed but are reviewed completely by the interdisciplinary team . 1. Review of R72's Resident Face Sheet, located under the Resident tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on [DATE] with a diagnosis including but not limited to, unspecified dementia. Review of R72's Care Plan located in the EMR under the RAI tab, dated 03/04/22, indicated the resident was considered a fall risk and directed the staff to place a fall mat at her bedside. Review of R72's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/20/23 located under the Resident Assessment Instrument (RAI) tab, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which revealed the resident was severely cognitively impaired. The Care Area Assessment (CAA) indicated the resident was a fall risk and directed the staff to develop a care plan. During an observation on 03/13/24 at 9:53 AM, R72 was in bed and had no floor mats on either side of her bed. At 10:32 AM, R72 was in bed and had no floor mats on either side of her bed. At 3:26 PM, R72 was in bed and had no floor mats on either side of her bed. During an interview on 03/13/24 at 3:50 PM, Certified Nurse Aide (CNA) 2 stated R72 did not use floor mats. During an observation on 03/14/24 at 7:50 AM, R72 was in bed and had no floor mats on either side of her bed. During an interview on 03/14/24 at 7:51 AM, CNA3 stated R72 did not use fall mats. During an interview on 03/14/24 at 3:32 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) stated the goal of the care plan was to paint a picture of the status and care needs of a resident. The DON stated this was done in collaboration with the Interdisciplinary Team. The DON stated the care plan could be updated at any time. The DON stated the care plan should accurately reflect the current status of a resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R125's undated Resident Face Sheet located in the EMR under the Resident tab, indicated R125 was admitted to the facility 09/21/23 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of R125's significant change MDS located in the EMR under the RAI tab included a BIMS with a score of 99 indicating the resident was unable to complete the interview. Review of R125's Care Conference Report located in the EMR under the Care Conference tab, indicated the resident had not had a care conference since 11/20/23. During an interview on 03/15/24 at 12:57 PM, the MDS Coordinator (MDSC)1 indicated the facility expectation for care conferences was that all residents should have had care conferences upon admission, quarterly, and with any significant change. MDSC1 confirmed that R125's last care conference was 11/20/23 and that the facility should have had one in February 2024, but did not. MDSC1 did not give a reason as to why a care conference was not held. 40824

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, and record review, the facility failed to apply Tubigrip stockings (compression stockings used to help manage edema) per physician orders for 1 of 28 sampled residents (Resident (R)7). Findings include: Review of R7's Face Sheet located under the Resident tab of the electronic medical record (EMR), revealed R7 was admitted to the facility on [DATE] with diagnoses including but not limited to: hypertensive chronic kidney disease, stage three; orthostatic hypotension; and nonrheumatic aortic valve stenosis. Review of R7's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/12/23 and located under the RAI [Resident Assessment Instrument] tab of the EMR, revealed R7 was severely impaired in cognitive skills for daily decision making and was dependent on staff for lower body dressing. Review of R7's Observation Detail List Report, dated 02/14/24 and located under the Resident tab of the EMR, revealed . noted BLE [bilateral lower extremity] +2 edema . Plan .Localized edema BLE (new) - order provided for tubigrip to BLE as tolerated and elevated BLE as tolerated . Review of R7's Orders, located under the Resident tab of the EMR, revealed a physician's order, dated 02/14/24, for R7 to have Tubigrip socks to the lower legs and for the lower extremities to be elevated at all times as tolerated. The order recorded for the Tubigrip socks to be applied in the morning and taken off in the evening. Review of R7's comprehensive Care Plan located under the RAI tab of the EMR, revealed no documentation related to the use of Tubigrip socks. During an observation on 03/13/24 at 2:06 PM, R7 was observed lying across her bed, her eyes were closed, and her feet were touching the floor. R7's feet were observed to be edematous, appeared puffy, and her skin appeared taunt (pulled tight). R7 did not have any Tubigrip socks on. Two