STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455670	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Retirement and Healthcare Community	1900 W State Hwy 6 Waco, TX 76712

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47243 Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 60 (Resident #1) residents reviewed for dignity The facility failed to allow Resident #1 to assist with her daily showers. The facility failed to put undergarments on Resident #1 after changing. The facility failed to place clean linens on Resident #1's bed. This failure could place Resident#1 at risk for decreased quality of life, loss of dignity, self-worth and disrespected. Findings include: Review of Resident # 1's Face sheet dated 05/01/2024 revealed a [AGE] year-old female admitted on [DATE] with diagnosis that include Unspecified Osteoarthritis Unspecified Site (A progressive, degenerative joint disease, the most common form of arthritis, especially in older persons), Age-Related Osteoporosis without Current pathologic Fracture (A condition of reduced bone mass, with decreased cortical thickness and a decrease in the number and size of the trabeculae of cancellous bone (but normal chemical composition), resulting in increased fracture incidence), Cognitive Communication deficit (Acquired cognitive-communication deficits may occur after a stroke, tumor, brain injury, progressive degenerative brain disorder, or other neurological damage), Other Abnormalities of gait and Mobility (a change to your walking pattern. Everyone's natural walking style is unique), Unspecified Dementia (dementia without a specific diagnosis). Review of Resident # 1 Quarterly MDS dated [DATE] revealed a BIMS score of 10 (8-12 suggest moderate cognitive impairment). Review of Resident #1 Care Plan dated 9/19/2024 revealed Resident #1 require limited assistance by x 1 staff with bathing/showering and as necessary. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #1 on 12/10/2023 at 12:10 PM revealed she was not allowed to bathe herself and because of it she denied taking showers. She stated she could shower herself and staff members made her take a shower even when she didn't want to. She stated they had gotten a lot better now and they assisted her if need be. Interview on 5/01/24 at 01: 17 PM Resident #1's family member revealed she had a concern regarding her Resident #1's care. On Easter Sunday March 31st, 2024. at approximately 3pm she arrived at the facility to find Resident #1 soiled in bed naked. She did not have a pad under her either to absorb the urine. She noticed the laundry was not done; which she said had to have been multiple days of staff not assisting responsible party to the bathroom since she knows responsible party will only use 2-4 squares of toilet paper when she goes. She stated the concerns had been brought to the attention of staff, but no formal grievance was filed. Interview with the DON on 5/1/2024 at12:20 PM revealed the DON stated the staff allow residents to do as much as they can. The CNA's standby the resident in case they lose their balance. DON state she advised Resident #1 responsible party she cannot bath herself and she needs assistance. The DON stated if Resident #1 refused to shower, staff are to encouraged her, but if she refuses, staff is to advise the nurse and it is documented. The DON stated it is her right to refuse to take a shower. But if it affects other resident because she has not taken one, staff will encourage Resident #1; if she still refuses have the family intervene. The DON stated she expects staff to take care of the residents, treat them right, and report any changes to the charge nurse if there are any problems with the residents. The DON stated if there aren't any clean sheets to make the bed, what needed or should have been done was staff should have gone into laundry and washed sheets. The DON stated there are always and if there is an empty bed, they can get the sheets off that bed. The DON stated the laundry cart is always full. The DON denied receiving a call or a text message from the Resident #1's responsible party. She stated housekeeping comes by daily. She stated one housekeeper cleaned the room and the other housekeeper cleans the bathroom. And if she sees the room is dirty housekeeping will come as needed. Interview with the CNA B on 5/1/2024 at 12:32PM revealed the CNA B stated the residents have the right to if they can assist with their ADL's. He stated if a resident refuses to take a shower he is to report it to the nurse, but residents usually don't refuse. If they refuse the whole week, staff will call the family and have them intervene. He stated staff check and change residents every 2 hours but if they are a heavy wetter, those residents are checked more often. The CNA B stated there is never a time there were not any sheets to make the bed and no resident should be lying in urine or under the covers unclothed. The CNA B stated he will get the resident out of the bed and make the bed. He stated, if need be, he will go down to laundry and wash and dry some sheets. He stated they usually have a lot of clean linen available. Observation of Resident #1 responsible party revealed captured by her responsible party revealed resident #1 bed was saturated with urine. Record review of the facility's Privacy and Resident Rights statement with an unknown date reflected: Resident/Patient Privacy include: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Residents shall be treated with dignity and respect. 2. Residents shall be groomed as they wish to be groomed. 3. Residents shall be encouraged and dressed in their own clothes. Resident/Patient Rights include: Employees shall treat all residents with kindness, respect, and dignity.

