

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Senior Care of Corpus Christi		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Fortune Dr Corpus Christi, TX 78405	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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** 48278 Based on observations, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference for four (Residents #254, #26, #66, #86) of fourteen residents reviewed for call light. The facility failed to ensure Residents #254, #26, #66, #86's call lights were within reach. This failure could place residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings were: 1. Record Review of Resident #254's face sheet dated 7/31/2024 indicated she was a [AGE] year-old female admitted on [DATE] with the diagnoses of Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease (a chronic lung disease that causes air flow limitation), Encephalopathy (damage or disease that affects the brain), Muscle Weakness, Chronic Kidney Disease Stage 3 (kidneys have mild to moderate damage, and they are less able to filter waste and fluid out of your blood), and Dementia. Record Review of Resident #254's Care Plan revised 7/30/24 revealed Resident #254 was at risk for falls r/t confusion, gait/balance problems. Intervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Record Review of Resident #254's BIMS assessment dated [DATE] revealed Resident #254's score was 0.0. Resident #254 was severely cognitively impaired. During an observation on 07/29/24 at 09:48 AM Resident #254 was lying in bed, alert, with the push button call light cord wrapped on the right side rail towards the back end of the rail. Resident #254 attempted to find and reach her call light using her left arm. Resident #254 stated she could not reach the call light. During an interview with LVN A on 07/29/24 at 09:05 AM stated that all staff are responsible for placing the call light within resident's reach. She stated it was important for the residents to have call lights within reach so that they can call them for help. The negative outcome was it keeps the resident from falling out of the bed by being able to call for assistance. The resident may not be feeling well and it may take long to have her needs being met if she cannot reach the call light. (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 - Some	During an interview with CNA D on 07/29/24 at 09:55 AM, stated she normally checks that the call lights are within the resident's reach every day. She has not done that this morning. She stated when she does her rounds, she checks that the call lights are within reach. During an interview with Residents #254's family member, on 07/29/24 at 10:38 AM, stated he stays and visits with Resident #254 from 9am until around 2pm. Then another family member comes and after that another family member. He stated if the resident needs anything, he will call staff for assistance. During an interview with CNA E on 07/31/24 at 10:00 AM, stated she was responsible for call lights being within resident's reach. She was assigned the first five rooms. She stated some residents tend to mess with the call lights. She tries not to wrap them too much; she prefers to clip them. She stated that Resident #254 usually has family member with her during the day. CNA E stated that the resident should have the call light within reach in case they need something. She rounds every two hours, but she got behind on her rounds today. The negative outcome of the resident not having the call light within reach is that they can be grasping for air, or may need to be changed, and repositioned but they are not able to call them. During an interview with ADON on 07/29/24 at 10:10 AM, stated all staff are responsible for placing the call light within the resident's reach. The negative outcome of resident not having the call light within reach was that a resident can have an emergency or fall. During an interview with DON on 07/31/24 at 4:04 PM, stated nurses, CNAs, and department heads do rounds for quality-of-life. They are responsible for placing the call lights within the resident's reach. He stated there is no negative outcome except customer service. DON stated the facility has no Policy available for call lights on 7/31/24 at 3:30pm. 2. Record review of the admission record for Resident #86 reflected Resident #86 was admitted to the facility on [DATE], was an [AGE] year-old male with diagnoses that included Unspecified Dementia (loss of cognitive functioning that interferes with daily life), other abnormalities of gait and mobility, other lack of coordination, muscle wasting and atrophy, cognitive communication deficit. Record review of Resident #86 Care Plan revised on 05/14/24 noted the resident is at risk for falls r/t impaired balance, cognitive deficits, psychoactive med use, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; and the resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position, personal items within reach) Record review of Resident #86's MDS assessment dated [DATE] reflected a BIMS score of 03, indicating severely impaired cognition. Section GG Functional Abilities and Goals stated the resident uses a walker and is independent in sit to stand movement, and setup assistance with walk of 10ft, 50ft and 150ft. Observation on 07/29/24 at 09:15 AM revealed Resident #86 was observed in bed, with the call light clipped on the privacy curtain out of reach of the resident. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/31/24 at 10:09 AM revealed Resident #86 lying in bed asleep with the call light clipped to the bedcover within reach of resident. 3. Record review of the admission record for Resident #26 reflected Resident #26 was admitted to the facility on [DATE], was a [AGE] year-old male with diagnoses that included Alzheimer's Disease (progressive brain disorder that causes gradual decline in memory, thinking behavior and social skills), lack of coordination, muscle wasting and atrophy (wasting or thinning of muscle mass. It can be caused by disuse of your muscles or neurogenic conditions), Chronic Obstructive Pulmonary Disorder (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and Hemiplegia (one-sided paralysis caused by brain, spinal cord or nerve problems) and Hemiparesis (one-sided muscle weakness caused by brain, spinal cord or nerve problems) following cerebral infarct (or stroke, is a brain lesion in which a cluster of brain cells die when they don't get enough blood.) affecting left non-dominant side. Record review of Resident #26's Care Plan revised on 07/29/24 noted the resident is at risk for falls or injuries r/t impaired balance, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; and the resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position, personal items within reach) Record review of Resident #26's MDS assessment dated [DATE] reflected a BIMS score of 99, indicating the resident was unable to complete the interview. Section GG Functional Abilities and Goals stated the resident is independent in sit to stand movement and is independent in sit to stand movement, and setup assistance with walk of 10ft, 50ft and 150ft. Observation on 07/29/24 at 09:17 AM revealed Resident #26 was observed in bed, with the call light wrapped down on the left side rail hinge between the rail and mattress, not within reach of the resident. Resident #26 did not respond or answer when asked about call light. Observation on 07/31/24 at 10:10 AM revealed Resident #26 lying in bed with the call light clipped to the bed within reach of resident. 