STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455653	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Nursing Center	3326 Burgoyne Dallas, TX 75233

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 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** 47690 Based on observation, interview and record review the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one of 7 residents (Resident#23) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system was within reach of Resident #23 when the resident was lying in bed . This failure could place residents at risk of being unable to have a means of directly contacting caregivers. Findings include: A record review of Resident#23's MDS quarterly assessment , dated 12/26/24, reflected a [AGE] year-old male with a BIMS score 12 of 15, which indicated moderate cognitive impairment. Resident #23 was admitted to the facility on [DATE] with diagnoses , which included, Stroke (a brain damaged due to a lack of blood flow due to blocked or ruptured blood vessel), drug induced subacute dyskinesia (a condition characterized by involuntary, repetitive, and purposeless movements), and muscle wasting. The review further reflected the resident was totally dependent on staff for the ADL's (Activities of Daily Living). A record review of Resident #23's, undated, Comprehensive Care Plan reflected Focus. [Resident #23] is at high risk for falls r/t muscle weakness, unsteady balance, poor safety awareness, poor impulse control, impaired cognition . Goal. [Resident #23] will be free of falls through the review date. Interventions. Anticipate and meet [Resident #23's] needs. Be sure that [Resident #23's] call light is within reach and encourage to use it for assistance as needed. Observation and interview on 01/27/25 at 11:22 AM revealed Resident #23 was lying in bed. Resident #23's call light was clipped to the bed cover sheet at the level of his left shoulder. Resident #23 was unable to reach the call light. RN A walked into Resident #23 room and handed him the call light. Resident #23 was unable to push the call light button related to his involuntary, repetitive, and purposeless hands movements. RN A stated she would give Resident #23 the flat call light that was appropriate for his condition . (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/29/25 at 10:58 AM revealed Resident #23 had a flat call light and was not able to use it . Interview on 01/27/25 at 11:33 AM, RN A stated the call light should be within the residents reach all the time. She stated Resident #23 should have a special call light for his condition. RN A stated the risk to the resident could be not getting help on time, could be a fall and possible injury. RN A stated it was the responsibility of all the staff to make sure the call light was within resident reach and usable by the resident before exiting the room. Interview on 01/29/25 at 4:01 PM, the DON stated the call-light should always be accessible to the resident, and it was the responsibility of all staff to make sure the call lights were always within reach of the residents. The DON stated the risk to the residents, if they could not reach the call light, they could not call for help, and they would not get the help they needed. Interview on 01/29/25 at 4:15 PM, the Administrator stated his expectation from all the staff was for the call light to be within reach of the resident before leaving the room either attached to the bed or the resident. He stated the risk to residents, they would not be able to make their needs known, and their needs would not be addressed in a timely manner. He stated the in service was done monthly. The Administrator further stated he would get Resident #23 a call light to accommodate his condition. Record review of the Facility's Policy Communication - Call System, Nursing Manual - Nursing Administration, revised 06/2020, reflected Purpose: To provide a mechanism for residents to promptly communicate with nursing staff . Procedure . II. Call cords will be placed within the resident's reach in the resident's room. VIII. An adaptive call bell (e.g., flat pad call cord, hand bell, etc) will be provided to a resident per the resident's needs.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observation, interview and record review the facility failed to ensure the resident had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for seven of eight hallways (shower rooms on 100, 200, 300, 400, 500, 700, and 800 hallways) reviewed for environment and 1 of 34 residents (Resident # 109) reviewed for clean linens. 