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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 - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on observations, interviews, and record reviews the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 2 of 20 residents (Resident #26 and Resident #49) reviewed for resident rights; in that: The facility failed to ensure Resident #26 and Resident #49's call lights were within reach. This failure could place residents at risk of needs not being met. Findings included: Record review of Resident #26's admission record, dated 04/30/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included: type 2 diabetes mellitus (a chronic condition that affects the way the body processes the blood sugar), dysphagia (difficulty swallowing), acute kidney failure (condition in which the kidneys suddenly cannot filter waste from the blood), and hemiplegia (paralysis of one side of the body). Record review of Resident #26's quarterly MDS assessment, dated 03/21/24, reflected Resident #26 had a BIMS score of 09, which indicated the resident was moderately cognitively impaired. The MDS reflected resident had active diagnoses of bed confinement status. Record review of Resident #26's care plan, initiated 03/22/24, reflected Resident #26 was care planned for an ADL self-care performance deficit r/t balance, Limited Mobility, Limited ROM, Musculoskeletal impairment with a goal of maintain current level of function through the review date. and had an intervention of resident is totally dependent on x 2 staff for repositioning and turning in bed as necessary and encourage the resident to use bell to call for assistance. In an observation on 04/29/24 at 11:44 AM, observed Resident #26's call light was out of the resident's reach. Resident #26's call light was lying on the floor on the left side of the bed. The resident was lying in bed. Resident #26 demonstrated that he could not reach the call light. In an interview on 04/29/24 at 11:45 AM with Resident #26, he stated things were fine and staff treated him well. He stated he could not always get to his call light. He stated he was right-handed, and he could only move his left hand a little bit, and the call light was normally placed on the left side of the bed. He stated he could not reach his call light at that time. He stated if he could not get to his call light he would yell for help or watch for a nurse or aide to go by and yell for them. He stated staff sometimes got to him in a timely manner and sometimes they did not. He stated he has no other concerns at this time. In an observation on 04/29/24 at 12:15 PM revealed Resident #26's call light was on the floor on the left side of the resident's bed and out of Resident #26's reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #49's admission record, dated 04/30/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #49 had diagnoses which included: paranoid schizophrenia (a mental disorder characterized by reoccurring episodes of psychosis that are correlated with a general misperception of reality), Parkinson's disease (neurodegenerative disease of mainly the central nervous system that affects both the motor system and non-motor systems), atherosclerotic heart disease (damage or disease in the heart's major blood vessels which is usually caused by the buildup of plaque), and anxiety (an emotion which is characterized by an unpleasant state if inner turmoil and includes feelings of dread over anticipated events). Record review of Resident #49's quarterly MDS assessment, dated 03/08/24, reflected Resident #49 had a BIMS score of 08, which indicated the resident was moderately cognitively impaired. The MDS reflected the resident had muscle weakness, lack of coordination, and difficulty in walking. Record review of Resident #49's care plan, initiated 12/06/21, reflected Resident #49 was care planned for an ADL self-care performance deficit r/t Parkinson's disease with a goal of maintain current level of function with ADL's through the review date. and had an intervention of encourage the resident to use bell to call for assistance. In an observation on 04/29/24 at 11:53 AM, observed Resident #49's call light out of the resident's reach. Resident #49's call light was laying on floor on the left side of the bed. The resident was lying in bed. Resident #49 demonstrated that he could not reach the call light. In an interview on 04/29/24 at 11:54 AM with Resident #49, he stated things were all good and staff treated him well. He stated he called his family member or pushed a button when he needed help. He stated he could not reach his call light at that time, and he did not know what he would do if he needed help and could not get to his call light, but he would probably go look for somebody or yell out for them. In an observation on 04/29/24 at 12:17 PM revealed Resident #49's call light was on the floor on the left side of the resident's bed and out of Resident #49's reach. In an interview on 04/29/2024 at 12:49 PM with CNA A, she stated she had worked in the facility for about 2 months. She stated she had been in-serviced on abuse, neglect, and misappropriation and call lights. She stated the call light in Resident #26's room was not in reach at that time, and it would normally have been clipped onto his gown. She stated she had been trained on keeping call lights in reach. She stated she did her rounds every 2 hours. She stated if a call light was not in reach a lot of bad things could happen such as a fall, or a resident having to wait to call for help, a resident being sick or vomiting, or the resident may not be able to breathe. She stated Resident #49's call light was not in reach either at that time and his would normally be on his pillow or pad because the resident continuously got up and down. In an interview on 04/29/2024 at 1:41 PM with RN A, she stated she had worked in the facility for about 2 weeks. She stated she had been in-serviced on abuse, neglect, and misappropriation and call lights. She stated if a resident's call light was out of reach it could lead to an injury or a fall and the resident may have felt like no one cared about them. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/29/2024 at 1:58 PM with MA A, he stated he had worked in the facility for about [AGE] years. He stated he had been in-serviced regularly on abuse, neglect, and misappropriation and call lights. He stated if a resident did not have their call light in reach it could have caused a resident to try to get up by themselves and the resident could have fallen and hurt themselves. In an interview on 05/01/2024 at 12:29 PM with the DON, she stated she was in-servicing staff regularly on abuse, neglect, and misappropriation and call lights. She stated staff had been trained on making sure residents' call lights were always in reach. She stated residents' call lights should be always in reach. She stated if a resident's call light was out of reach the resident could possibly harm themselves. Record review of the facility's in-service which included title of call lights dated 03/17/24 revealed staff had been in-serviced regarding call lights. A policy for call lights was requested on 05/01/24 at 9:00 AM but not received.

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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** 41654 Based on observation, interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 3 of 8 residents (Residents #17, #28 & # 44) reviewed for resident assessments. The facility failed to ensure Resident #17's two most recent MDS's reflected that Resident #17 received dialysis services. Resident #44's quarterly MDS incorrectly documented the resident as having an indwelling catheter. Resident #28's Admission and Significant Change MDS's incorrectly documented the resident received dialysis services. This deficient practice could place residents at-risk for inadequate care due to inaccurate assessments. Findings include: A record review of Resident #17's face sheet dated 04/30/24 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #17's diagnosis included hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal failure (high blood pressure makes it more likely that your kidney disease will get worse and you will have heart problems), end stage renal disease (when chronic kidney disease reaches an advanced state with the gradual loss of kidney function), dependence on renal dialysis (regime which treats but does not cure and sustains life but does not heal), and type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy. A record review of Resident #17's Annual Comprehensive MDS assessment, dated 11/16/23, reflected the resident had a BIMS score of 12, which indicated cognition was moderately impaired. Resident #17's Quarterly MDS reflected Resident #17 had an active diagnosis of renal insufficiency, renal failure, or end stage renal disease (ESRD) and that resident did not receive dialysis services. A record review of Resident #17's Quarterly MDS assessment, dated 02/16/24, reflected the resident had a BIMS score of 12, which indicated cognition was moderately impaired. Resident #17's Quarterly MDS reflected Resident #17 had an active diagnosis of renal insufficiency, renal failure, or end stage renal disease (ESRD) and that resident did not receive dialysis services. A record review of Resident #17's care plan, dated 01/08/2024, reflected Resident #17 was care planned for requiring dialysis hemodialysis/peritoneal r/t renal failure. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/30/24 at 09:29 AM Resident #17 communicated by shaking his head yes or no. Resident #17 also had a communication board to assist in communication. Resident #17 shook his head yes when asked if he was doing well and if staff treated him well. Resident #17 shook his head yes when asked if he received dialysis services and if he got to dialysis and back to the facility without problems. Resident #17 shook his head no when asked if he had any issues or concerns with dialysis or if he had any other concerns. A record review of Resident #28's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #28's diagnosis included other seizures (uncontrolled burst of electrical activity between brain cells that cause temporary abnormalities in muscle tone or movements), muscle wasting and atrophy (the decrease in size and wasting of muscle tissue), weakness (lack of physical or muscle strength), and cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, and remembering information) A record review of Resident #28s Admission MDS assessment, dated 12/22/2023, reflected the resident had a BIMS score of 09, which indicated moderately impaired. Resident #28's Admission MDS reflected Resident #28 received hemodialysis and peritoneal dialysis. A record review of Resident #28's Significant Change MDS assessment, dated 02/21/2023, reflected the resident had a BIMS score of 09, which indicated moderately impaired. Resident #28's Significant Change MDS reflected Resident #28 received hemodialysis and peritoneal dialysis. A record review of Resident #28's care plan, dated 04/19/2024, reflected Resident #28 was not receiving dialysis services. An interview with Resident #28 on 04/30/24 at 2:45pm, Resident #28 stated she did not receive dialysis. An interview with the Hospice Provider Representative on 04/30/24 at 2:55pm, the Hospice Provider Representative stated that Resident #28 did not receive dialysis services. A record review of Resident #44's