4. Record review of the admission record for Resident #66 reflected Resident #66 was admitted to the facility on [DATE], was a [AGE] year-old female with diagnoses that included Unspecified Dementia (loss of cognitive functioning that interferes with daily life), other abnormalities of gait and mobility, other lack of coordination, muscle wasting and atrophy, cognitive communication deficit and unspecified mood disorder. Record review of Resident #66's Care Plan revised on 04/19/24 noted the resident is at risk for falls r/t gait/balance problems, incontinence, psychoactive med use, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; and the resident needs a safe environment with: (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position, personal items within reach) (continued on next page)		

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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** 50039 Based on observation, interview, and record review, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment for 1 of 27 residents (Resident #4) reviewed for homelike environment. The facility failed to fix a broken face plate covering an outlet, restore damaged walls, investigate a dark substance on the ceiling, and fix a sharps container that was attached to the wall at a single point allowing it to rotate freely. These failures place residents at risk of experiencing a diminished quality of life potentially leading to psychosocial harm. The findings included: Record review of Resident #4's face sheet dated 07/29/2024 reflected a [AGE] year-old female with an initial admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included Alzheimer's disease, major depressive disorder with psychotic symptoms and schizoaffective disorder (chronic mental illness causing symptoms of both schizophrenia and a mood disorder at the same time). Record review of Resident #4's MDS assessment section C, cognitive patterns, dated 06/01/2024 reflected a BIMS score of 9 (moderate impairment). In an attempted interview with Resident #4 on 07/29/2024 at 11:07 AM, Resident #4 was not responding to questions. Subsequently, no interview information was obtained. During an observation inside Resident #4's room at 07/30/24 at 8:30 AM, a sharps container was seen hanging on the wall to the left immediately after walking in. The sharps container was attached to the wall by a single point, allowing it to spin freely. Sharps could be heard inside moving around as the container spun. Approximately 24 inches off the ground on the wall an outlet face plate had been cracked and pieces broken off exposing a hole in the wall. Inside the hole a wire could be seen barely protruding out of the hole. On the ceiling of the room closer to the window were dark colored streaks. The streaks were approximately 5 feet long and when combined were approximately 12 inches wide. There were several small holes in the walls. Part of the wall approximately 12 inches below the cracked face plate appeared to be sloughing off. In an interview with CNA C on 07/31/2024 at 2:29 PM, CNA C stated Resident #4's room is not a homelike environment and that she would not want to live in a room with similar amounts of damage. CNA C stated that she was not aware of the damage to the outlet face plate or the general damage to the walls. CNA C stated she did not know what the dark stains were on the ceiling and that she did not know how long they have been there. (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 with LVN E on 07/31/2024 at 2:42 PM, LVN E stated Resident #4's room looked raggedy. LVN E stated that he did not think the room posed any harm to Resident #4 as long as the exposed wire was not active. LVN E stated he has only been in Resident #4's room [ROOM NUMBER]-3 times before now. LVN E stated the dark stains on the ceiling looked like water damage. In an interview with MS on 07/31/2024 at 2:59 PM, MS stated that, prior to today, the last time he was in Resident #4's room was to fix a plumbing issue in her bathroom a few weeks ago. MS stated that to complete all of the work necessary to fix the walls and outlet face plate was approximately 3 hours not including drying time. MS stated that he would not want to live in a room with the damage that was on the walls. MS stated that the wire barely protruding out of the hole was an old phone line that had been disconnected. MS stated that the wire did not pose any risk of electrocution. MS stated that the only danger in the room was the jagged edges of the broken outlet face plate. MS stated that he was not sure what the dark stains on the ceiling were, but that they looked like water damage. MS stated that he thought the damage to the walls was from furniture moving around. In an interview with the DON on 07/31/2024 at 3:15 PM, the DON stated that he went in Resident #4's room daily. The DON stated that this morning was the first time he had noticed the damage to the outlet face plate. The DON stated that there was a 2nd bed in the room covering that part of the wall that was moved out of the room recently. The DON stated that it was possible that Resident #4 could have hurt herself on the jagged edges of the broken outlet face plate. The DON stated that if he had similar damage in his home then he would have fixed it. The DON stated that they have higher expectations for their facility than what was presented in Resident #4's room. The DON stated that he removed the sharps container from Resident #4's room and placed it in his office in the morning of 07/31/2024. On 07/31/2024 at 4:01 PM, policies were requested from the DON and ADM covering the expectations for a safe, homelike environment but none could be located.		