STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Redfield	1015 Third Street East Redfield, SD 57469

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, and policy review, the provider failed to maintain a clean and homelike environment for 5 of 49 sampled residents (6, 7, 13, 16, and 19) and for the residents who ate their meals in the main dining room. Findings include: 1. Observation on 12/3/24 at 9:00 a.m. in the bathroom shared by residents 16 and 19 revealed: *The floor at the base of the toilet was wet. -There were areas of an unidentified black substance. -The caulking at the base of the toilet was peeling and missing in several areas. 2. Observation on 12/3/24 at 9:29 a.m. in resident 17's room revealed: *The faucet on the sink in that room had a white and green, thick, unidentified build-up, and areas of the faucet were missing. -This was not a cleanable surface. -The handle spun around in a circle and the surveyor was unable to get hot water at that sink. 3. Observation on 12/3/24 at 9:25 a.m. revealed a wall-mounted hand sanitizer outside of residents 16 and 19's room that did not dispense hand sanitizer and flopped forward when the lever was depressed. 4. Observation on 12/4/24 at 8:30 a.m. in residents 6 and 13's room revealed: *The wood cabinet below the sink was scratched, scuffed, and lacked varnish. It was not a cleanable surface. *The area behind the toilet had flaking paint and an area where the drywall was exposed. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The bathroom door had a plastic protector with pieces missing that exposed rough edges and bare wood. *The cover to the heater in the bathroom was leaning against the door frame and the heating element was exposed. 5. Observation on 12/4/24 at 8:12 a.m. in the dining room revealed: *A 10 to 12-inch long gouge to the back wall located to the right of the door, next to the heater that had exposed drywall. *The heater under the windows was visibly dirty and had rusted areas on the front and along the top vents. *The area behind the hand wash sink had exposed drywall, unidentified food substances, and bubbling paint. *The door to the kitchen located in the dining room labeled Authorized Personnel Only was worn and delaminated in several areas exposing the wood. 6. Observation on 12/4/24 at 8:15 a.m. revealed the North Nurses station door near the entrance of the building was worn and delaminated around the handle and was not a cleanable surface. 7. Interview on 12/5/24 at 3:29 p.m. with maintenance director G revealed: *The facility used an online work order system for maintenance issues to be reported. *Many small issues were reported to him in person. *He expected staff to report any issues that needed to be repaired urgently directly to him and to log issues that could wait to be repaired in the online system. -He did not log the repairs he made that had been reported directly to him. *He confirmed that the handle of the faucet in room [ROOM NUMBER] spun all the way around. -He became aware that the faucet needed to be replaced and ordered a new one when the life safety surveyor had pointed it out to him. -He stated he had found a position on that faucet where it provided hot water. *He was aware that several of the doors throughout the facility had areas where the wood was exposed. Review of the Maintenance Work Orders Log revealed: *The log contained closed work orders from 1/1/24 through 12/4/24. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The log did not contain any open or unaddressed work orders. *There were no work orders for the above observations. Review of the provider's revised 8/16/24 Maintenance policy revealed: *It is the facility's policy to maintain equipment and the building environment. *Any staff who is made aware of malfunctioning equipment or any part of the building that is in disrepair will report the issue to the maintenance department. *The maintenance department will address the issue as soon as possible. *Any equipment that can not be fixed will be replaced accordingly. Review of the provider's reviewed 9/30/24 Homelike Environment policy revealed: *Residents are provided with a safe, clean, comfortable and homelike environment . *The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: cleanliness and order; Walls and door scuffs/chips repaired with paint/stain when needed. *The facility will have a mechanism for reporting disrepair to Maintenance personnel and staff will be educated on the process.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46453 Based on observation, interview, record review, and policy review, the provider failed to ensure: *The foam filter was replaced on one of one sampled resident's (34) oxygen concentrator machine. *One of one sampled resident (34) had current physician's orders to receive oxygen therapy. *Facility policy had been followed regarding documenting oxygen tubing and foam filter replacement in one of one sampled resident's (34) electronic medical record (EMR). Findings include: 1. Observation and interview on 12/3/24 at 3:11 p.m. with resident 34 in her room revealed: *She was receiving oxygen through a nasal cannula (flexible tubing with prongs to deliver oxygen through the nose). *There was no foam filter on the back of the oxygen concentrator machine. *She said the staff gave her new oxygen tubing that morning. *The oxygen concentrator machine was delivering oxygen at a rate of 3L (liters per minute). 