1. The facility failed to ensure the shower rooms were cleaned throughout the day, kept orderly, and maintained in a sanitary and comfortable condition for resident use. 2. The facility failed to ensure Resident #109 had clean linens on 01/28/2024 from 9:27 AM until 11:00 AM. This failure could place residents at risk of exposure to infectious diseases and other unsanitary health hazards. Findings include: 1. In a confidential group interview with 12 residents revealed 8 residents had concerns with the cleanliness of the shower rooms and stated it did not seem like the showers rooms were cleaned on all the hallways. Interview revealed the confidental group stated it bothered them because it was not hygienic and no residents had refused showers because of it. In an observation and interview on 01/28/2025 at 1:00 PM with CNA D revealed the shower rooms for halls 100, 200, 300, 400, 500, 600, 700 and 800 all showers but one had orange, pink, and light brown residue along the grout lines of the bottom perimeter of the tiled shower, on areas of the tile wall and in the grout lines along the wall. Hall 200 shower room had dark brown and black areas of grout where the floor and wall met. Hall 300 shower room had dark green and black raised residue along the floor's grout line. CNA D stated it was the responsibility of housekeeping staff to clean the showers. He stated he heard residents complained about the showers and he verbally told housekeeping. He stated he observed housekeeping clean the showers every day and he was not aware of any residents refusing a shower due to cleanliness. He stated it was important the shower rooms were cleaned thoroughly to ensure good hygiene, infection control, and a homelike environment for the residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/29/2025 at 11:24 AM with Housekeeper E revealed she cleaned Hall 100 shower yesterday and had not gotten to it today. She stated the cleaning solution she used was called odor control and she thought it was a sanitizing liquid. She observed the shower in Hall 100 and stated it would come off if she used a brush and demonstrated using the odor control solution to spray and then use the toilet bowl brush to scrub the tile perimeter. She stated she used a different toilet brush for the toilets, and typically used the flat mop in the shower room. In observation of a bottle of odor cleaning solution with Housekeeper E revealed it was a multipurpose liquid odor control with a label that stated .Fresh scents and power odor neutralizing action .Simply mist into the air to suppress strong odors . This formula may also be used to control odors on hard surfaces .use regularly to deodorize floors and rugs . Housekeeper E stated that she did not know if the formula was a sanitizing solution and if the formula was not a sanitizing solution it placed residents' health at risk due to germs and they could get sick . In an observation and interview on 01/29/2025 at 12:35 PM with Housekeeper F of Hall 200 shower room revealed (last) week the Hall 200 shower was supposed to be deep cleaned but it was not done because they did not have time to do it . She stated she had the sanitizing solution and the odor control solution on her cart and thought they were out of the sanitizing solution in the supply room. She stated one cleaner might be stronger than the other and the odor control solution helped to make things smell better so it cleaned surfaces. She stated the shower was not really clean to the standard they wanted but it had been cleaned so there were not any risks to the residents. She stated it was important for the shower rooms to be deep cleaned to prevent the spread of germs. In observation and interview on 01/29/2025 at 12:40 PM with the Housekeeping Supervisor of the cleaning supply closet revealed the liquid Housekeeper E used as an odor control solution did not sanitize surfaces and there was not any sanitizing solution in the supply closet. She stated she was not aware Housekeeper E was using odor control solution instead of sanitizing solution and supplies in the closet were going to be restocked today . She stated they were not completely out of the solution because the cleaning carts had the solution. She stated the shower rooms were not cleaned to their standard and it was the responsibility of housekeeping to clean the shower rooms. She stated she was not aware if any had missed the deep cleaning schedule . She stated the shower rooms were typically deep cleaned every week, but they tried to push it to every 2 weeks if they could and there was no documentation kept to show they were completed. She stated not cleaning the showers properly or without sanitizing solution placed the residents health at risk and it was important for infection control. In an interview on 01/29/2025 at 4:00 PM with the Housekeeping Supervisor revealed she restocked the sanitizing solution, had resupplied Housekeeper E with the correct solution, and provided the label which reflected Peroxide Multi Surface Cleaner and Disinfectant . ACTIVE INGREDIENT: Hydrogen Peroxide . 8. 0%. She stated that she did find a bottle of disinfectant upstairs and checked the housekeeping carts. She stated Housekeeper F already had the sanitizing solution and odor control on her cart and Housekeeper E only had odor control. She stated the facility did not have a policy regarding cleaning the shower rooms and the deep clean checklist that was provided were only for resident rooms and did not address the hallway shower rooms. 2. Record review of Resident #109's face sheet, dated printed 01/29/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #109 had diagnoses which included dementia (loss of cognition), dysphagia (difficulty swallowing) and hyperlipidemia (high fat levels in blood). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #109's Quarterly MDS, dated [DATE], reflected he had a BIMS score of 5, which indicated severe cognitive impairment. Record review of Resident #109's nurses progress note, dated 01/29/2025, reflected a progress note written by RN C which stated the resident had a .productive cough with yellow sputum. Observation on 01/28/2025 at 9:27 AM revealed Resident #109 was lying in bed with yellow green smears on bed linen. Observation and interview on 01/28/2025 at 10:57 AM with Resident #109 revealed there were light green, thick, fluid substance on the resident's bed linen and on a towel. The resident was unable to state what the substance was, how long it had been there , or if he had asked anyone to clean it. Observation and interview on 01/28/2025 at 10:59 AM revealed RN C observed Resident #109's bedding and observed the substance on the bedding. Interview revealed it appeared to be from resident coughing . RN C stated she would notify the physician about the coughing. RN C stated CNA's were responsible for changing the linen. She stated Resident #109 was on hospice services and hospice also changed the linen. RN C stated hospice had not visited the resident today (01/28/25) and CNA C should have changed the linen. She stated it was important to change linen when soiled for infection control. Interview on 01/28/2025 at 11:03 AM with CNA C revealed he started working at 7:00 AM and had not gotten to Resident #109's room until now to change the linen. CNA C stated he and hospice were responsible to promptly change bed linens when they were soiled and it was not acceptable for the linen to be soiled from around 9 AM to 11 AM. He stated it was important to change bed linens as soon as they were soiled because it was the residents home and they should have clean bedding. Interview on 01/29/2025 at 5:09 PM with the Housekeeping Supervisor revealed it was the CNA's responsibility to change resident linens and it should be changed as soon as it was soiled because it put residents at risk for infection and not having a homelike environment. Record review of the facility's, undated, deep clean check list, titled Deep Clean Checklist, reflected there was no shower rooms listed. Record review of the facility's housekeeping policy titled Housekeeping-General, dated revised August 2020, reflected the facility was .to ensure that the Facility is clean, sanitary, and in good repair at all times so as to promote the health and safety of residents, staff, and visitors . The Housekeeping Staff's general duties are to clean all surfaces in restrooms, showers . Cleaning, Sanitizing, Disinfecting . A. In this Facility, 'cleaning' always means to clean and disinfect . Record review of the facility's linen handling policy titled Linen Handling, dated May 2017, reflected .It is the policy of this home that staff will handle linens in a manner to prevent the spread of infection .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 2 of 4 residents (Resident #14 and Resident #31) reviewed for ADLs. 1. The facility failed to ensure Resident #14 had her fingernails trimmed on 01/27/25. 2. The facility failed to ensure Resident #31 had his fingernails cleaned and trimmed on 01/29/25. These failures could place residents at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: 1. Record review of Resident #14's Quarterly MDS assessment, dated 01/09/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #14 had diagnoses which included dementia (diseases that affect memory, thinking, and the ability to perform daily activities), muscle wasting, and anxiety disorder (a common mental health condition characterized by excessive worry, fear, and nervousness). Resident #14 had a BIMS score of 05/15 which indicated Resident #14's cognition was severely impaired. Further Resident#14 required extensive assistance of one-person physical assistance with dressing and personal hygiene. Record review of Resident #14's, undated, Comprehensive Care Plan reflected the following: Focus: [Resident #14] has an ADL self-Care Performance Deficit r/t Dementia. Goal: [Resident #14] will demonstrate the appropriate use of adaptive devices(s) to increase ability in all ADLS through the review date. Intervention .Personal hygiene/Oral care: the resident requires extensive 1 person assistance with personal hygiene An observation and interview on 01/27/25 at 10:29 AM revealed Resident #14 was lying in her bed. The nails on both hands were approximately 0.4 cm in length extending from the tip of his fingers, and chipped. Resident #14 was unable to answer questions. Observation and interview on 01/28/25 at 10:29 AM revealed RN A looked at Resident #14 fingernails and stated they looked long and chipped and needed to be trimmed. RN A stated CNAs were responsible to clean and trim residents' nails during the showers. RN A stated only nurses cut residents' nails if they were diabetic. RN A stated Resident #14 was on hospice and the hospice Aide could clean and trim her fingernails. RN A stated it was the responsibility of the charge nurses for the Hall to make sure residents were getting appropriate care. RN A stated the risk would be potential for infection and skin integrity problem . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #31's Quarterly MDS assessment, dated 01/09/25, reflected a [AGE] year-old male who was admitted to the facility initially on 07/08/2022 and readmitted on [DATE]. Resident #31 had diagnoses which included diabetes mellitus (a chronic metabolic disease characterized by high blood sugar levels), cognitive communication deficit, and lack of coordination. Resident #31's BIMS score of 00, which indicated Resident #31's cognition was severely impaired. The MDS assessment indicated Resident #31 required moderate assistance with personal hygiene. Record review of Resident #31's, undated, Comprehensive Care Plan, reflected the following: Focus: [Resident #31] has an ADL selfcare performance deficit . Goal: will maintain current level of function . Interventions . Personal hygiene/oral care: The resident requires one staff assistance In an observation on 01/29/25 at 10:05 AM revealed Resident #31 was in his wheelchair. The nails on both hands were approximately 0.4 cm in length extending from the tip of his fingers. The nails were discolored tan and had yellow greenish colored residue underside and on the nails' bed. Resident #31 was unable to answer questions because of his confusion. In an interview on 01/29/25 at 10:13 AM, CNA K stated CNAs and nurses were responsible to clean and cut the residents' nails as needed. CNA K stated only nurses cut residents' nails if they were diabetic. CNA K stated she did not notice Resident #31's nails. She stated she would do it right then. She stated the risk would be infection and injury. In an interview on 01/29/25 at 11:45 AM, the DON stated nail care should be completed as needed and every time aides washed the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated the ADON and the DON would do the routine rounds to monitor and she would follow up with refusal every day. The DON stated residents who had long and dirty nails could be an infection control issue. Record review of the facility's, undated, policy Grooming Care of the Fingernails and Toenails, reflected the following: . Nail care is given to clean and keep the nails trimmed . Fingernail are trimmed by Certified Nursing Assistants except for residents with the following condition A. Diabetes or circulatory impairment of the hands, B. Ingrown, infected, or painful nails 47690

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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** 42971 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, administering of drugs and biologicals, to meet the needs of each resident for of 3 medication carts 1 (nurses cart hall 100) reviewed for pharmacy services. 1. The facility failed to ensure RN C, who was responsible for Nurses Cart Hall 100, removed medications in unsecure containers from the Nurses Cart. 2. The facility failed to ensure the Nurses Cart Hall 100 did not have an expired insulin pen for Resident #55 These failures could place residents at risk of not having the medication available due to possible drug diversion, diminished effectiveness, and not receiving the therapeutic benefits of the medications. Findings Include: Observation and record review on [DATE] at 10:10 AM of nurses cart hall 100, with RN C revealed: - the blister pack for Resident #89's hydrocodone acetaminophen ,d+[DATE] mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister. - the blister pack for Resident #21's tramadol 50 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister. - The pen of insulin lispro 100 unit /ml for Resident #55 with an expired opened date of [DATE]. Interview on [DATE] at 10:23 AM, RN C stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seal was broken, and she was not aware of who might have damaged the blisters. She stated the risk would be a potential for drug diversion. She stated the nurses were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would report it to the DON She also stated she did not give insulin to Resident #55 and she did not check the pen for the open date. RN C stated the purpose for putting an open date was for expiration purposes because the insulin was only good for 28 days. RN C stated after 28 days the insulin would be ineffective . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:45 AM, the DON stated she expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON, and the DON were supposed to check the carts weekly. The DON stated the insulin flex pens, once opened, needed to be dated because each insulin pen had a specific days shelf life and if not thrown out before that time the insulin could lose its effectiveness. The DON stated the ADON and the DON were supposed to do random checks of the medication carts for monitoring. Record review of the facility's policy titled Storage of Medication, dated [DATE], reflected in part .8. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists Record review of the facility's policy Storage of Medication, revised [DATE], reflected the following: . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closure are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists. Record review of the facility's policy, Vials and Ampules of Injectable Medications, revised [DATE], reflected, 2. Unopened vials expire on the manufacturer's expiration date. Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to record on multi-dose vials. At a minimum, the date opened must be recorded . 4. If a multi-dose vial is opened and does not indicate the date opened, the date opened reverts to the date of dispensing on the container, and the use period is determined from that date. If the dispensing date cannot be determined, the product should not be used and should be discarded according to the facility's policy.