unidentified Certified Nurse Aides (CNAs) entered the room and transferred R7 to her reclining chair. The CNAs did not attempt to place the Tubigrip socks on R7's lower extremities. Review of R7's Medication Administration Record (MAR), dated 03/13/24, revealed documentation that R7's Tubigrip socks were applied on the day shift and refused on the evening shift. Review of R7's Progress Notes, located under the Resident tab of the EMR, revealed no documentation on 03/13/24 that R7 had refused or not tolerated her Tubigrip socks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/14/24 at 9:50 AM, Registered Nurse (RN)1 removed the bed linens from R7's bed, revealing her lower extremities. R7 did not have Tubigrip socks on, and her feet were not elevated. R7 had yellow non-slip socks on. RN1 confirmed R7's feet were edematous, with 2 to 3+ edema. RN1 confirmed R7's feet were not elevated. RN1 stated she believed that R7 had orders for Tubigrip socks but stated, I haven't got to her yet. RN1 stated the CNAs could have applied the Tubigrip socks but the nurses were ultimately responsible for ensuring they were put on. RN1 stated she had started her shift at 7:00 AM. RN1 looked at R7's bedside table and confirmed there was a pair of Tubigrip socks located in the upper drawer. RN1 confirmed the purpose of the Tubigrip socks was to help control edema and stated she would make sure the socks were applied. During an interview on 03/14/24 at 3:36 PM, the Director of Nursing (DON) stated the purpose of Tubigrip socks was to help control edema, for blood clot prevention, and as medically necessary. The DON confirmed the CNAs could have applied the Tubigrip socks but stated she preferred for the nurses to do it. The DON stated her expectation was for staff to execute physician orders and apply Tubigrip socks when they were ordered. The DON stated pertinent information should have been included on a resident's plan of care and that it would be a good practice for the use of Tubigrip socks to be care planned. The DON confirmed the Tubigrip socks had not been included in R7's plan of care. The DON confirmed documentation in the clinical record should have been an accurate reflection of the resident's care and stated she would have to investigate as to why it was documented R7 had her Tubigrip socks on 03/13/24.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, and record review, the facility failed to ensure 1 of 28 sampled residents (Resident (R)14) was competent to perform suprapubic catheter care independently. The facility failed to conduct and document assessments and/or evaluations of R14's capabilities and obtain physician orders prior to allowing R14 to complete his own suprapubic catheter care. Findings include: Review of R14's Face Sheet, located under the Resident tab of the electronic medical record (EMR), revealed R14 was admitted to the facility on [DATE] with diagnoses including but not limited to: morbid obesity, atherosclerotic heart disease, hypertensive chronic kidney disease, stage two, neuromuscular dysfunction of the bladder, and osteoarthritis. It was documented R14 was admitted with a suprapubic catheter. Review of R14's Care Plan, dated 10/18/23 and located under the RAI [Resident Assessment Instrument] tab of the EMR, revealed a problem related to R14's suprapubic catheter. Interventions included changing the catheter monthly. There was no documentation related to R14 performing catheter care independently. Review of R14's Orders, dated 11/07/23 and located under the Resident tab of the EMR, revealed a physician's order for suprapubic catheter site care to be performed twice daily. There were no orders for R14 to complete the catheter care independently. Review of R14's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/23 and located under the RAI tab of the EMR, revealed R14 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R14 was cognitively intact. The assessment recorded R14 had an indwelling urinary catheter. Review of R14's Resident and RAI tabs of the EMR revealed no documentation R14 had been assessed as competent in performing suprapubic catheter care independently. During an observation on 03/13/24 at 9:54 AM, R14 was observed lying in bed, with a catheter drainage bag hanging from the side of his bed. During an observation and interview on 03/14/24 at 9:45 AM, Registered Nurse (RN)1 was noted to be in R14's room. The surveyor requested to see RN1 perform suprapubic catheter care for R14. R14 stated that was fine, but he had already completed the task. RN1 stated R14 completed his own suprapubic catheter care. RN1 stated R14 was alert and oriented, she had observed him performing the care, and she had found him to be competent in completing the care. RN1 stated she had not completed a written assessment or evaluation related to R14's capabilities. RN1 was asked if the information should have been included in R14's care plan. RN1 stated she would think so. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/14/24 at 3:52 PM, the Director of Nursing (DON) was asked what the facility's policy was on allowing residents to complete their own care, such as suprapubic catheter care. The DON stated that the nursing staff typically completed that type of care. The DON stated, We don't have residents who do their own skilled care. The DON confirmed that suprapubic catheter site care would be considered skilled care. The DON stated suprapubic catheter care would typically be something the nurses did and that it was not typical for the nurses to allow R14 to complete his own care. The DON confirmed that RN1 had informed her that R14 was completing his own suprapubic catheter site care and stated that the nurses were typically in the room with R14 when he did the care. The DON stated the facility did not have a policy or formal type assessment to complete related to residents performing their own care, but if that were going to occur, they would review the policy with the resident, require a demonstration to verify competency, and have a system in place to monitor. The DON confirmed that it would be good practice to include any resident self-care on the resident's care plan. During an interview on 03/15/24 at 9:15 AM, R14 confirmed that he completed his catheter care without nursing staff present at times.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 25232 Based on observation, record review, interviews, and test tray evaluation, the facility failed to serve food that was palatable and at a safe and appetizing temperature for 7 of 7 residents (Resident (R)3, R71, R73, R97, R56, R14, and R63) reviewed for food palatability. This failure had the potential to affect 131 residents who consumed food prepared from the facility's kitchen. Findings include: 1. Review of R3's Face Sheet, provided by the facility, indicated that R3 was admitted to the facility on [DATE] with diagnoses including but not limited to: coronary artery disease (CAD) and anemia. Review of R3's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 12/20/23, indicated that R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated that R3 was cognitively intact. During an interview on 03/13/24 at 12:21 PM, R3 indicated that the food was cold when it should have been hot. 2. Review of R71's Face Sheet, provided by the facility, indicated that R71 was admitted to the facility on [DATE] with diagnoses including but not limited to: cancer, CAD, end stage renal disease (ESRD), and hypertension. Review of R71's annual MDS with an ARD of 12/19/23, indicated that R71 had a BIMS of 14 out of 15 which indicated R71 was cognitively intact. During an interview on 03/13/24 at 11:19 AM, R71 indicated that there were times that the food was served cold, and that he did not like cold grits or cold coffee. 3. Review of R73's Face Sheet, located in the electronic medical record (EMR) under the Resident tab, indicated R73 was readmitted to the facility on [DATE] with a primary diagnosis of Alzheimer's disease with late onset. Review of R73's quarterly MDS assessment with an ARD of 01/04/24, located in the EMR under the Resident Assessment Instrument (RAI) tab, revealed a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. During an interview on 03/13/24 at 9:45 AM, R73 stated the food was frequently overcooked, indicating that the meat was too hard to cut. R73 also indicated that the biscuits were hard. 4. Review of R97's Face Sheet, provided by the facility, indicated that R97 was admitted to the facility on [DATE] with diagnoses including but not limited to: ESRD, hypertension, and hyperlipidemia. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R97's quarterly MDS assessment with an ARD of 12/27/23, revealed that R97 had a BIMS score of 15 out of 15 which indicated R97 was cognitively intact. During an interview on 03/13/24 at 9:19 AM, R97 indicated that lunch and dinner were not hot, and the taste was not good. R97 stated that she had complained to the facility, and they indicated that they would fix it; however, there had been no improvements. 