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 48278 Based on interviews and record review, the facility failed to send a copy of the notice of transfer or discharge and the reasons for the transfer or discharge in writing to the Office of the State Long-Term Care Ombudsman for two (Resident #82 and Resident 93) of two residents reviewed for transfer and discharge. The facility failed to send a transfer or discharge notice in writing to the facility's Ombudsman as soon as practicable when Resident #82 was discharged home on 7/25/24. The facility failed to send a transfer or discharge notice in writing to the facility's Ombudsman as soon as practicable when Resident #93 was discharged to another facility on 5/11/24. This failure could affect residents at the facility by placing them at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and the appeal processes. Findings included: 1. Resident #82 Record Review of Resident #82's face sheet dated 7/31/2024 indicated she was a [AGE] year-old female admitted on [DATE] with the diagnosis of Cellulitis (a deep infection of the skin caused by bacteria), Muscle Wasting and Atrophy, Muscle Weakness, Type 2 Diabetes Mellitus, Essential Hypertension (high blood pressure), and Morbid Obesity (more than 80 to 100 pounds above their ideal body weight). Reviewed discharge summary dated 7/25/24. During an interview on 7/30/24 at 4:10pm with SW, stated that Resident #82's discharge was a planned discharge. The facility got a medical provider notice. She got a signed a NOMNC (a notice that indicates when Medicare coverage is about to end). She stated this medical provider sends them these notices for all WellMed patients. It tells her when the residents last day of therapy will be. This information was provided to Resident #82 and the resident's responsible party. She stated they both received a copy of the medical provider NOMNC, and both were made aware of Resident #82 was going to be discharged on [DATE]. She was not aware that she needed to notify the Ombudsmen. She stated she did not notify Ombudsmen but will from here on out. 2. Resident #93 Record review of Resident #93's face sheet dated 7/30/24 reflected a [AGE] year-old male with an original admitted [DATE]. Diagnoses included cerebral infarction (type of stroke that occurs when a blood vessel that supplies blood to the brain is blocked) and diabetes type two (insufficient insulin production in the body). There was no discharge notice reviewed. (continued on next page)		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/30/24 at 03:02 PM the SW stated Resident #93 was discharged to another facility due to resident needed to be in a memory care unit since Resident #93 was exit seeking. The SW stated the doctor made the referral for Resident #93 to be discharged to a memory unit. The SW sated a referral was discussed with Resident #93's family and the family agreed to the transfer. The SW stated she was not sure if a written notice was done and provided to Resident #93, Resident #93's responsible party, and local Ombudsman. The SW stated she was responsible for discharge procedures and notifying residents, resident's family, and the local Ombudsman. In an interview on 07/31/24 at 09:30 AM the SW stated she felt the discharge process the facility conducted was appropriate due to Resident #93 was being immediately discharged because the family was in agreeance and the facility spoke with the other facility and they accepted Resident #93. The SW She stated Resident #93 was a certain insurance patient and that insurance company sends them the notices and information about transfers. The SW stated after talking with the facility team, they felt they completed the transfer appropriately. The SW stated with every discharge, the family and resident are aware of the discharge and discharge plan wither through a care plan meeting or through a 30-day discharge notice. The SW stated for Resident #93's transfer to another facility, written notice was not given to Resident #93, Resident #93's family, or the local Ombudsman but they were made aware of the transfer. Record review of the facility's Transfer or Discharge, Facility-Initiated policy dated October 2022, revealed 3. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 5 of 6 (Resident #12, Resident #7, Resident#254, Resident#396, and Resident #36) residents reviewed for respiratory care. 1. The facility failed to ensure Resident #12 had the required emergency supplies at bedside including a suction machine, supply of suction catheters, sterile gloves and flush solution on 07/30/2024 at 10:08 AM. 2.The facility failed to ensure Resident #7's oxygen tubing was connected to the concentrator and the oxygen was administered at the correct setting of 2 liters per minute on Resident #7's oxygen concentrator was set at 3 liters per minute 7/29/24 at 9:05 AM. 3.The facility failed to ensure Resident #254's had the oxygen sign posted outside his room entrance door on 7/29/24 at 8:40 AM. 4.The facility failed to ensure Resident #254's oxygen was administered at the correct setting of 2 liters per minute on 7/29/24 at 8:40 AM. 5.The facility failed to ensure Resident #396's oxygen was administered at the correct setting of 3 liters per minute on 7/29/24 at 9:30 AM. 6.The facility failed to ensure Resident #36's oxygen was administered at the correct setting of 3 as per physician order and received oxygen at 2.5L/min. This failure places residents who receive respiratory care at an increased risk of danger in a respiratory emergency due to a longer response time and at risk of developing respiratory complications, and a decreased quality of care. The findings included: 1.Record review of Resident #12's face sheet dated 07/30/2024 reflected a [AGE] year-old male with an initial admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (chronic inflammatory lung disease that makes it difficult to breathe) and Tracheostomy Status. Record review of Resident #12's annual MDS assessment section C, cognitive patterns, dated 06/04/2024 reflected a BIMS score of 15 (cognition intact). MDS assessment section O, Special Treatments, Procedures and Programs, reflected tracheostomy care has been performed while a resident of the facility within the last 14 days. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's order summary report revealed an active order stating Trach care to include changing disposable inner cannula every Tuesday and Saturday (patient will do himself). Inner cannula size #8. Trach tube size 8. Resident does own trach care. Resident #12 had no active orders for emergency respiratory equipment. Record review of Resident #12's care plan dated 06/21/2024 revealed there were no interventions mentioning keeping a suction machine, supply of suction catheters, sterile gloves and flush solution available at bedside in the case of a respiratory emergency. In an interview with Resident #12 on 07/30/2024 at 10:08 AM, Resident #12 stated that he takes care of his own tracheostomy. Resident #12 stated that the nurses assist him sometimes if he needs help. Resident #12 stated that he did not know if there were emergency supplies in his room incase he developed a respiratory emergency. During an observation of Resident #12's room on 07/30/2024 at 10:08 AM, no suction machine, supply of suction catheters, sterile gloves or flush solution could be located. In an interview with CNA B on 07/30/2024 at 3:52 PM, CNA B stated that in a respiratory emergency involving a tracheostomy she would make sure the resident's head was elevated and then go and get the nurse to let them know there was an emergency. Afterwards, CNA B stated she would assist the nurse with whatever they needed in caring for the resident. In an interview with LVN C on 07/30/2024 at 3:55 PM, LVN C stated that in a respiratory emergency involving a tracheostomy she would assess the air way and use a suction as needed to clear the airway. LVN C stated that Resident #12 handles his self-care for the most part. LVN C stated that