2. Review of resident 34's EMR revealed: *There was no current physician's order for supplemental oxygen. *Three of her recent Minimum Data Set (MDS) assessments indicated she was receiving oxygen therapy. -Quarterly MDS dated [DATE]. -Significant change MDS dated [DATE]. -Quarterly MDS dated [DATE]. *Her physician had assessed her on 11/27/24 and noted in the vitals section of the assessment that the resident was receiving oxygen through a nasal cannula at 2.5L. -She was observed receiving oxygen through a nasal cannula at 3L on 12/3/24 at 3:11 p.m. *There was no documentation indicating when the oxygen tubing was last changed, or when the foam filter was last cleaned and replaced. *She had a physician's order for supplemental oxygen at 2L from April 2024 to at least May 2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*There was a physician's note from 7/29/24 that mentioned, questioning if O2 [oxygen] is new . 3. Interview on 12/5/24 at 9:25 a.m. with registered nurse (RN) O about resident oxygen use revealed: *She was not aware that there was no foam filter on resident 34's oxygen concentrator machine. *The facility's normal practice was to change the oxygen tubing and clean the concentrator's foam filter weekly. *The staff in charge of changing the tubing were to mark that task as completed in the resident's treatment administration record (TAR). *Regarding resident 34, she confirmed: -There were no physician's orders for oxygen use. -The resident's care plan did not include oxygen use. *She indicated that the orders might have fallen off with the resident's recent trips to the emergency department. 4. Interview on 12/5/24 at 4:25 p.m. with director of nursing B and MDS coordinator P revealed: *Resident 34 had been receiving supplemental oxygen for a while. *They confirmed there was no current physician's order for oxygen therapy in the resident's orders list. *They were not aware that the foam filter was missing and indicated it should have been replaced at the same time the oxygen tubing was replaced. *They both indicated that resident 34's oxygen therapy orders may have fallen off one of the times she went to the emergency department and back. *DON B indicated the oxygen therapy should have been included on the resident's physician orders list. 5. Review of the provider's 11/19/24 Oxygen Administration policy revealed: *Procedures: -1. Verify that there is a physician's order for oxygen that includes route (via mask or nasal cannula), liter flow, and duration (i.e., continuous, prn, at night, etc.) -2. Review the resident's care plan to assess for any special needs of the resident. *General Guidelines (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1. Oxygen therapy is administered by way of an oxygen mask or nasal cannula. -- .b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. The nasal cannula and tubing will be changed weekly and as needed. Change of tubing and cannula would be documented in the medical record. - .2. Oxygen concentrators will have exterior wiped down when soiled and at least weekly. If equipped with a filter, filter will be cleaned at least weekly by rinsing with water and allowing to dry. If filter becomes torn, filter should be replaced. Weekly cleaning of the concentrator and filter should be documented in the medical record.

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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** 49958 51471 Based on observation, interview, and document review, the provider failed to ensure food items were appropriately labeled, stored, handled, prepared, and served to residents in a safe and sanitary manner in one of one kitchen and one of one dining rooms for the following: *One of one kitchen was not maintained in a safe and sanitary manner. *One of one commercial refrigerator contained beverage items that were not labeled, dated, or discarded by the use-by date. *Unsafe meat thawing practices. *Inappropriate glove use and hand hygiene by four of four observed dietary staff (dietary manager C, cook D, cook E, and dietary aide (DA) I) while preparing and serving residents' food. *Inappropriate glove use and hand hygiene by four of four observed staff (certified nursing assistant (CNA) K, CNA L, CNA N, and restorative aide (RA) J) while assisting residents in the dining room. Findings include: 1. Observation on [DATE] at 7:47 a.m. of CNA K and CNA N in the main dining room revealed: *CNA K and CNA N were seated at a table with four residents who had not yet been identified. *CNA K and CNA N were both wearing gloves and assisted the resident to their right and the resident to their left to eat breakfast. *CNA K and CNA N wore the same gloves throughout the observation and touched items on the table while they assisted residents with those same gloved hands. 2. Observation on [DATE] at 7:50 a.m. during the initial tour of the kitchen revealed: *An unidentified black substance between the caulking and the area above the sink next to the dishwasher. *An unidentified white and orange flaking substance along the edges of the dishwasher that appeared to be limescale. *An unidentified thick, black substance on the floor drain under the dishwasher and along the wall under the dishwasher. A visibly dirty plastic cup was between the dishwasher and the wall. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Cracked and missing floor tiles from the entrance of the food storeroom door that continued into the storage room and were uncleanable surfaces. *The frame of that door was rusted and uncleanable. *The floor under the commercial gas stove had a thick, brown, oily substance that extended behind the stove. *A metal container on the floor to the left of the stove caught grease as it dripped from the bottom of the stove. *A metal pan contained two sandwiches that had not been labeled or dated in refrigerator three *An unidentified black stringy substance hung from the front edge of the steam table. *An unidentified black and brown substance in the cut marks of the cutting board that was attached to the steam table. *Cook D, DA I, and DM C ate leftover breakfast food while standing in the kitchen where the food was pre-pared. *Cook D, DA I and DM C left the kitchen unattended with: -The serving utensils in the uncovered pans on the steam table. -Plastic containers of dry rice cereal and brown sugar were not labeled or dated and left uncovered at the steam table. -An unmarked container on the counter with a scoop in a yellow unidentified food that was partially covered. *The cabinet handles near the serving table that contained dishes used to serve the residents were dirty with a black, oily, and sticky substance. *A clear plastic hose from the overhead ventilations system was attached to the faucet of the handwashing sink. -The handwashing sink was also the eye wash sink. -There was an unidentified black and orange substance in the hose. -A clear liquid dripped into the sink. -There was a metal strainer in that sink that contained unidentified white flaky particles. *The Hydrion chemical sanitizer test strips used to test the sanitizer level in the sanitizer buckets and the dishwashing sink had an expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Interview on [DATE] at 8:15 a.m. with DM C and cook D revealed: *DM C confirmed that the expiration date on the sanitizer test strips was [DATE] and stated, We just opened them a month ago. -He was unaware that they had expired, and then stated, I will order more. *Cook D confirmed that the sanitizer buckets were filled that morning. -She then refilled the sanitizer bucket and used those test strips to test the sanitizer level -She stated the level of sanitizer was 200. 4. Observation on [DATE] at 8:20 a.m. of the residential style fridge with a top freezer revealed: *The bottom row of the refrigerator door contained: -An open jug of thickened cranberry juice labeled ,d+[DATE] with a black marker. -An open jug of thickened apple juice with a manufacturer use by date of [DATE] labeled ,d+[DATE] in black marker. -An open jug of thickened orange juice with a manufacturer use by date of [DATE] labeled ,d+[DATE] in black marker. -An open jug of thickened water labeled with two dates ,d+[DATE] and ,d+[DATE] in black marker. -An open jug of thickened apple juice labeled ,d+[DATE] in black marker. *The second to bottom row of the refrigerator door contained: -An open carton of thickened lemon water labeled ,d+[DATE] in black marker. -An open carton of thickened orange juice labeled ,d+[DATE] in black marker. *On the top shelf inside the refrigerator there were five pitchers of juice that were not labeled or dated. 5. Observation and interview on [DATE] at 8:30 a.m. with cook D revealed she: *Had been employed as a cook at the facility for eight years. *Confirmed the all in one sheet was where the daily food temperatures, the sanitizer levels, and the refrigerator and freezer temps were logged. -The log sheet for [DATE] was blank. There was no documentation to indicate that the food temperatures, the sanitizer levels, and the refrigerator and freezer temps had been checked. The log sheets are to be completed daily. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Had cooked breakfast that morning, *Stated she had checked the temperature of the food when the food came out of the oven and again when she had served the food. *When was asked where the food temperature checks for that day had been logged, she pointed to her head. 6. Observations on [DATE] at 11:27 a.m.to 11:54 a.m. in the dining room revealed: *The ice machine had an unidentified white flaky substance at the base of it along the edges of the metal stand of that machine. -There were two orange, circular, fuzzy areas on the grill of the overflow tray. -There was a significant buildup of an unidentified white flaking substance inside of the ice shoot *DA I lifted the drinking cups out of the ice tray and held those cups by the area where the resident placed their lips to drink from those cups. *DM C served a resident plate while wearing gloves, then with those gloved hands he: -Took a straw from the container and gave it to the resident. -Removed those gloves, and without performing hand hygiene (HH) he touched the cupboard door with his right hand and then left the room. -He returned to the dining room and touched the door with his right hand. His left hand was in his pants pocket. Without washing his hands, he put on a pair of gloves and delivered another plate to a resident. *RA J delivered a plate of food to a resident, then touched her pants, crossed her arms, and without performing HH delivered another meal. -Her apron was visibly soiled. *CNA L delivered a plate of food, crossed her arms, touched a chair, without performing HH she put on a pair of gloves and assisted resident 4 drinking from a cup. With those gloved hands she then assisted resident 19 by placing a sandwich into her hand. With those same gloved hands, she touched resident 19's wheelchair then removed the sandwich from resident 19's hand and placed it on her plate. 