STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455510	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Hills Rehabilitation and Care Center	8020 Blanco Rd San Antonio, TX 78216

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622 Based on observations, interviews, and record reviews, the facility failed to ensure that residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences that would not endanger the health or safety of the residents for 1 resident 6 (Resident # 22) reviewed for call lights. Resident #22's was in bed with the call light on the floor at the foot of the bed, out of reach for the resident. This failure could place residents at risk of achieving independent functioning, dignity, and well-being. The findings included: Record review of Resident #22's face sheet dated 8/22/2024 AT 10:15AM revealed the resident was admitted [DATE] with diagnoses that included: ESRD (End Stage Renal Disease), MDD (Major Depression Disorder), A-fib (Atrial fibrillation). Record review of Resident #22's Quarterly MDS dated [DATE] revealed a BIMS score of 13. Record review of the Care Plan dated 7/30/2024 revealed the resident was Care Planned for falls with interventions for call light to be in reach. 08/22/24 10:49 AM observed Resident # 22 asleep in bed, turned to her left side with her arm laying across the bedrail and with her tray of food from breakfast. She was easily aroused from her sleep and stated she was tired from dialysis and that she had recently returned to her room. The Resident's call light was on the floor at the foot of her bed out of Resident # 22's reach. During an interview on 8/22/2024 at 10:55AM the investigator asked the DON to look at Resident #22 while she slept in bed. The DON verified that the Resident #22's call light was on the floor at the foot of the bed. The DON stated it was important to follow the Care Plan for residents to provide the proper care and not following the Care Plan could cause a resident to not get the care they need because each Care Plan was Person Centered. She stated the call should have been placed for the Resident to be able to reach to be able to make her needs known. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/23/2024 at 1:22 the Administrator stated the call light should be in place for the residents to reach to be able to get the attention of the staff when they need assistance and there could be something that may be an emergent situation. Record review of facility policy titled Answering the Call Light dated September 2022 stated in part; General Guidelines #5- Ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and rom the floor.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 3 of 14 residents (Residents #8, #14, and #26) whose assessments were reviewed, in that: 1. Resident #8 was a smoker, but Resident #8's annual MDS, dated [DATE], reflected the resident did not use tobacco. 2. Resident #14 was taking Plavix (Antiplatelet) for cerebral infarction, but Resident #14's annual MDS, dated [DATE], reflected the resident was taking anticoagulant. 3. Resident #26 did not take any anticoagulant, but Resident #26's annual MDS, dated [DATE], reflected the resident was taking anticoagulant. This failure could place residents at-risk for inadequate care and services due to inaccurate assessments. The findings were: 1. Record review of Resident #8's face sheet, dated 08/23/2024, revealed an admitted [DATE] with diagnoses that included: Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), hypothyroidism (A condition in which the thyroid gland doesn't produce enough thyroid hormone), type 2 Diabetes mellitus (high level of sugar in the blood), chronic obstructive pulmonary disease (lung diseases that damage the airways and other parts of the lungs, making it difficult to breathe), and nicotine dependence (need nicotine and can't stop using it). Record review of Resident #8's annul MDS assessment, dated 10/31/2023, indicated his BIMS score was 12 of 15 reflecting he had moderate cognitive impairment. Further record review of Resident #8's annual MDS, dated [DATE], indicated the question of Current tobacco use in the Section J (Health Conditions) was answered No. Record review of Resident #8's comprehensive care plan, dated 07/15/2024, reflected [Resident #8] is a smoker, and the intervention was instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Record review of Resident #8's smoking assessment, dated 09/25/2023, reflected Resident #8 was a smoker and smoking four times a day at the facility smoking area under supervision. Interview on 08/20/2024 at 2:26 p.m. with Resident #8 stated the resident was smoking cigarettes for long time even before he was admitted to the facility. Interview on 08/23/2024 at 9:26 a.m. with MDS nurse acknowledged Resident #8's annual MDS dated [DATE]'s question of Current tobacco use in the Section J (Health Conditions) was answered No, and it was mistake because Resident #8 has been smoking since he was admitted to the facility. Further interview with the MDS nurse stated the question of current tobacco use should have been answered Yes. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/23/2024 at 12:23 p.m. with DON stated because Resident #8 had been smoking since he was admitted to the facility, Resident #8's annual MDS dated [DATE] was inaccurate. The potential harm was inaccurate MDS might affect incorrect care to the resident. 