5. Review of R56's Face Sheet, located in the EMR under the Resident tab, revealed R56 was admitted to the facility on [DATE] with diagnoses including but not limited to: end stage renal disease, dysphagia, and type two diabetes mellitus. Review of R56's quarterly MDS with an ARD of 12/28/23 and located under the RAI tab of the EMR, revealed R56 had a BIMS score of 14 out of 15, which indicated R56 was cognitively intact. During an interview on 03/13/24 at 11:37 AM, R56 stated the food tasted bad, was not always hot, and there was not always a protein source with each meal. 6. Review of R14's Face Sheet, located under the Resident tab of the EMR, revealed R14 was admitted to the facility on [DATE] with diagnoses including but not limited to: morbid obesity, atherosclerotic heart disease, hypertensive chronic kidney disease, stage two, iron deficiency anemia, and osteoarthritis. Review of R14's quarterly MDS with an ARD of 12/14/23 and located under the RAI tab of the EMR, revealed R14 scored 15 out of 15 on the BIMS, which indicated R14 was cognitively intact. Review of a facility Service Recovery Form, dated 02/23/24 and provided by the facility's Director of Patient & Family Services (DPFS), revealed [R14] .reported that sometimes he receives meat [and] vegetables that are burnt, will receive a hot dog with bun only - no chili or any condiments . The form recorded the issues that had been discussed with staff and was signed by Nurse Manager (NM)3. During an interview on 03/13/24 at 9:56 AM, R14 stated he had concerns with the food served at the facility. R14 showed the surveyor pictures on his phone of meals at the facility. One picture, dated 02/17/24, showed a plate holding a bowl of beans and several cherry tomatoes. R14 stated this was what he was served for the evening meal that day. R14 showed the surveyor another picture, dated 03/03/24, which showed a plate containing noodles and a piece of bread. The noodles appeared to have no sauce on them. R14 stated the meal was supposed to be fettuccine alfredo, but the noodles had been served without any sauce for the evening meal on 03/03/24. R14 stated the food was often cold and did not appear appetizing. During an interview on 03/14/24 at 2:51 PM, R14 stated he had talked with staff about his food concerns, but the issues persisted. R14 showed the surveyor additional pictures on his phone. One picture, dated 01/17/24, showed a plate of what appeared to be noodles and pieces of ground meat in a yellow-colored liquid. R14 stated the noodles and meat were swimming in grease. R14 showed the surveyor another picture, dated 03/14/24, of what appeared to be a dark brown piece of chicken. R14 stated the piece of chicken was burnt and inedible. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/15/24 at 11:24 AM, the Director of Dietary (DM) stated she had talked with R14 about his food concerns; however, it was her understanding that his concerns pertained to a lack of options and special requests. The DM stated she had purchased specific things for R14, and those items were available at his bedside and in the unit pantry. The DM stated she was aware of food concerns at the facility. She stated she attended resident council meetings when asked. The DM was asked what she was doing to address the residents' food complaints. She stated when complaints were made, she talked with the residents and tried to accommodate their wishes. 7. Review of R63's Face Sheet, located under the Resident tab of the EMR, revealed R63 was admitted to the facility on [DATE] with diagnoses including but not limited to: iron deficiency anemia, chronic diastolic (congestive) heart failure, and unspecified atrial fibrillation. Review of R63's quarterly MDS with an ARD of 01/16/24 and located under the RAI tab of the EMR, revealed R63 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. During an observation and interview on 03/13/24 at 11:02 AM, R63 stated, Food is my biggest complaint. R63's breakfast tray was still in his room. Potatoes were noted on the plate. R63 stated he did not like potatoes and that it was documented on his meal tickets to not serve potatoes, but staff continued to serve the potatoes. R63 stated that often times, the potatoes were not cooked and were hard. R63 showed the surveyor his breakfast meal tray ticket for 03/13/24. The top of the ticket revealed, No Eggs/Tomatoes/Cheese/Potatoes/Banana. R63 stated he did like eggs; he just did not like scrambled eggs. R63 stated he liked over-light eggs but had been told by the facility that he could not have over-light eggs. R63 stated in the past he had been served a chicken patty that was not cooked on one side. R63 stated the food was often cold when served. During an interview on 03/15/24 at 11:22 AM, R63 was asked who he talked with regarding his food concerns and the fact that he wanted over-light eggs. R63 stated that he had talked with the admitting lady [Admissions Coordinator (AC)], the DPFS, and the Administrator about the way his eggs were prepared, and