7. Observation and interview on [DATE] at 8:53 a.m. with DM C in the kitchen revealed: *The unidentified orange and white substance remained on the dishwasher. -DM C stated he cleaned the dishwasher a week ago. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*A hole in the wall under the dishwasher sink exposed drywall and had unidentified brown dried substance on it. -DM C stated that he had been aware of that area and had notified the maintenance department. *The storage room floor was dirty, and a pile of trash and empty boxes sat on the floor. -DM C confirmed he was aware of the missing tiles on the floor near the exit door. *The wall and door frame in that storage room had paint peeling and were uncleanable surfaces. 8. Observation on [DATE] at 9:02 a.m. to 9:09 a.m. in the food storage room revealed: *Three plastic zip bags labeled Pretzels ,d+[DATE], Pretzels ,d+[DATE], and Vanilla Wafers ,d+[DATE]. *A plastic zip bag that was not labeled had pretzels in it and was dated ,d+[DATE]. *A plastic zip bag that appeared to have corn chips in it was dated ,d+[DATE]. *Two unidentified black splatter marks on the wall. *A plastic container with a red lid that appeared to have graham cracker crumbs in it that was not labeled or dated. 9. Observations on [DATE] between 10:53 a.m. and 11:25 a.m. in the kitchen revealed: *DA I filled two cups with thickened lemon water and apple juice from containers dated ,d+[DATE] with black marker. *Cook D moved the mashed potatoes, carrots, and meat directly from the oven to the steam table. -She cleaned the thermometer with an alcohol wipe between each food as she checked each food's temperature. *She stated the following food temperatures: -Mechanical meat 166 degrees Fahrenheit. -Puree meat 203 degrees Fahrenheit. -Puree carrots 186 degrees Fahrenheit. -Mashed potatoes 182 degrees Fahrenheit. -Fried potatoes 187 degrees Fahrenheit. -Sausage 205 degrees Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Cook D wet her hands at the three-compartment dishwashing sink without using soap, then dried her hands on her apron, and then used the thermometer to check the temperature of the dessert. -Without performing HH, she placed the lids on the food items on the warm serving table, wiped her hands on her apron, scooped the dessert into small serving bowls, touched the inside of the bowls, and wiped her hands on her apron in between each serving. *At 11:06 a.m. cook D stated she had forgotten to log the food temperatures and filled out the temperature log. *Cook D placed a bag of rolls on the food prep counter, wet her hands at the three-compartment sink, wiped those hands on her apron, then placed the fruit into the puree mixer adjusting that fruit with her bare hand. *Cook D moved the refrigerated food items to the ice packs at the serving area. -The temperature of the refrigerated items was not checked prior to serving them. *Cook D placed a clean, wet dishcloth against her apron, folded it, and then set it on the edge of the cutting board on the warm serving table. *Cook D opened a bag of rolls for the sausages and without performing HH she put on a pair of gloves. With those gloved hands she: -Opened the cabinet and took out serving bowls, -Touched a resident's menu. -Took a plate from the warmer and with those gloved hands placed the roll on that plate. -Touched the utensil handles and placed a sausage in that roll. -Scooped potatoes on to that plate and with those gloved hands touched the potatoes and moved them away from the edge of the plate. -Took the next paper menu and continued to prepare several more plates with those gloved hands. *Cook D then removed those gloves, threw them in the trash can, stated My hands are sweaty, and without performing HH put on a new pair of gloves and continued to serve the remaining plates of food. 10. Interview on [DATE] at 5:08 p.m. with director of nursing (DON) B and registered nurse in-service director (RNID) M revealed: *DON B and RNID M provided education to the nursing staff on hand washing and glove use but did not provide that education to the kitchen staff. -The dietary manager or dietician would have provided education to the dietary staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*DON B expected staff to wear gloves only when touching ready-to-eat foods such as a sandwich, but stated, They could cut the sandwich and feed it with a fork. *DON B and RNID M confirmed they expected staff to use hand sanitizer between assisting residents. *DON B stated They are allowed to feed 2 residents at once as long as they use the residents' utensils and don't touch their food. They should be using hand sanitizer if they touch other surfaces in the dining room. *RNID M confirmed that hand sanitizer and a hand-washing sink are available in the dining room. *DON B stated about the