face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #44's diagnosis included muscle weakness (lack of physical or muscle strength), chronic kidney disease stage 2 (a condition in which the kidneys are damaged and cannot filter blood as well as they should), cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, and remembering information), essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition), and polyneuropathy (when multiple peripheral nerves become damaged). A record review of Resident #44's Quarterly MDS assessment, dated 03/02/2024, reflected the resident had a BIMS score of 99, which indicated the patient interview was not successful. Resident #44's Quarterly MDS reflected Resident #44 had an indwelling catheter. A record review of Resident #44's care plan, dated 04/24/2024, reflected Resident #44 was care planned for an indwelling foley catheter. Resident #44's care plan was revised on 03/24/2024 to reflect his indwelling foley catheter. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #44's care plan, dated 04/24/2024, reflected no physician order for an indwelling foley catheter. An interview and observation on 04/30/24 at 3:25pm with Resident #44, Resident #44 stated that he has not had a catheter in a long time but did not remember when it was removed. Resident #44 did not have a catheter bag attached to his person. An interview with the MDS Coordinator on 05/01/24 at 12:55pm, the MDS Coordinator stated that she was responsible for completing the MDS assessment accurately. The MDS Coordinator stated if a resident was receiving dialysis, then the MDS would reflect dialysis services but if a resident was not receiving dialysis, then the MDS should not reflect dialysis services. The MDS Coordinator stated if a resident's MDS was inaccurate the resident would not receive the appropriate care or services they may need. An interview with the MDS Coordinator on 05/01/24 at 12:55pm, the MDS Coordinator stated that she was responsible for completing the MDS assessment accurately. The MDS Coordinator stated if a resident was receiving dialysis, then the MDS would reflect dialysis services but if a resident was not receiving dialysis, then the MDS should not reflect dialysis services. The MDS Coordinator stated if a resident's MDS was inaccurate the resident would not receive the appropriate care or services they may need. An interview with the DON on 05/01/24 at 1:30pm, the DON stated that Resident #28 did not receive dialysis services and that Resident #44 did not have an indwelling catheter. The DON stated that Resident #17 received dialysis services. The DON stated the MDS nurse was responsible for complete the MDS accurately. The DON stated if the MDS was not accurate then residents may not receive the appropriate care. The DON also stated that if a MDS was done incorrectly, it could cause staff to not know how to care for the resident correctly. The DON stated she was not aware that any residents MDS's were completed incorrectly. A record review of the facility's Electronic Transmission of the MDS, not dated, reflected Policy Statement All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.0 and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with the current OBRA regulations governing the transmission and MDS data. Policy Interpretation and Implementation 1. All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the MDS RAI instruction Manual, before being permitted to use the MDS information system. A copy of the MDS RAI instruction Manual is maintained by the Resident Assessment Coordinator. 5. The MDS Coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45957

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 6 residents (Residents #44 & #163) reviewed for comprehensive care plans. Resident #44's care plan incorrectly documented the resident as having an indwelling catheter. The facility failed to ensure Resident #163's comprehensive care plan addressed Resident #163's full code advance directive. This deficient practice could place residents at risk for not receiving proper care and services due to inaccurate care plans. Findings include: A record review of Resident #44's face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #44's diagnosis included muscle weakness (lack of physical or muscle strength), chronic kidney disease stage 2 (a condition in which the kidneys are damaged and cannot filter blood as well as they should), cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, and remembering information), essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition), and polyneuropathy (when multiple peripheral nerves become damaged). A record review of Resident #44's Quarterly MDS assessment, dated 03/02/2024, reflected the resident had a BIMS score of 99, which indicated the patient interview was not successful. Resident #44's Quarterly MDS reflected Resident #44 had an indwelling catheter. A record review of Resident #44's care plan, dated 04/24/2024, reflected Resident #44 was care planned for an indwelling foley catheter. Resident #44's care plan was revised on 03/24/2024 to reflect his indwelling foley catheter. A record review of Resident #44's care plan, dated 04/24/2024, reflected no physician's order for an indwelling foley catheter. An interview and observation on 04/30/24 at 3:25pm with Resident #44, Resident #44 stated that he had not had a catheter in a long time and did not remember when it was removed. Resident #44 did not have a catheter bag attached to his person. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #163's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #163's diagnoses included end stage renal disease (last stage of long-term chronic kidney disease), muscle wasting and atrophy (the decrease in size and wasting of muscle tissue), weakness (lack of physical or muscle strength), cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, and remembering information), Hypokalemia (lower than normal potassium level in your bloodstream), Hypomagnesemia (an electrolyte disorder in which there is a high level of magnesium in the blood), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). A record review of Resident #163's Admission MDS assessment, dated 12/11/2023, reflected Resident #163 had a BIMS score of 14, which indicated the resident was cognitively intact. A record review of Resident #163's physician orders, dated 04/30/2024, reflected Resident #163 had an active order for a full code advance directive with an order revision date of 12/14/2023. A record review of Resident #163's care plan, dated 01/19/2024, did not reflect Resident #163's advance directive. An interview with the MDS Coordinator on 05/01/24 at 12:55pm, the MDS Coordinator stated that she was responsible for completing the care plan assessment accurately. The MDS Coordinator stated a resident's advance directive should have been reflected on the care plan. The MDS Coordinator stated if a resident did not have a catheter, then that should not have been care planned. The MDS Coordinator stated if a resident's care plan was inaccurate the resident would not receive the appropriate care or services they may need. An interview with the DON on 05/01/24 at 1:30pm, the DON stated that all residents advance directives should be care planned. The DON stated if an advance directive was not care planned then that would cause confusion regarding the resident's advance directive. The DON stated if a resident did not have a catheter, then that should not be reflect on the resident's care plan. The DON stated the MDS Coordinator was responsible for complete the care plans accurately. The DON stated if the care plan was not accurate then residents may not receive the appropriate care. The DON stated that she was not aware that any residents care plans were completed incorrectly. A record review of the facility's Care Plans, Comprehensive Person-Centered policy, not dated, reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 8. The Comprehensive, person-centered care plan will: a. Include measurable objective and time frames; (continued on next page)

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	455670	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Retirement and Healthcare Community	1900 W State Hwy 6 Waco, TX 76712

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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** 49099 Based on observation, interview and record review the facility failed to store, prepare, distribute food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen and food sanitation. 1. The facility failed to label and date all food items located in the reach in refrigerator and reach in freezer. 2. The facility failed to ensure all items stored in the reach in refrigerator and reach in freezers were sealed ensuring food contents were not exposed to air. 3. The facility failed to ensure dietary staff practiced proper hand hygiene and glove use. 4. The facility failed to ensure the blender and utensils were sanitized during food preparation. 5. The facility failed to dispose of expired items in dry storage. These failures could place residents at risk for food contamination and foodborne illness. Findings Included: During the initial tour of the kitchen on [DATE] at 10:04 AM the following was observed: 1. The reach in refrigerator contained sliced deli ham in a plastic bag that was torn open and exposed to air; singles cheddar cheese sandwich slices were in a separate plastic bag that was torn open and exposed to air; and grape jelly was in a plastic container with a green lid that was not properly sealed and exposed to air. 2. The reach in freezer contained 4 separate plastic bags containing frozen chicken patties, sweet potato fries, regular fries, and hash browns. Each bag was torn open exposing the contents to air and were not labeled with neither the received nor opened date. 3. In a separate reach in refrigerator there was a plastic container of banana pudding dated ,d+[DATE] (it was not identified on the label if that was the prepared or use by date), and the container was not properly sealed exposing the contents to air. 4. The dry storage room contained a bottle of browning and seasoning sauce with 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	In an interview with the DM on [DATE] at 10:28 AM she said it was her expectation that all items were dated to include the preparation date or the date it was received, the date opened, and the use by date. The DM stated that all food items stored in the refrigerator and freezer should be placed in zip seal bags; if using a container, it should have the appropriate fitting lid so that there is an airtight seal, so no food items are exposed to air. The DM stated that a potential negative outcome to having food exposed to air is it could cause the food to be contaminated which could lead to illnesses that she said could cause residents to end up in the hospital. The DM said that if food items are not labeled or dated, they would not have any way of knowing what the item is, when it arrived, or when it should be thrown out. She stated she expects that dietary staff to check once a week for expired items throughout the kitchen. She said there should be no negative outcome to expired items in the kitchen because expired items should never make it to a resident. In an observation on [DATE] at 09:30 AM in a kitchen follow up for pureed foods the following was observed: 1. The [NAME] was observed handling soiled dishes with gloves then moving straight to food preparation and touching chicken patties used to make the mechanical chicken for lunch without changing her gloves or washing her hands. 