Resident #12 is a full-code (medical directive that indicates a patient's wish for life saving measures in case of emergency) so she would bring the crash cart (wheeled container carrying medicine and equipment for use in emergency resuscitations) in as needed. LVN C stated she was unable to locate a suction machine, supply of suction catheters, sterile gloves or flush solution inside Resident #12's room. LVN C stated that she would have had to go get the crash cart during a respiratory emergency for Resident #12 to obtain the necessary supplies. LVN C stated that Resident #12 would receive care much quicker if the emergency supplies were by his bedside. LVN C stated that the nurses taking care of Resident #12 would be responsible for making sure the emergency supplies were in the room. During an observation of the crash cart on 7/30/2024 at 4:08 PM, a suction machine, supply of suction catheters, sterile gloves and flush solution were available on the cart. The cart was located at the entrance to the 100 hall, approximately 54 steps away from Resident #12's door. In an interview with the DON on 07/31/2024 at 3:15 PM, the DON stated the purpose of keeping emergency equipment by a resident with a tracheostomy is to provide a quick response time to the resident when they are experiencing a respiratory emergency. The DON stated that a resident could have worse outcomes with the emergency equipment not being in the room because it would take longer before emergency care could begin. The DON stated that it was the DON's responsibility to ensure emergency equipment was available in the room. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Record Review of Resident #7's face sheet dated 7/30/2024 indicated she was a [AGE] year old female initially admitted on [DATE], with the diagnoses of Chronic Obstructive Pulmonary disease (a common lung disease causing restrictive airflow and breathing problems), Hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), Hypertension (a condition in which the force of the blood against the artery walls is too high), Hypomagnesemia (an electrolyte disturbance caused by low levels of magnesium in the blood). Record Review of Resident #7's comprehensive care plan dated 4/29/24 indicated Resident #7 has oxygen therapy related to ineffective gas exchange Diagnoses Chronic Obstructive Pulmonary D isease (lung disease), OXYGEN SETTINGS: OXYGEN at 2 liters per minute via Nasal cannula every shift for to relieve signs and symptoms of hypoxia related to shortness of breath, Date Initiated: 06/01/2022 and Revision on: 04/19/2023. Record Review of Resident #7's significant change Minimum Data Set assessment dated [DATE] indicated she received oxygen therapy while a resident. Record Review of Resident #7's July 2024 physician's orders indicated OXYGEN at 2 liters per minute via Nasal cannula every shift for to relieve signs and symptoms of hypoxia related to shortness of breath. Observation of Resident #7 on 07/29/24 at 9:05 AM revealed her oxygen tubing was not connected to the concentrator. Resident #7's oxygen concentrator was set at 3 liters per minute. LVN A checked oxygen level before and after connecting tubing. LVN A checked Resident #7's oxygen saturation and received a reading of 88%. After LVN A connected the tubing to the oxygen concentrator, Resident #7's oxygen saturation increased to 91%. Observation of Resident #7 on 07/31/24 at 09:44 AM revealed oxygen tubing was connected, oxygen setting was at 2 liters per minute, Resident #7 stated she was doing fine. No respiratory distress noted. 3.Record Review of Resident #254's face sheet dated 7/31/2024 indicated she was a [AGE] year-old female admitted on [DATE] with the diagnosis of Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease (a chronic lung disease that causes air flow limitation), Encephalopathy (damage or disease that affects the brain), Muscle Weakness, Chronic Kidney Disease Stage 3 (kidneys have mild to moderate damage, and they are less able to filter waste and fluid out of your blood), and Dementia. Record Review of Resident #254's physician's orders dated 7/29/24 indicated O2@2L via nasal cannula continuous. To relieve s/s of Hypoxia r/t Chronic Obstructive Pulmonary Disease. During an observation on 07/29/24 at 08:40 AM, Resident #254 was lying on a bed and had on a nasal cannula with the oxygen concentrator set at 3 liters per minute. Outside of the bedroom entrance door revealed there was not a sign indicating oxygen in use/no smoking. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN A on 07/29/24 at 9:05 AM revealed she was Resident #7's and Resident #254's nurse. She stated she was responsible for checking the oxygen setting on the oxygen concentrator. She stated she usually checked every shift, but she has not checked Resident #7 or Resident #254. She was not aware Resident #7 was not receiving oxygen until told by the surveyor. It is important to check if the tubing was connected to the concentrator because if it was not connected the resident is not receiving oxygen. Resident #7's oxygen setting was at 3 liters per minute and physician order written for 2 liters per minute continuous. LVN A stated a negative outcome can be cyanosis (bluish or grayish color of the skin, nails, lips, or around the eyes), and the resident will not be well oxygenated. LVN A stated that Resident #7's oxygen level was low and that she was going to contact the physician to make them aware about the incident. LVN A stated she cannot recall about respiratory in-service or training. 4.Record Review of Resident #396's face sheet dated 7/31/2024 indicated she was an [AGE] year old female initially admitted on [DATE], with the diagnoses of Chronic Obstructive Pulmonary disease (a common lung disease causing restrictive airflow and breathing problems), unspecified systolic (congestive) heart failure (a specific type of heart failure that occurs in the heart's left ventricle), Paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Record review of Resident #396's comprehensive care plan dated 7/25/24 indicated Resident #396 has oxygen therapy related to The resident has Emphysema/Chronic Obstructive Pulmonary Disease OXYGEN at 3 Liters per minute via NASAL CANNULA CONTINUOUS TO RELIEVE Signs and Symptoms OF HYPOXIA Date Initiated: 07/30/2024 Revision on: 07/30/2024 Record review of Resident #396's July 2024 physician's orders indicated OXYGEN at 3 liters per minute via Nasal cannula every shift continuously for to relieve signs and symptoms of hypoxia related to Chronic Obstructive Pulmonary Disease. During an observation of Resident's #396 on 7/29/24 at 9:30am, her oxygen concentrator setting was at 5 Liters per minute via nasal cannula. During an observation of Resident #396 on 7/31/24 at 10:08am her oxygen concentrator setting was at 2.5 liters per minute via nasal cannula. LVN B verified setting at 2.5 liters per minute and stated that she had just been in resident's room, and it was at the correct setting. At this time LVN B was observed to adjust the concentrator setting at 3 liters per minute. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN B on 7/31/24 at 9:50 AM she stated the nurses are responsible to check oxygen tubing and settings once per shift. She stated she checked them this morning already except for one resident. She makes sure that the tubing was within date, oxygen level was correct and that there was water on concentrator for residents who are on continuous. She reconciled the physician order with the settings. LVN B said the CNAs are their extra eyes and ears so they would tell her if something was wrong with the resident or if the tubing was disconnected. LVN B said in December she had a skill check off on Respiratory care and it included how to use equipment. She said a negative outcome if the setting is low is that a resident can have hypoxia or if too high, LVN B stated the negative outcome will be that residents can be send out to the emergency room for evaluation. Skill check offs for oxygen use were done when she got hired. It was basically showing that they are competent on how to use equipment and check oxygen. LVN B stated the nurses are responsible for the oxygen signage on the outside of the room. If someone does not know the resident, they do not know where to look or how to identify the resident's needs for oxygen and it can cause a fire for example. The oxygen sign was an extra identifier. During an interview with the ADON on 07/29/24 at 10:10 AM she stated that all staff are responsible for placing the oxygen sign outside the room. She stated that Resident #254 was previously on isolation. She was then moved, and the sign did not get moved with her. She stated that all staff are responsible for checking the oxygen when they do their rounds. This includes changing the oxygen tubing. During an interview with the ADON on 7/31/24 at 09:37 AM she stated the nurses are the ones responsible for checking the settings on the concentrators every shift or periodically. The nurses are responsible to put the orders in the system. The negative outcome was over oxygenation or hypoxia, and the last skills check offs were done last December and they are done annually. The ADON said the nurse was responsible to check if tubing is connected appropriately and if a CNA sees it, they have to let the nurse know. If a resident was not receiving the oxygenation the negative outcome can be respiratory distress. During an interview with the DON on 7/31/24 at 4:04 PM he stated the nurses, ADON, staffing educators, and himself are responsible for checking the settings on the concentrators. He stated the managers check oxygen on the hall in the morning before the morning meeting then again at the end of the day. They are checking the tubing, setting, and every week they change filters. DON stated the Tubing is changed on Sundays. Negative outcome of setting not being accurate, not much could happen since a resident can be up to 5 liters per minute and resident can tolerate depending on acuity level . DON stated the facility does skill check offs for oxygen upon hire and annually. 5.Record review of the admission record for Resident #36 reflected Resident #36 was readmitted to the facility on [DATE], was a [AGE] year-old female with diagnoses that included Chronic respiratory failure, Hypercapnia, chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), iron deficiency anemia(a condition in which blood lacks adequate healthy red blood cells.), sleep apnea(sleep disorder in which breathing repeatedly stops and starts) and other pulmonary embolism without acute cor pulmonale (blood clot that blocks and stops blood flow to an artery in the lung but does not cause sudden enlargement of the right ventricle of the heart) (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #36's Care Plan with admitted [DATE] and last revised 03/14/24 stated the resident has congestive heart failure, at risk for activity intolerance, edema, fluid overload, OXYGEN SETTINGS: O2 prn as ordered. The care plan also stated the resident has oxygen therapy r/t CHF, ineffective gas exchange, respiratory illness, OXYGEN @3L/min via NC at HS and PRN at bedtime for the relieve[sic] of s&sx of hypoxia r/t SOB. AND as needed for relive[sic] of sign and symptoms of hypoxia. The care plan also noted that the resident has altered respiratory status/difficulty breathing r/t CHF, OXYGEN SETTINGS: O2 as ordered. Record review of Resident #36's Quarterly MDS assessment dated [DATE] reflected she has a BIMS score of 15, indicating intact cognition. Section O Special Treatments, Procedures, and Programs: Respiratory Treatments has an X on C1 selecting Oxygen Therapy. Record Review of Nurse's Note by LVN F for Resident # 36, dated 07/18/24 stated Resident readmit from [hospital] via [ambulance company] stretcher. Alert x 4. Was admitted pain/SOB and Rt arm pain. Resident states has a Fx Rt arm is wearing a wrapped cast, from voice pain with movement. Has multiple bruising to bi-lat arms/legs abd., yeast under ab and groin area. Remains on routine o2 at 3L per N/C with stats at 98%. Is on 1200 cc flu F/U appt. with cardiologist. Did not receive D/C med list from hospital sent [physician] for now pending fax. Observation on 07/29/24 at 09:04 AM revealed Resident #36 was in bed with oxygen via NC at 2.5L/min. Interview on 07/30/24 at 02:02 PM with Resident #36, she stated that she has always had oxygen on since return from hospital and prior to going to hospital. It was observed that resident# 36 had oxygen via NC at 2.5L/min. Interview on 07/30/24 at 02:02 PM with CNA A, stated she thinks resident #36's oxygen rate is usually at 3L. Interview on 07/30/24 at 02:11 PM with LVN B without reviewing chart stated Resident #36 is on oxygen at 3L via NC. When asked for order LVN B could not find an order for oxygen for Resident #36. Interview on 07/31/24 at 01:46 PM DON stated that they will conduct rounds frequently and in-services on oxygen rates. DON stated they are getting all staff involved to ensure oxygen rates are as ordered. DON stated they assumed it was already at 3 yesterday. This morning it was adjusted to correct rate during morning rounds . DON stated he was working on a plan of correction to in-service nursing staff by DON and designee on random rounds to ensure accuracy of orders being carried out. Record Review of Order Summary and order details on 07/30/24, noted physician order with start date 07/30/24 at 15:41 (3:41pm)Oxygen @ 3 L/pm via NC continuous to relieve s/s of hypoxia r/t COPD was noted in Resident #36's point click care (electronic health record) profile. Observation on 07/30/24 at 03:54 PM revealed Resident #36 observed in bed with oxygen via NC still set at 2.5L/min. Observation on 07/31/24 at 10:18 AM revealed Resident #36 observed in bed with oxygen via NC at 3L/min. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the facility policy Tracheostomy Care last revised August 2013 stated: A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times. Record review of the facility's Oxygen Administration policy dated October 2010, revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administrations. Preparation: Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. General Guidelines: 1. Oxygen therapy is administered by way of an oxygen mask and nasal cannula. b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. Steps in the Procedure: 1.Place an Oxygen in Use sign on the outside of the room entrance door. Close the door. 3.Check the tubing connected to the oxygen cylinder to assure that is free of kinks. Record Review of the facility's oxygen administration policy dated October 2010, reflected Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 50039 50487		