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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. 34399 Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for Food and Nutrition Services. 1. The facility failed to ensure 6 tomatoes in the walk-in refrigerator were not bruised. 2. The facility failed to ensure three of six dietary staff (Dietary [NAME] O, Dietary Aide P and Dietary [NAME] T) used proper hand hygiene while handling and serving food during the lunch meal preparation and service on 01/28/25. 3. The facility failed to ensure five of six dietary staff (Dietary Aide P, Dietary Aide Q, Dietary Aide R, Dietary [NAME] T and Dietary Supervisor) used effective hair restraints while in the kitchen on 01/28/25 during the lunch meal preparation and service. 4. The facility failed to take the temperature of the 2nd container of zucchini and gravy before serving to residents for lunch on 01/28/25. These failures could place residents at risk for food-borne illness if consumed and food contamination . Observation and interview on 01/27/25 at 10:10 AM revealed 6 tomatoes were bruised in the refrigerator. Interview with the Dietary Supervisor revealed she was responsible to check the produce weekly when she got a new shipment so this was when she would throw out any produce. She asked another dietary staff member to go through the tomatoes and throw out any tomatoes with bruises in the trash . Observations on 01/28/25 during lunch meal preparation and service revealed the following: - 11:40 AM, Dietary [NAME] O temped first container of gravy and zucchini vegetables. Dietary [NAME] O did not temp the 2nd container of gravy which was on the stove. - 11:42 AM, Dietary [NAME] O finished food temperatures on the steam table, she then put gloves on, did not wash her hands and started plating food which included putting fried chicken and scooping mashed potatoes with gloved hands on resident plates. - 11:45 AM, Dietary Aide P was plating food on resident plates and touched the inner part of the plate for the lunch meal trays and wore a hat that did not cover 1/2 inch hair in the front and back of hat. - 11:48 AM, Dietary Aide Q's beard restraint was not covering 3/4 inch of facial hair on left side of his face while putting utensils and resident lunch plates on meal trays. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 11:54 AM, Dietary Supervisor wore a hair restraint and about 1/2 inch uncovered hair near both ears and 1 inch in the back of the hair was uncovered, while she stirred zucchini vegetables with a spoon on stove. -11:55 AM, Dietary Aide R wore a hat with uncovered hair of 1/2 inch near both ears and 3/4 inch of hair in the back of the head while he was cutting potatoes for meal preparation. - 12:04 PM, Dietary [NAME] T wore a hair restraint that did not cover about 1/2 inch of hair near both of her ears while taking fried chicken out of the fryer. Dietary [NAME] T took her gloves off and did not wash her hands, she continued with food preparation. - 12:05 PM, 2nd container of Zucchini vegetables being cooked on the stove. - 12:09 PM, Dietary Aide P took gloves off, did not wash hands, and plated food with gloved hands touched the inner plate along with scooping mashed potatoes and gravy on plate touching gloved hands. - 12:18 PM, A 2nd container of Zucchini vegetables was not temped prior to being served, was put in bowl on resident lunch trays by Dietary [NAME] O and Dietary Aide P. - 12:20 PM, A 2nd batch of Gravy was put on the steam table, Dietary [NAME] O scooped gravy on chicken fried steak and mashed potatoes on resident lunch plates. Interview on 01/28/25 at 12:17 PM with Dietary [NAME] T revealed she did change gloves and should have washed her hands prior to putting on new gloves . She was not aware her hair restraint was not covering her hair in the front and it should be covering her hair while in the kitchen . Interview on 01/28/25 at 12:38 PM with Dietary [NAME] O revealed she could not recall if she had washed her hands after doing the food temps prior to putting on new gloves when she began to put food on resident lunch trays. Interview on 01/28/25 at 12:39 PM with Dietary Aide P revealed her hat was able to cover her hair but she got hot in the kitchen so she adjusted it. She stated she should wash her hands when changing gloves. She was aware she should be wearing an effective hair restraint . Interview on 01/28/25 at 12:40 PM with Dietary Aide R revealed he was not aware his hat was not fully covering his hair. Interview on 01/28/25 at 12:41 AM with Dietary [NAME] O and Dietary Supervisor revealed, both stated they did not temp the 2nd food container of gravy and the 2nd food container of zucchini vegetables since both of the containers were still cooking when they did the food temps prior to serving. They stated they should have checked the food temperatures prior to serving to ensure food temperatures were at appropriate warm temperatures for serving . Interview on 01/29/25 at 12:43 PM with Dietary Aide Q revealed he was not aware his facial hair restraint was not fully covering his beard. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455653	A. Building B. Wing	01/29/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/29/25 at 10:09 AM with Dietary Supervisor revealed she was not aware her hair restraint was not effectively covering her hair in the front during the lunch meal service yesterday. The Dietary Supervisor stated she would be more diligent in ensuring hair which included facial hair was effectively covered. She stated it was important for dietary staff to effectively cover all hair which included facial hair to ensure hair did not get in the food and cross contamination . She stated she expected facility staff to wash their hands when changing gloves before putting on new gloves. She stated they should wash hands when they touched their facial restraints. She stated hand hygiene was important for dietary staff to prevent cross contamination. She stated she would provide in-service on hand hygiene and hair restraints within the last year. She stated they usually completed hand hygiene and hair restraint in-service annually. She stated the dietary staff should have tempered the zucchini veg . and the gravy for the 2nd batch. She stated it was important to do the food temperatures prior to serving to ensure hot food temperature was within appropriate range. She stated she would need to check more often than weekly to ensure produce was not bruised and showed signs needs to be thrown out. Record review of the facility's policy Hand Hygiene last revised June 2020 reflected To ensure that all individuals use appropriate hand hygiene while at the facility. The Facility considers hand hygiene a primary means to prevent the spread of infections .Facility staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors. The policy did not specify about dietary staff hand hygiene practices. Record review of the facility's policy Food Storage, last revised 09/26/24, reflected Food items will be stored . and prepared in accordance with good sanitary practice .Fresh Fruits Storage Guidelines A. Fresh Fruit should be checked and sorted for ripeness .E. Fruit will be stored in bins, containers .because it retards spoilage and loss of moisture. Record review of the facility's policy Food Temperatures, last revised 09/26/24, reflected Foods prepared and served in the facility will be served at proper temperatures to ensure food safety .Measuring Food Temperature .F. Take the temperature of each pan of product before serving . It reflected the acceptable serving temperatures of gravy and vegetables was greater than 135 F. Record review of the Food and Drug Administration Food Code, dated 2022, reflected .2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks . (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42971 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 8 residents (Resident #9 and Resident #109) reviewed for infection control. The facility failed to ensure CAN J changed her gloves and performed hand hygiene while providing incontinence care to Resident #9 on 01/28/25 . These failures could place residents at risk of cross-contamination and development of infections. Findings include: In an observation on 01/28/25 at 03:24 PM revealed CNA J and CNA B entered Resident #9's room to provide peri care. Both staff washed their hands and put on gloves CNA J unfastened the resident brief and she cleaned his front pubic area with several wipes. CNA J rolled the resident on his side, removed the soiled brief, and wiped the anal area from front to back and then the buttocks, changing to a clean wipe with each swipe. CNA J then pushed the soiled draw sheet under the resident and with soiled gloves placed a clean draw sheet and brief under the resident. Both staff then rolled the resident over and CNA B removed the soiled sheet and pulled the clean sheet under the resident. the staff closed the resident brief, repositioned him in bed, offloaded his feet and covered the resident. Both staff then removed their gloves and sanitized their hands in the hallway. In an interview on 01/28/25 at 03:33 PM, CNA J and CNA B stated they should change their gloves and perform hand hygiene when they went from dirty to clean. CNA J stated failing to provide proper care exposed the resident to infections. CNA J stated she did not realize she had soiled gloves on when she put the clean sheet and brief under the resident. In an interview on 01/29/25 at 11:45 AM, the DON stated they trained at length on when staff were to change their gloves and sanitize their hands. She stated staff needed to change their gloves when they went from dirty to clean. She stated the risk was increased risk of infections. She stated she and the ADON would be re-training and observing care to ensure staff compliance. Record review of the facility's policy, Perineal Care, dated June 2020, reflected Wash hands .Put on gloves . Wash the penis .Wash the scrotum .Turn the resident on side .wash, rinse and dry buttocks and peri-anal area without contaminating perineal area .Remove gloves. Wash hands or use alcohol-based sanitizer .Note: Do not touch anything with soiled gloves after procedure (example: curtain, side rails, clean liens, call bell, .) . put on clean gloves .Clean and return all equipment to its proper place .Place soiled linen in proper container .Removed gloves. Wash hands. Record review of the facility's policy titled, Hand Hygiene, dated June 2020, reflected The facility considers hand hygiene the primary means to prevent the spread of infections .Facility Staff .must perform hand hygiene procedures in the following circumstances .Wash hands with soap and water .when soiled with visible dirt or debris .Hand hygiene is always the final step after removing and disposing of personal protective equipment