2. The [NAME] was observed reusing a soiled spatula that was at the bottom of the one compartment sink and blender that was only being rinsed with hot water in a one compartment sink with no soap or sanitizer during food preparation. 3. The [NAME] was observed touching the trash can with her gloves and retuning to the food preparation, preparing white gravy without changing her gloves or washing her hands. 4. The [NAME] was observed dropping a scoop used for food thickener in the one compartment sink along with other soiled dishes and then pulling it out to reuse the soiled scoop after only rinsing it in hot water with no soap or sanitizer. 5. The [NAME] was observed not sanitizing the thermometer probe before each use when checking the food temperatures. In an interview on [DATE] at 11:10 AM with the [NAME] she said she was supposed to wash her hands and change her gloves after touching anything that contaminates them. She stated that failing to change her gloves or wash her hands could lead to cross contamination or bacteria being passed to food. The [NAME] said that the blender and utensils were supposed to be washed with soap and water and sanitized in the three-compartment sink. She stated she was nervous and forgot to sanitize the blender and utensils or wash her hands/change her gloves. She said a potential negative outcome to residents in failing to sanitize the equipment or utensils is food particles left behind can mix causing cross contamination or leading to allergens. The [NAME] stated she was supposed to clean the thermometer probe with hot water, and she believed that was an appropriate way of cleaning the probe. She stated that there are not any alcohol wipes available to clean the thermometer probe in between uses. The [NAME] clarified that hot water alone was not an appropriate way to clean and sanitize the spatula or other equipment/utensils in the one compartment sink; she said it can lead to bacterial growth, allergic reactions, and cross contamination by failing to wash and sanitize equipment and utensils. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 11:10 AM with the DM she said it was her expectation that dietary staff washed their hands and changed their gloves after touching trash, after cooking and/or serving, or after touching the dishwasher or anything that could contaminate the hands or gloves. She stated that a negative outcome to not changing gloves or washing hands would be cross contamination, staff could pass germs that could make the residents sick. The DM stated that it was her expectation that the blender be sanitized in between uses as well as any utensils. She stated that dietary staff are to wash all utensils and equipment such as the blender in the three-compartment sink with soap and water, rinse, and sanitize. The DM said that the thermometer probe should have been sanitized prior to using it on food and in between food items and alcohol wipes are to be used to sanitize the probe. She stated dietary staff were made aware that alcohol wipes are in the filing cabinet of the kitchen office and that is what is to be used to sanitize the probe. The DM stated failure to follow sanitation policy and practices would lead to cross contamination, and the residents potentially becoming ill. In an interview on [DATE] at 01:15 PM with the DON (who was also being used in place of the Administrator per corporate) she stated that all kitchen items should have been dated with the open date as well as the use by date which should be a day or two after the prepared date depending on what it is. The DON stated that all items in the refrigerator and freezer should be properly sealed in either zip seal bags or an appropriate airtight container in order to prevent contamination. She said all expired items should be discarded and that it was her expectation that dietary staff check daily to ensure there are no expired items. The DON said that the blender used in food preparation must be sanitized after each use and in between each pureed item. She stated rinsing it in hot water was not sufficient and that she expected dietary staff to use soap and water and sanitizer. The DON said that the thermometer probe should be cleaned after each use and that dietary staff should be washing their hands and changing their gloves regularly and especially after they become contaminated. The DON said that a potential negative outcome to not following sanitation guidelines such as washing hands/ changing gloves, washing, and sanitizing the blender/utensils/thermometer probe could lead to cross contamination which would make the residents sick. Review of the undated facility Food Preparation and Service policy reflected: Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. Appropriate measures are used to prevent cross contamination. These include: - Cleaning and sanitizing work surfaces and food contact equipment between uses, following food code guidelines. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illnesses. Handwashing sinks are located near food preparation and clean dish areas and are separate from ware washing sinks. Food thermometers used to check food temperatures are clean, sanitized, and calibrated for accuracy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single use items and are discarded after each use. Review of the undated facility Food Receiving and Storage policy reflected: Food shall be received and stored in a manner that complies with safe food handling practices. Dietary staff, or other designated staff, will always maintain clean food storage areas. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18.