2. Record review of Resident #14's face sheet, dated 08/23/2024, revealed an admitted [DATE] and re-admitted [DATE] with diagnoses that included: cerebral infarction (when blood flow to the brain is blocked), aphasia (loss of ability to understand or express speech), type 2 Diabetes mellitus (high level of sugar in the blood), dysphagia (difficulty swallowing), coronary artery diseases (reducing blood flow to the heart muscle), and epilepsy (the brain is disturbed, causing seizures). Record review of Resident #14's annul MDS assessment, dated 08/12/2024, indicated his BIMS score was 14 of 15 reflecting he was cognitively intact. Further record review of Resident #14's annual MDS, dated [DATE], indicated the question of High-risk drug classes: Use and indication - is the resident taking anticoagulant? in the Section N (Medications) was answered Yes. Record review of Resident #14's physician orders, dated 02/10/2024, indicated Aspirin 81 mg oral tablet chewable give 1 tablet by mouth one time a day for coronary artery disease, and Plavix Tablet 75 mg give 1 tablet by mouth one time a day for cerebral infarction. Further record review of Resident #14's physician orders reflected there was no order for anticoagulant. Interview on 08/22/2024 at 3:02 p.m. with MDS nurse acknowledged Resident #14 was taking Plavix, and it was not anticoagulant (blood thinner) but antiplatelet (preventing platelets from sticking together and forming blood clots). Resident #14 was not taking any anticoagulant. The resident's annual MDS, dated [DATE], was inaccurate. The answer regarding the question is the resident taking anticoagulant? in the Section N (Medications) should have been No. It was a mistake. The potential harm was inaccurate MDS might affect incorrect care to the resident. 3. Record review of Resident #26's face sheet, dated 08/23/2024, revealed an admitted [DATE] and re-admitted [DATE] with diagnoses that included: hemiplegia and hemiparesis (weakness and paralysis on one side of the body), dysphagia (difficulty swallowing), type 2 Diabetes mellitus (high level of sugar in the blood), atherosclerotic heart disease (plaque builds up in the arteries, causing them to thicken and harden), and hypertension (high blood pressure). Record review of Resident #26's annul MDS assessment, dated 08/05/2024, indicated his BIMS score was 10 of 15 reflecting he had moderate cognitive impairment. Further record review of Resident #26's annual MDS, dated [DATE], indicated the question of High-risk drug classes: Use and indication - is the resident taking anticoagulant? in the Section N (Medications) was answered Yes. Record review of Resident #26's physician orders, dated from 07/09/2024 to 08/22/2024, indicated there was no order for anticoagulant. Interview on 08/22/2024 at 3:02 p.m. with MDS nurse acknowledged Resident #26 was not taking any anticoagulant (blood thinner), but the resident's annual MDS, dated [DATE], reflected High-risk drug classes: Use and indication - is the resident taking anticoagulant? in the Section N (Medications) was answered Yes. The MDS was inaccurate. The answer should have been No. It was a mistake, and the MDS nurse had responsibility for accuracy. The potential harm was inaccurate MDS might affect incorrect care to the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy, titled Resident Assessment, revised 03/2022, indicated 1. the resident assessment coordinator is responsibility for ensuring that the interdisciplinary team conducts timely, accurate, and appropriate resident assessment. Record review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18. 11, October 2023, revealed, N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Record review of the CMS MDS 3.0 Manual dated October 2023 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622 Based on observations, interviews, and record reviews, the facility failed to ensure that 1 of 4 residents (Resident #22) received treatment and care in accordance with professional standards of practice that would meet the resident's physical needs for 1 of 5 (Resident #22) residents reviewed for quality of care. Resident #22 was in a low bed with not fall mat next to the bed. This failure could place the resident at risk for injury by not following the person-centered Care Plan. The findings included: During an observation and interview on 08/22/24 at 10:30 AM Resident # 22 was asleep in bed, turned to her left side with her arm laying across the bedrail. She stated she had recently returned from dialysis, and she was very tired. There was no fall mat on the floor next to the bed. Record review of Resident #22's face sheet dated 8/22/2024 AT 10:15AM revealed the resident was admitted [DATE] with diagnoses that included: ESRD (End Stage Renal Disease), MDD (Major Depression Disorder), and A-fib (Atrial fibrillation- chronic elevated heart rate). Record review of Resident #22's Quarterly MDS dated [DATE] revealed a BIMS score of 13. The resident was coded for falls. Record review of the Care Plan for Resident #22, dated 7/30/2024 revealed the resident was Care Planned for falls with interventions for low bed and a fall mat next to the bed. During an interview on 8/22/2024 at 10:55AM the investigator asked the DON to look at Resident #22 while she slept in bed. The DON verified that the Resident did not have a fall mat on the floor next to the bed. The DON stated it was important to follow the Care Plan for residents to provide the proper care and not following the Care Plan could cause a resident to not get the care they need because each Care Plan was Person Centered. She stated a fall mat was supposed to be next to the bed. During an interview on 8/23/2024 at 1:20PM the Administrator stated it was important to follow Care Plan for safety and for the welfare of the residents. He stated the Care Plan was instructions on how to take care of each resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Safety and Supervision of Residents dated July 2017 stated in part: Policy Statement-Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Individualized, Resident-Centered Approach to Safety: 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently.