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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. 50039 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for one glucometer (Hall 100 Glucometer check log) of three glucometers reviewed for proper calibration. The facility failed to ensure the 100 hall glucometer was calibrated daily for accuracy of reading on 10 separate days in July 2024. This failure could place residents at risk of not receiving accurate blood glucose measurements to assure reliable results and treatment. The findings included: Record review of the 100 hall glucometer log dated July 2024 reflected no entries to indicate calibration was performed on the following days: 07/02/24, 07/03/24, 07/10/24, 07/11/24, 07/12/24, 07/13/24, 07/16/24, 07/25/24, 07/26/24, 07/30/24. Interview with LVN F on 07/31/24 at 9:55 AM revealed she said glucometer calibrations were performed by the night shift nurse every night. LVN F said she had not checked or noticed that the 100 hall glucometer was not calibrated because she assumed the night shift had done it. LVN F said had she known that the calibration was not done, she would have done one before using the glucometer machine. LVN F said it was important to calibrate the glucometer machines to ensure accuracy of readings. Interview with the DON on 07/31/24 at 10:00 AM revealed he stated the glucometer checks are to be done each shift. The DON said calibration of the glucometer checks are the responsibility of the nurses. The DON said the nurse were to check the log for completion of calibration at the beginning of each shift. The DON said he had not reviewed the glucometer logs for completion and did not know the calibration of the glucometer was not being performed consistently, and I need to be more aware of the logs. The DON said the purpose of glucometer calibration was to receive accurate readings and appropriate treatment. The DON said an inaccurate reading could place the resident at risk for inaccurate treatment. The DON said he did not know if the facility had a policy and procedure regarding glucometer calibrations. Subsequent interview with the DON on 07/31/24 at 1:35 PM, the DON stated there was no policy that addressed calibration of the glucometers.		

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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** 49157 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 dietary services. 1. The facility failed to ensure that food items in the walk- in cooler were labeled and dated. 2. The facility failed to ensure that food items in the walk- in cooler were discarded after the use by date. 3. The facility failed to ensure that food containers in the walk- in cooler were tightly sealed. 4. The facility failed to ensure that items labeled keep frozen were kept in the freezer. 5. The facility failed to ensure that food items in the dry storage area were labeled and dated. 6. The facility failed to ensure that food items were refrigerated after opening per the manufacturer's label. 7. The facility failed to ensure that food items in the dry storage area were closed and/or sealed properly. 8. The facility failed to ensure that food items in the reach in cooler were labeled and dated. 9. The facility failed to ensure that food items in the reach in cooler were not expired. 10. The facility failed to ensure that there were no personal items stored in the reach in cooler. 11. The facility failed to ensure that food items were covered when not being actively prepared or served. 12. The facility failed to record food temperatures for all food at all meals. 13. The facility failed to serve some foods at safe temperatures. These failures could place all residents who consumed food from the kitchen at risk for food borne illness. Findings included: Observation of the facility's walk- in cooler on [DATE] at 08:59am revealed the following: An unknown reddish substance inside a clear, square plastic container with a green lid that had no label on it. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An original carton that contained approximately half of a ,d+[DATE] pound block of cream cheese that was stamped, made [DATE] and a shipping type sticker that had [DATE] on it. This carton was sitting on top of another carton of the same type of cream cheese (unused) that was stamped, made on [DATE]. Above that, a date of ,d+[DATE] was written in black marker. The above referenced carton containing approximately half of a ,d+[DATE] pound block of cream cheese had 2 stains of an unknown origin that were beige colored with a clear outer margin that covered approximately ,d+[DATE] of the top of the carton. Corn inside a clear, square plastic container with a green lid that had a label with only ,d+[DATE] on it. An unknown yellowish substance inside a clear, square plastic container with a green lid that had a label with ChNS and ,d+[DATE] on it. An unknown reddish brown substance inside a clear, square plastic container with a red lid that had a label with ,d+[DATE] marked out and ,d+[DATE] on it. Dill relish in its original container that was approximately ,d+[DATE] empty with no date on it. Texas One Step Chili in its original container that had KEEP FROZEN on the lid. 4 cartons of Pasteurized liquid egg product- Whole eggs- with an expiration date of [DATE]. A Ziplock bag that contained what appeared to be half of a green pepper and half of an avocado that was not labeled or dated. A Ziplock bag that contained what appeared to be half of a red onion and half of a tomato that was not labeled or dated. A large, black metal pot that contained an unknown substance with foil over the top that was not tightly sealed nor labeled or dated. The inside walls of the walk- in cooler had black spots of what appeared to be mold or mildew on them. Observation of the facility's dry food storage on [DATE] at 09:10am revealed: Karo corn syrup in its original 1 gallon container that was approximately ,d+[DATE] full with a sticker that read Use First, writing in black marker that read open [DATE] and ,d+[DATE] written in black marker below that. There was a shipping type label on it that read [DATE]. Maraschino cherries in liquid in the original container that had ,d+[DATE] written in black marker on the lid. The container had been opened and was approximately ,d+[DATE] full. The manufacturer label read Refrigerate after opening. A Ziplock bag that contained bacon bits that was only sealed approximately ,d+[DATE] at the top. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Teriyaki sauce in the original container that had 7/?? written in black marker on the lid. The container had been opened and was approximately ,d+[DATE] full. The manufacturer label read Refrigerate after opening. A bottle of ketchup that was opened with no date on it. Apple cider vinegar that was in the original container that did not have a date on it. The container had been opened and was approximately ,d+[DATE] full. On the outside of the above referenced vinegar container there were approximately 10 spots of a black crusty substance. Lemon and Pepper Seasoning salt in the original container that was approximately half full with the lid not tightly closed. A black milk type crate on its side with two stacks of tortillas in separate plastic bags sealed with twist ties. Neither bag had a date on it. The milk crate had a label that had corn tortillas [DATE] written in black marker on it. A black milk type crate on its side with 2 stacks of tortillas in separate plastic bags sealed with plastic bread clips. Neither bag had a date on it. There was a label on the inside of the top of the crate that had flour tortilla [DATE] written in black marker on it and another label on the inside of the back of the crate that had tortillas , d+[DATE] written in black marker on it. Both labels were clearly visible. Coleslaw dressing that was in its original container with a use first sticker and [DATE] written in blue marker on the lid. The container had been opened, however it appeared full. The manufacturer label read Refrigerate after opening. Brown gravy mix in its original plastic bag that was cut open at the top and not sealed shut. ,d+[DATE] was written in black marker on the front of the bag. Brown gravy mix in its original plastic bag that was rolled down and sealed with a label that did not have a date on it. There was no date anywhere else on the bag. Instant mashed potatoes sealed with a label that did not have a date on it. There was no date anywhere else on the bag. 2 bags of unopened sweetened coconut flakes that had Best if used by Mar-,d+[DATE] printed by the manufacturer on the front. A white five gallon bucket with a green lid on it that contained what appeared to be brown sugar. The lid was not on tight and fell off when the bucket was moved. Observation of the facility's reach in cooler on [DATE] at 09:30am revealed: A clear jelly like substance in a square, clear plastic container with a green lid that was not tightly sealed and did not have a label or date on it. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A red jelly like substance in a square, clear plastic container with a green lid that did not have a label or date on it. A metal bin that had a label with Ranch [DATE] written in black marker on it. The bin contained 1 prepackaged vanilla pudding and approximately ,d+[DATE] portion cups that had what appeared to be ranch dressing, shredded cheese, and bacon bits in them (in separate portion cups) that had no identifiers or dates on them. A tub of sour cream in its original container that had a label that had opened ,d+[DATE] written in black marker on the top of it. The manufacturer printing on the side of the container read Best if used by [DATE]. A metal bin that had a label with C,Ch ,d+[DATE] written in black marker on it. The bin contained approximately ,d+[DATE] portion cups that had what appeared to be shredded white cheese in them that had no identifiers or dates on them. A brown, plastic grocery store bag that had an opened container of coconut water in it. A white plastic pitcher with a blue lid that contained what appeared to be orange juice that was not labeled or dated. A tray that had snacks [DATE] written in orange marker on a label stuck on it that had 6 portion cups with a yellow pudding like substance in them, 17 portion cups with a white pudding like substance in them and 3 portion cups with a brown pudding like substance in them -none of them were dated; 3 portion cups with what appeared to be fruit salad with ,d+[DATE] written in black marker on the top of them; 1 portion cup with what appeared to be mixed fruit in it with no date on it; 1 portion cup with a yellowish liquid substance in it with no date on it. 3 cups that had red liquid in them with plastic wrap sealing the tops with no dates on them. A tray that had a paper liner on the bottom of it with red stains on it. The paper liner also had a sticker label with PM Drinks ,d+[DATE] written in black marker on the left front of it, a sticker label with [NAME] ,d+[DATE] written in black marker on the front center of it, and a sticker label with Sandwiches written on it in black marker on the right front of it. The left side of the tray had approximately ,d+[DATE] sandwiches in Ziplock bags that had ,d+[DATE] Tuna written in black marker on them; the center of the tray had approximately 15 sandwiches in Ziplock bags that had HC or HL written in black marker on the front of them; the right side of the tray had approximately 10 sandwiches in Ziplock bags that had ,d+[DATE] and possibly Ce written in black marker on the front of them. Observation kitchen on [DATE] at 09:45am revealed ,d+[DATE] capacity muffin tins and ,d+[DATE] capacity muffin tin that had uncooked biscuits in them sitting on top of the steam table. All 4 of the muffin tins were uncovered and a fly landed on the edge of one of the muffin tins. The DM was observed throwing away all the biscuit dough immediately after it was brought to her attention. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Senior Care of Corpus Christi		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Fortune Dr Corpus Christi, TX 78405	
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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 1:43pm, the DM stated that everything in the refrigerators and dry food storage areas should have been sealed, labeled, and dated. The DM stated things needed to be sealed to prevent contamination. The DM stated that sauces and dressings should be refrigerated after opening per the manufacturer's labels to prevent spoiling or the possibility of bacterial growth. The DM stated that portion cups needed to be dated to make sure the contents did not go bad. The DM stated that most things should be disposed of ,d+[DATE] days after opening and that sandwiches and pudding were only good for 5 days after they were made. The DM stated pureed and cooked food were only good for 3 days. The DM stated she was going to throw away all the unlabeled and undated items that were in the walk in and reach in coolers. The DM stated she was also going to throw away the coconut water that was in the reach in cooler because it belonged to an employee, not the facility. In an interview on [DATE] at 9:33am, the DM stated that everyone was responsible for labeling and dating items and it should be done immediately before putting things into the freezer, refrigerators, or dry storage. The DM stated that she was ultimately responsible for making sure that everything was labeled, and the outdated things were disposed of. The DM stated she would go in every Monday morning to check labels/dates and throw away the things that were beyond their use by date. The DM stated the RD came in every week to make sure that labels were done and such and she had her own checklist that she did. The DM stated she had done an in-service on [DATE] on labeling and that she would be doing an in-service on [DATE] on temperatures and temperature logs. Record review of the facility's Food Storage Policy, Policy Number 03.003, dated [DATE] and revised on [DATE] that was provided by the facility stated in part: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and US Food Codes and HACCP guidelines. Procedure: 1. Dry Storage Rooms d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. g. Use the first-in, first-out (FIFO) rotation method. Date packages and place new items behind existing supplies, so that the older items are used first. 