staff assisting residents in the dining room, They never usually wear gloves, and I don't know why they did while you were here. 11. Observation and interview on [DATE] at 9:16 a.m. with DM C in the kitchen revealed: *Thickened beverage containers should be labeled when they are opened with OP and a date and the date for three days later when to discard that container. *The container stated use in 7 days but it was his expectation that it be discarded in three days. *The thick black marker date was the date the item was received. *He confirmed that the following containers were expired and threw them in the trash. -An open jug of thickened apple juice with a manufacturer's use by date of [DATE] labeled ,d+[DATE]. -An open jug of thickened cranberry Juice labeled ,d+[DATE]. -An open jug of thickened orange juice with a manufacturer's use by date of [DATE] labeled ,d+[DATE]. -An open jug of thickened water labeled ,d+[DATE] and ,d+[DATE]. -An open jug of thickened apple juice labeled ,d+[DATE]. -An open carton of thickened orange juice labeled ,d+[DATE]. 12. Interview on [DATE] at 2:04 p.m. with DM C revealed: *He completed training with the dietary staff and re-educated them as needed. *He expected dietary staff to wash their hands and to wear gloves to cover cuts when preparing or serving food. *He expected dietary staff to use hand sanitizer in between serving resident meals. (continued on next page)

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	435054	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Redfield	1015 Third Street East Redfield, SD 57469

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*He expected the food temperatures to be taken and recorded when it came out of the oven and again before it was served if it was over 45 minutes. *He expected tongs to be used when serving buns or ready-to-eat foods. -If gloves were used instead of tongs, then he expected no other food items or objects would be touched with those gloved hands. *He stated the main cleaning was scheduled to be done on the evening shifts. -He had trouble getting the staff to complete those tasks. -The dishwasher was delimed once a week. 13. Observation and interview on [DATE] at 2:58 p.m. with DM C and cook E during a return tour of the kitchen revealed: *Several small pieces of raw chicken in the wash compartment of the three-compartment dishwashing sink. -Cook E confirmed that she had thawed the chicken in a bin with running water because it was needed for dinner. *Cook E stated that she had thawed the chicken in the three-compartment sink because the two-compartment food preparation sink leaked. *The cabinet under the two-compartment sink contained wet towels, a plastic bin that contained individually wrapped filters, and an orange and brown unidentified substance coated all the items. *The floor under the commercial gas stove had not been cleaned. -There was grease dripping from the grease drawer and the left edge of the griddle. -The grease drawer was full of a partially congealed black substance. *DM C confirmed that the three burners with pilot lights lit on the right side of the stove, were the only ones that worked. *DM C confirmed that the clear hose attached to the sink faucet was from the air conditioning unit. -That was the only hand-washing sink in the kitchen. 14. Review of the provider's Kitchen Cleaning Schedule revealed: *Dispose of Out-of-Date products Daily. *Remember Your 'Opened-On Dates! (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*For the week of [DATE] all daily tasks were marked completed on Sunday through Thursday. -Daily tasks were not marked completed on Friday or Saturday. -Twice weekly tasks were all marked completed on Sunday and Thursday. *The cleaning schedules for [DATE] through [DATE] both had several tasks not marked as completed. Review of the provider's undated Handwashing and Glove Use Policy revealed: *Hands must be washed prior to beginning work .and following contact with any unsanitary surfaces i.e. touching hair, sneezing, opening doors, etc. *Washing procedure .Wet hands. Apply soap. Lather, vigorously rubbing hands together for 20 seconds. Rince hands to remove soap and debris. Dry hands with a disposable paper towel. Discard paper towel(s) into a waste container without touching the container, *Gloves must be worn when touching any ready-to-eat food. *When gloves are used, handwashing must occur per above procedure prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed, see above. Gloves may be used for one task only. *It is important to remember that gloves can often give a false sense of security and can carry germs the same as our hands. Review of the provider's undated Food Storage Policy revealed: *Food items should be stored, thawed, and prepared in accordance with good sanitary practice. *Any expired or outdated food products should be discarded. *Frozen Meat/Poultry and Foods: Thaw foods at 41 [degrees Fahrenheit] or less or in refrigerator. Thawing foods under cold running water is no longer recommended due to strict guidelines set forth by the 2013 Food Code. Review of the provider's undated Dish machine policy revealed: *After each meal, clean machine according to cleaning procedure. *Frequency: After each meal Wipe exterior of machine and soap dispenser. Dry and Polish with cloth. *Frequency: Weekly .Clean dish machine exterior with deliming solution. Review of the provider's undated Cleaning Schedules Policy revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*The Food and Nutrition Services staff shall maintain the sanitation of the Food and Nutrition Services Department through compliance with written, comprehensive cleaning schedules developed for the community by the Director of Food and Nutrition Services or other clinically qualified nutrition professionals. -2. A cleaning schedule shall be posted with tasks designated to specific positions in the department. -6. On the Position cleaning schedules the Director of Food and Nutrition Services or other clinically qualified nutrition professional fills in the Position, the item to be cleaned, Frequency I.e. daily, day of the week, or week 1,2,3,4. Review of the Dining Services Guideline revealed: *Person serving the food follows meal ticket, noting the diet order, allergies, likes/dislikes, religious or cultural notes. -Assisted, Cued, Restorative Resident's list is in the kitchen. This is for each meal. a. when assisting residents, you are not getting up to get other residents items. b. Sit at eye level to assist. c. You can assist and cue at the same time. d. Alternate food and fluids. e. Ensure the resident is sitting upright in chair. Please review Signs and Symptoms of Dysphagia starting on page two.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, and policy review, the provider failed to ensure that essential dietary department kitchen equipment was in safe working condition including: *Five of the eight stove-top burners on the commercial gas stove that did not ignite. *Two of the two ovens in the commercial gas stove that were not in working condition. *One of one flattop grill that leaked oil down the side of the equipment and onto the floor beneath. *The two-compartment food preparation sink leaked and was not used to prepare food. *The air conditioning unit in the kitchen ceiling had condensation tubing attached to the faucet and drained into the handwashing sink. Findings include: 1. Observation on 12/3/24 at 7:50 a.m. during the initial tour of the kitchen revealed: *The floor under the commercial gas stove and flattop grill had a thick brown oily substance on the left side that extended behind the stove. A large can containing grease was on the floor to the left of the stove and appeared to be catching grease as it dripped from the flattop grill and the bottom of the stove. *A clear plastic hose was attached to the faucet of the hand washing and eye wash sink. -It dripped liquid that appeared to be water into that sink. -It was attached to the overhead ventilation system. -The hose contained an unidentified orange and black substance. -A metal strainer in that sink contained unidentified white flaky particles. -The base of the faucet of that sink contained an unidentified black substance. 2. Observation and interview on 12/5/24 at 2:58 p.m. with dietary manager (DM) C and cook E during a return tour of the kitchen revealed: *Several small pieces of raw chicken in the wash compartment of the three-compartment dishwashing sink. *Cook E stated that she had thawed the chicken in the three-compartment sink because the two-compartment food preparation sink leaked. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The cabinet under the two-compartment sink contained wet towels, a plastic bin that contained individually wrapped filters, and an orange and brown unidentified substance coated all the items. *The floor under the commercial gas stove had not been cleaned. -There was grease dripping from the grease drawer. -DM C suspected that grease was dripping from the flattop grill due to potentially faulty [NAME] along the edges. *DM C confirmed that the three burners with pilot lights lit, on the right side of the stove, were the only ones that worked. *DM C stated that the lower two ovens in that commercial gas stove were not operational. *DM C confirmed that the clear hose attached to the sink faucet was from the air conditioning unit. -That was the only hand-washing sink in the kitchen. 3. Interview on 12/5/24 at 3:29 p.m. with maintenance director G revealed: *He was not aware that the burners or the oven of the commercial gas stove did not work. *He was not aware that the food preparation sink was leaking. *He expected that staff would have entered a work order if something was broken. 4. Review of the Maintenance Work Orders Log revealed: *The log contained closed work orders from 1/1/24 through 12/4/24. *Work order number 2216 sink at prep table is leaking, was assigned a medium priority in the kitchen. -There was no date associated with that work order. *Work order number 2222 leak, was assigned a medium priority in the kitchen. -There was no date associated with that work order. Review of the provider's revised 8/16/24 Maintenance policy revealed: *It is the facility's policy to maintain equipment and the building environment. *Any staff who is made aware of [a] malfunctioning equipment or any part of the building that is in disrepair will report the issue to the maintenance department. *The maintenance department will address the issue as soon as possible. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Any equipment that can not be fixed will be replaced accordingly.