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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** 39049 Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 resident (Residents #24) reviewed for incontinent care. While providing incontinent care on 08/22/2024 at 2:35 p.m. for Resident #24, CNA A did not return Resident #24's foreskin to the original position. This failure could place residents at-risk for infection, paraphimosis (urologic emergency in uncircumcised males) and skin break down due to improper care practices. The findings were: Record review of Resident #24's electronic face sheet dated 08/23/2024 reflected he was originally admitted to the facility on [DATE]. His diagnoses included: cerebral infarction (when blood flow to the brain is blocked), dysphagia (difficulty swallowing), need for assistance with personal care, hemiplegia and hemiparesis (weakness and paralysis on one side of the body), and dementia (the loss of cognitive functioning). Record review of Resident #24's quarterly MDS assessment with an ARD of 06/28/2024 reflected he scored a 5/15 on his BIMS which signified he had severe cognitive impairment. He was frequently incontinent of bladder and always incontinent of bowel. He was dependent for his activities of daily livings except for eating which he only required set up. Toilet transfer was not attempted. Record review of Resident #24's comprehensive care plan revised date 03/27/2024 reflect he was incontinent of bowel and bladder, and the interventions was check resident every two hours and assist with toileting as needed and provide peri care after each incontinence episode. Observation on 08/22/2024 at 2:35 p.m. indicated CNA A and CNA B were performing incontinent care for Resident #24. CNA A pulled Resident #24's foreskin back to clean his penis and did not return the foreskin to its original position. Interview on 08/22/2024 at 2:44 p.m. with CNA A stated she did not know why she did not return Resident #24's foreskin to its original position after she retracted it to clean his penis. She stated she was nervous. She stated she was trained to return the foreskin of a male during incontinent care and if it were not returned it could cause irritation, swelling and infection of the penis. Interview on 08/22/2024 at 4:00 p.m. with the DON stated CNA A needed to put Resident #24's foreskin back to the normal position because of the potential complications such as infection and prevention of blood circulation to the area. The DON stated competencies were completed for CNA A, provided a copy to the surveyor, and said the DON was responsibility for overseeing CNA A's competency once a year and as needed through the skill check-off. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA A's Incontinent care skill checklist dated 05/02/2023 reflected the CNA A satisfactorily completed the checklist for incontinent care for a male to include: Gently grasp shaft of penis and if uncircumcised, retract foreskin. Position and assist patient to comfortable. Record review of the facility policy and procedure titled Perineal Care revised 02/2018 reflected . d. Retract foreskin of the uncircumcised male. j. Reposition foreskin of uncircumcised male.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 1 of 5 (CNA A) nursing staff reviewed for competent nursing care. While providing incontinent care on 08/22/2024 at 2:35 p.m. for Resident #24, CNA A did not return Resident #24's foreskin to the original position. These failure affect residents who depend on nursing care and could place residents at risk for injury, infection, and harm. The findings included: Record review of Resident #24's electronic face sheet dated 08/23/2024 reflected he was originally admitted to the facility on [DATE]. His diagnoses included: cerebral infarction (when blood flow to the brain is blocked), dysphagia (difficulty swallowing), need for assistance with personal care, hemiplegia and hemiparesis (weakness and paralysis on one side of the body), and dementia (the loss of cognitive functioning). Record review of Resident #24's quarterly MDS assessment with an ARD of 06/28/2024 reflected he scored a 5/15 on his BIMS which signified he had severe cognitive impairment. He was frequently incontinent of bladder and always incontinent of bowel. He was dependent for his activities of daily livings except for eating which he only required set up. Toilet transfer was not attempted. Record review of Resident #24's comprehensive care plan revised date 03/27/2024 reflect he was incontinent of bowel and bladder, and the interventions was check resident every two hours and assist with toileting as needed and provide peri care after each incontinence episode. Observation on 08/22/2024 at 2:35 p.m. indicated CNA A and CNA B were performing incontinent care for Resident #24. CNA A pulled Resident #24's foreskin back to clean his penis and did not return the foreskin to its original position. Interview on 08/22/2024 at 2:44 p.m. with CNA A stated she did not know why she did not return Resident #24's foreskin to its original position after she retracted it to clean his penis. She stated she was nervous. She stated she was trained to return the foreskin of a male during incontinent care and if it were not returned it could cause irritation, swelling and infection of the penis. Interview on 08/22/2024 at 4:00 p.m. with the DON stated CNA A needed to put Resident #24's foreskin back to the normal position because of the potential complications such as infection and prevention of blood circulation to the area. The DON stated competencies were completed for CNA A, provided a copy to the surveyor, and said the DON was responsibility for overseeing CNA A's competency once a year and as needed through the skill check-off. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA A's Incontinent care skill checklist dated 05/02/2023 reflected the CNA A satisfactorily completed the checklist for incontinent care for a male to include: Gently grasp shaft of penis and if uncircumcised, retract foreskin. Position and assist patient to comfortable. Record review of the facility policy and procedure titled Perineal Care revised 02/2018 reflected . d. Retract foreskin of the uncircumcised male. j. Reposition foreskin of uncircumcised male.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring (monitoring for expiration dates), receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 medication carts (South unit medication aide cart). 1.South unit medication aide cart had thickened water for administering medications on [DATE], and the thickened water was expired on [DATE]. This failure could place residents at risk for not receiving therapeutic effects of medication administration. The findings included: 1. Observation on [DATE] at 10:06 a.m. indicated South unit medication aide cart had thickened lemon flavor water with high vitamin C, and the thickened water was expired on [DATE]. Interview on [DATE] at 10:06 a.m. with medication aide A indicated one bottle of thickened lemon flavor water with high vitamin C was on the South unit medication aide cart, and the thickened water was expired on [DATE]. Further interview with the medication aide A stated she did not open the thickened lemon flavor water yet because there was no resident on the south unit who needed to have the thickened water. However, the medication aide kept the thickened water on the cart because she might use it for new residents who needed it for administering medications, and the medication aide did not know the reason the thickened water was on the cart. Interview on [DATE] at 10:10 a.m. the DON stated South unit medication aide cart had thickened lemon flavor water with high vitamin C, and the thickened water was expired on [DATE]. Any medication or food for medication administration should have been discard if they were expired. The DON was responsibility for overseeing if or not nursing staff checked expiration dates through reviewing medication carts. The potential harm was resident who took the expired water might get sick. Record review of the facility policy, titled Storage of Medications, revised ,d+[DATE], revealed 1. Drugs and biologicals used on the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medication have access to locked mediations. 4. Drugs container that have missing, incomplete, improper, or incorrect labels are returned the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record reviews, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys, for 1 of 3 medication carts (South unit medication aide cart) reviewed for drug security and 1 of 14 residents (Resident #3) reviewed for medications at the bedside. 1. Resident #3's 0.9% sodium chloride irrigation sterile water was left unattended and unsecured on the nightstand at the resident's bedside on 08/20/2024. These failures could place residents at risk for misappropriation of property and could place residents at risk for accidents, hazards, and not receiving therapeutic effects. The findings included: 1. Record review of Resident #3's electronic face sheet, dated 08/23/2024, reflected the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included: hydrocephalus (fluid (CSF) builds up in the brain's ventricles, causing them to widen and put pressure on brain tissue), parkinsonism (clinical syndrome characterized by tremor), pruritus (itching), and profound intellectual disability (average mental age of 3 years or less). Record review of Resident #3's annual MDS assessment with an ARD of 08/08/2024 reflected the resident scored an 0/15 on his BIMS which signified the resident had severe cognitive impairment, and the resident was total dependent to all activities of daily livings. Record review of Resident #3's physician order, dated 04/19/2024, reflected Flush Foley catheter with sterile water [sodium chloride] 30 ml every shift for sediment and history of urinary tract infection. Observation on 08/20/2024 at 9:48 a.m. revealed in Resident #3's room, 0.9% sodium chloride irrigation sterile water was on the nightstand at the resident's bedside unattended. Resident #3 was not in his room. Interview on 08/20/2024 at 9:55 a.m. with LVN A stated Resident #3's 0.9% sodium chloride irrigation sterile water was on the nightstand at the resident's bedside unattended. Further interview with the LVN A stated it was medication and all medications should not be in resident's room. They did not know the reason the medication was on the nightstand unattended in Resident #3's room. The potential harm was that Resident #3 or other residents might use the medication incorrectly. Interview on 08/22/2024 at 4:00 p.m. the DON stated all medications should not be in resident's room unattended per the facility policy. (continued on next page)