all had told him he could not have over-light eggs. R63 stated he had verbalized his other food concerns to them as well. During an interview on 03/15/24 at 11:24 AM, the DM stated she had not received any requests for over-light eggs. The DM confirmed the facility had pasteurized eggs that could be used to fix over-light eggs. The DM stated when she received food complaints, she would go and talk with the resident and tried to resolve any concern. During an interview on 03/15/24 at 11:39 AM, the AC confirmed R63 had talked with her about his food concerns in the past, and when he did, she would take him to the kitchen and have dietary staff speak with him. The AC stated she did not remember R63 speaking to her about how his eggs were prepared. During an interview on 03/15/24 at 11:43 AM, the DPFS confirmed R63 had brought food concerns to her. The DPFS stated R63 had verbalized food concerns such as not getting condiments, the food not being hot when he received it, or requesting one item but receiving another. The DPFS stated she did not remember any concern related to how R63's eggs were prepared. The DPFS stated when R63 came to her with concerns, she had the DM speak with him. The DPFS stated R63 knew to speak with the DM and the dietician if he had food concerns. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/15/24 at 1:00 PM, the Administrator stated he had no knowledge of R63 requesting his eggs to be prepared over-light. The Administrator confirmed R63 could have his eggs prepared in the manner of his choice. 8. During a test tray evaluation for Station One lunch meal on 03/13/24, the meal trays (which included a test tray) were placed in a closed tray cart with no heating element at 1:15 PM and left the kitchen at 1:16 PM. The tray cart arrived at Station One at 1:17 PM, and the last resident tray was passed at 1:34 PM. At this time, the food temperature on the regular test tray was taken. The temperature for the cowboy chili mac was 108 degrees. Next, the food temperature on the alternate test tray was taken. The temperature for the breaded chicken was 115 degrees and French fries were at 105.3 degrees. The regular and alternate trays were sampled in the presence of the facility's DM and Certified Nursing Assistant (CNA)5. The test tray evaluation revealed the following: a. The cowboy chili mac served on the regular test tray was at room temperature when tasted but was seasoned well. CNA2 also tasted the cowboy chili mac and confirmed it was seasoned well, but it was at room temperature. b. The breaded chicken served on the alternate test tray was at room temperature when tasted; however, seasoned well, and tender. CNA2 also tasted the breaded chicken and confirmed it was seasoned well, and tender, but was at room temperature. c. The French fries served on the alternate test tray was cold and hard to eat/swallow. CNA2 also tasted the French fries and confirmed that they were cold and hard to eat/swallow. Review of the Tray Line Food Temperatures, dated 03/13/24, revealed no evidence that the temperature of the French fries was taken. During an interview on 03/15/24 at 2:58 PM, the DM indicated that when the food came out to the facility's hallways, it should have remained at 120 degrees.

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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. 25232 Based on observations, interviews, and facility policy review, the facility failed to ensure that kitchen staff wore hair nets that covered all their hair, failed to ensure that kitchen staff wore beard guards, and failed to ensure that kitchen staff did not touch food items with their bare hands and/or preformed hand hygiene after coming in contact with non-food items. In addition, the facility failed to ensure that 1 of 3 nutritional refrigerators had food items labeled and/or dated. This has the potential to affect 131 residents who received an oral diet from the kitchen. Findings include: Review of the facility policy titled, Hygienic and Safety Practices, revised 11/17, revealed Effective personal hygienic and safety practices are essential in preventing food contamination .Guidelines . 