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	455510	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Hills Rehabilitation and Care Center	8020 Blanco Rd San Antonio, TX 78216

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled Storage of Medications, revised 11/2020, revealed 1. Drugs and biologicals used on the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medication have access to locked mediations. 4. Drugs container that have missing, incomplete, improper, or incorrect labels are returned the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to provide special eating equipment and utensils for residents who need them for 1 of 14 Residents (Resident #4) who were observed during meal service. The facility did not provide a built-up spoon to Resident #4 on 08/20/2024 at 12:40 PM. The meal ticket indicated Resident #4 needed to have a built-up spoon. This failure could affect residents who depended on assistive devices and infringe on the resident's dignity and feeding independence. The findings were: Record review of Resident #4's face sheet, dated 08/23/2024, revealed an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: intracranial injury (brain injury), protein-calorie malnutrition (inadequate intake of food), type 2 Diabetes mellitus (high level of sugar in the blood), dysphagia (difficulty swallowing), and intellectual disabilities (limitation in cognitive functioning and skills). Record review of Resident #4's annual MDS assessment with an ARD of 08/12/2024 reflected the resident scored an 1/15 on his BIMS which signified the resident had severe cognitive impairment, and the resident was total dependent to all activities of daily livings such as hygiene, transfer, and dressing, except eating, which was required partial/moderate assistance (helper does less than half the efforts). Record review of Resident #4's care plan, date initiated 11/19/2022, revealed [Resident #4] has potential for nutritional issues related to swallowing problem, and Intervention - divided plate with built-up spoon. Record review of Resident #4's meal ticket, dated 08/20/2024, revealed Resident #4 needed to have a built-up spoon with meal tray. Observation of the facility's dining room on 08/20/2024 at 12:40 PM revealed Resident #4 was eating his lunch at the dining room but was not provided a built-up spoon. Resident #4 was provided a regular spoon. Resident #4 was eating well without any swallowing problem. Attempted interview on 08/20/2024 at 12:40 PM with Resident #4, but the resident was non-interviewable. Interview on 08/20/2024 at 12:45 PM with the nutrition service director stated Resident #4 was eating his lunch with a regular spoon at this time, but the resident was supposed to receive a built-up spoon for preventing potential swallowing problem. Resident #4 received a built-up spoon for today's breakfast, but kitchen staff could not find a built-up spoon for lunch time, and that was why kitchen staff might have provided a regular spoon. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/20/2024 at 12:52 PM with LVN B stated LVN B checked Resident #4's meal ticket and said to the kitchen that Resident #4 needed a built-up spoon, but the kitchen could not find it. One of the kitchen staff went to other office to get a new built-up spoon, and the staff set up the lunch with a regular spoon for Resident #4, and the resident started eating his lunch with a regular spoon. Staff should have held Resident #4's lunch tray until getting a built-up spoon, and nurses had responsibility for checking meal ticket through comparing the meal tray against the ticket. The potential harm was that Resident #4 might have swallowing problem because the resident might eat fast with a regular spoon. Record review of the facility's policy, titled Assistance with Meals, revised 03/2022, revealed Resident who may benefit from assistive devices: adaptive devices (special eating equipment and utensils) will be provided for resident who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46677 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen observed for food service. The facility failed to ensure items stored in the reach in freezer, reach in refrigerator, dry storage, walk in refrigerator were labeled after opening. The facility failed to ensure strawberries stored in the walk-in cooler were free from mold. The facility failed to ensure food stored in the reach in refrigerator located in the kitchen were stored at or below 41 degrees. These failures could place residents at risk of food borne illnesses. The findings were: Observation of the facility's only kitchen on [DATE] at 9:48 AM revealed four bags of open food stored in the reach in freezer unlabeled and undated, one tray of portioned out bowls of dry cereal covered and not labeled, one tray of cups with liquids in them covered and not labeled. Two 1-pound containers of strawberries had white fuzzy substance on the strawberries. Interview with the Dietary Manager on [DATE] at 10:00 AM revealed all open food stored in the refrigerator, freezer and dry storage were to be labeled with the item, date opened and use by date. The Dietary Manager stated it was the responsibility of all staff to label and date open items being stored and the responsibility of the Dietary Manager to ensure staff have labeled open food items. The Dietary Manager stated that it was the responsibility of the Dietary Manager to ensure food items stored in the refrigerator were not spoiled or contained mold. The Dietary Manager stated that these failures could lead to food born illnesses. Observation of the facility's only reach in refrigerator on [DATE] at 11:45 AM revealed the facility's thermometer read 60 degrees. No food was served from the reach in refrigerator during lunch services. Interview with the Dietitian on [DATE] at 12:35 PM revealed the temperature of the reach in refrigerator was checked and recorded daily and should be 41 degrees or lower. The Dietitian stated the temperature was recorded at 32 degrees during the AM shift. The Dietitian did not know what time the temperature was checked during the AM shift. The Dietitian stated the food that was in the reach in refrigerator when the temperature read 60 degrees would be thrown away since it could not be determined how long the reach in refrigerator was over temperature. Interview with [NAME] A on [DATE] at 12:40 PM revealed [NAME] A took the temperature of the reach in refrigerator at 6 am and the temperature was 32 degrees. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's temperature log on [DATE] revealed the temperature was recorded at 32 degrees when checked on the AM shift. Record review of the facility's policy named Refrigerators and Freezers revised [DATE] on [DATE] revealed I. Acceptable temperature ranges are 35 F to 40 F for refrigerators and less than 0 F for freezers, 7. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from ca es for storage. 'Use by' dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by' dates indicated once food is opened, 8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed ,d+[DATE].17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed , d+[DATE].11 Temperature. (A) Except as specified in (B) of this section, refrigerated, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be at a temperature of 5oC (41oF) or below when received.,

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 14 residents (Resident #8) reviewed for safe and functional equipment. Resident #8's bed headboard was loosed and swinging up and down. This failure could place residents at risk for skin tears, injury, falls and discomfort during transfers. Findings included: Record review of Resident'#8's face sheet, dated 08/23/2024, revealed an admitted [DATE] with diagnoses that included: Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), hypothyroidism (A condition in which the thyroid gland do'sn't produce enough thyroid hormone), type 2 Diabetes mellitus (high level of sugar in the blood), chronic obstructive pulmonary disease (lung diseases that damage the airways and other parts of the lungs, making it difficult to breathe), and nicotine dependence (need nicotine and 'an't stop using it). Record review of Resident'#8's annul MDS assessment, dated 10/31/2023, indicated his BIMS score was 12 of 15 reflecting he had moderately cognitive impairment. Further record review of Resident #8's annual MDS, dated [DATE], indicated the resident required partial/moderate assistance (helper does less than half the effort) to sit to lying, sit to stand, chair/bed to chair transfer, and toilet transfer. Observation on 08/20/2024 at 2:21 PM indicated Resident #8 was laying on the bed in his room, and the bed's headboard was loose and swinging up and down. Interview on 08/20/2024 at 2:21 PM with Resident #8 stated his headboard was loose and swinging up and down, and it was a little bit uncomfortable, but he did not say anything to staff because he thought he was fine, and he did not know how long the headboard was loose. Interview on 08/21/2024 at 3:45 PM with LVN C acknowledged Resident #8's headboard of the bed was loose and swinging up and down, and it might cause the resident to fall. Interview on 08/21/2024 at 3:49 PM with Medical Record and Equipment acknowledged Resident #8's headboard of the bed was loose, and it was the Medical Record and Equipment's responsibility to monitor all medical equipment was safe. Nobody reported Resident #8's headboard of the bed to the Medical Record and Equipment. Record review of the facility policy, titled Safety and supervision of residents, revised 07/2017, revealed Our facility strived to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility -wide priorities.