3. Hair restraints for partners (Food Code 2-402.11), a. partners shall wear hair restraints such as hats, hair coverings, or net, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils and linens; and unwrapped single-service and single-use articles. Review of facility policy titled, Food Brought into Center from Outside Sources, dated 11/17, revealed Patients, families, and/or visitors will be educated on safe food handling practices regarding food being brought in from outside sources. Food and/or beverages brought into the healthcare center from the outside will be monitored by center partners for contamination, spoilage, and overall food safety. Guidelines: 1. Food and/or beverage items brought into the center should be securely packaged and labeled with the patient's name and the date the item (s) were brought into the center. The center should have large zip-type storage bags and markers, or other appropriate supplies, available for packaging, labeling, and identifying food brought in from an outside source. During the initial tour of the kitchen on 03/13/24 between 8:36 AM - 9:07 AM, revealed Cook1 was not wearing a beard guard. During an observation on 03/13/24 between 1:03 PM - 1:15 PM, while a test tray for station one was being fixed for the second cart, Dietary Aide (DA)1 fixed the sixth plate, when she picked up a piece of garlic bread with her bare right hand and placed it on the plate. Then the plate was placed into the cart. While fixing the ninth plate, DA1, touched a gray square of pureed bread with her bare left hand, after using tongs to place it on the plate. During an observation on 03/14/24 between 8:02 AM - 8:40 AM, DA2, who was working the tray line warming up plates and placing them on the trays, had the back of her hair hanging out of her hair net. Her hair net reached round her face and a quarter of the way down in the back. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During further observation on 03/14/24 at 5:25 PM, after entering the kitchen, DA3 was observed not wearing his beard guard. The beard guard was pulled below his chin. In addition, DA3 had his hair net half of the way on his head, exposing some hair. Continuing to watch the evening meal being prepared, DA4, who was the staff on the tray line heating up plates, was observed rubbing under her nose with her left hand and touching the top of her hair net with her left hand. DA4 did not complete hand hygiene afterwards while continuing to heat up trays. In addition, DA5 who was working the tray line and placing the food onto the plates, did not have her hair covered in the back, lower left side. Further observation revealed DA6 was observed on the tray line, without a hair net, but had on a burgundy hat that did not cover all her hair on the sides or back. DA6 was placing trays on the hall carts. During observation of station three refrigerator and freezer on 03/15/24 at 12:15 PM, revealed the following concerns: -Four Oikos-Pro yogurts in the door of the refrigerator were unlabeled and not dated. -One package of strawberries on the bottom shelf of the refrigerator, labeled with a resident's name but not dated. -One package of mixed apple slices on top of strawberries in the refrigerator, labeled with a resident's name but not dated. -One small bowl of what appeared to be a tart, labeled with a resident's name but not dated. -One, 30.4-ounce (oz) core water bottle laying in freezer, frozen. It was not labeled and not dated. -One Walmart bag tied and when untied, inside was a 48-ounce tub of Great Value butter pecan ice cream, and one box of Helados Mexico ice cream bars that were not labeled or dated. During an interview on 03/15/24 at 12:25 PM, Certified Nursing Assistant (CNA)6 confirmed all the items in the refrigerator and/or freezer were not labeled, and/or dated. She stated that this refrigerator was for residents only, and that all items should have been labeled and dated. During an interview on 03/15/24 at 12:30 PM, the Assistant Director of Nursing (ADON) stated that the dietary department was responsible for cleaning the unit refrigerator and freezers; however, everyone was responsible for labeling and dating. During an observation of the kitchen on 03/15/24 at 12:44 PM, DA6 was wearing a burgundy hat, without a hair net, which did not cover all her hair in the back, and Cook1 was not wearing a beard guard. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/15/24 at 12:45 PM, the Director of Dietary (DM) stated that she expected staff to cover all their hair and could wear hats if all their hair was covered up. She stated that male staff were to wear a beard guard only when they had visible hair. She stated that she expected staff, if they touched their hair net, or other non-food items; they were to wash their hands. The DM stated she also expected that staff did not touch cooked food with their bare hands and said that staff should always used tongs. She stated the refrigerator and freezers were the kitchen's responsibility for cleaning, but it was the staff that worked at that location to make sure things were labeled and dated. She stated dietary tried to do spot checks which were at least when dietary took food items to the station.