2. Refrigerators d. Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. Record review of the facility's Food Storage Policy, Policy Number 03.03.003, dated [DATE] that was attached to the in-service sign in done on [DATE] and provided by the DM stated in part: (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy: The consultant dietician will monitor the storage of foods to ensure that all food served by the facility is of good quality and safe for consumption. All food will be stored according to the state and Federal Food Codes. The following guidelines should be followed. Guidelines: 2. Refrigerators a. All refrigerated foods are stored per state and federal guidelines. e. All refrigerated foods are dated, labeled and tightly sealed, including leftovers, using clean, nonabsorbent, covered containers that are approved for food storage. All leftovers are used within 48 hours. Items that are over 48 hours old are discarded. Section ,d+[DATE] listed recommended maximum storage periods of unopened dry goods. Section , d+[DATE] listed recommended maximum storage periods of unopened refrigerated items. Section ,d+[DATE] listed recommended maximum storage periods of frozen items. The policies differ on how long leftovers were to be used or discarded. Neither policy had guidance on how long other opened items were usable for whether frozen, refrigerated, or in dry storage. Observation of the kitchen on [DATE] at 10:03am revealed the food temperature log was not filled out or unsafe temperatures were recorded for 27 of 36 days reviewed: [DATE] Dinner: Regular vegetable temperature recorded as 35 by [NAME] A. [DATE] Dinner: Regular vegetable temperature recorded as 35 by [NAME] A. [DATE] Lunch: Milk and Supplement temperature recorded as 170 by [NAME] A. [DATE] Dinner: (filled out but whited out with no temps recorded). [DATE] Dinner: Regular starches temperature recorded as 35 by [NAME] A. [DATE] Dinner: Regular vegetable temperature recorded as 35 by [NAME] A. [DATE] Dinner: Pureed vegetable temperature recorded as 35 by [NAME] A. [DATE] Dinner: Regular vegetable temperature not recorded by [NAME] A. [DATE] Dinner: Blank- No temperatures recorded. [DATE] Dinner: Blank- No temperatures recorded. [DATE] Dinner: Blank- No temperatures recorded. [DATE] Dinner: Temperatures only recorded for soup, milk and supplemental, cold fruit, and hazardous dessert. No other temperatures recorded, and no initials documented. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[DATE] Dinner: Blank- No temperatures recorded. [DATE] Dinner: Blank- No temperatures recorded. [DATE] Dinner: Blank- No temperatures recorded. [DATE] Dinner: Blank- No temperatures recorded. [DATE] Dinner: Blank- No temperatures recorded. [DATE] Dinner: Mechanically altered entree temperature recorded as 35 by [NAME] A. [DATE] Dinner: Pureed entree temperature recorded as 35 by [NAME] A. [DATE] Dinner: Regular starches temperature recorded as 35 by [NAME] A. [DATE] Dinner: Puree starches temperature recorded as 35 by [NAME] A. [DATE] Dinner: Regular vegetable temperature recorded as 35 by [NAME] A. [DATE] Dinner: Regular vegetable temperature recorded as 35 by [NAME] A, but [NAME] A's initials were scribbled out. [DATE] Dinner: Blank- No temperatures recorded. [DATE] Dinner: Regular vegetable temperature recorded as 35 by [NAME] A. [DATE] Dinner: Regular vegetable temperature recorded as 35 by [NAME] A. [DATE] Breakfast and Lunch: Blank- No temperatures recorded. [DATE] Breakfast, Lunch, and Dinner: Blank- No temperatures recorded. [DATE] Breakfast, Lunch, and Dinner: Blank- No temperatures recorded. [DATE] Breakfast and Lunch: Blank- No temperatures recorded. [DATE] Breakfast and Lunch: Blank- No temperatures recorded. [DATE] Dinner: Regular vegetable blank- no temperature recorded. [DATE] Breakfast and Lunch: Blank- No temperatures recorded. [DATE] Dinner: Regular vegetable temperature recorded as 35 by [NAME] A. [DATE] Breakfast: Blank- No temperatures recorded. (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 1:00pm, [NAME] C was able to correctly explain and demonstrate the correct procedure for checking the temperatures of food items. [NAME] C was also able to explain the proper food storage and serving temperatures. Neither [NAME] A nor [NAME] B were available for interview. In an interview on [DATE] at 1:30pm, the DM stated they had a new cook (Cook B) who started around [DATE]st. The DM stated that [NAME] B's job performance was sub-par; [NAME] B had some issues with following directions and was not doing the temperature logs. The DM stated [NAME] B was off the schedule now. The DM stated the temperature logs were important so they could make sure food was cooked to the proper temperature to inhibit bacterial growth so residents would not get sick. The DM stated if foods were not at proper temperatures, residents could get sick which could cause dehydration, malnutrition, hospitalization , and even death. The DM stated undercooked foods could cause a facility wide outbreak of Salmonella. In an interview on [DATE] at 9:33am, the DM stated it was the cook's responsibility to fill out the temperature logs and the DM's responsibility to make sure they got done. The DM stated the cooks would typically write the temperatures on a piece of paper and then transfer them into the log, despite being told to write them directly in the book. The DM stated temperatures were done ,d+[DATE] minutes before serving the food. The DM stated they cooks were reminded daily about logging the temperatures and they had monthly in-services on labeling and storage, temperature logs, sanitizing, and other policies and procedures. The DM stated each in-service was on a single topic with quizzes afterward. The DM did not say why the temperature logs were not checked. Record review of the Facility's Nutrition Services in-service dated [DATE] revealed a sheet that stated in part: Recommended Safe Food Temperatures: 165 degrees Fahrenheit . Poultry, ground poultry. Stuffing with poultry. Meat and fish. Microwave cooking and reheating. Reheating leftovers. 155 degrees Fahrenheit . Ground meat and fish 145 degrees Fahrenheit . Meat, fish, and raw shell eggs 135 degrees Fahrenheit . Hot holding of foods -If hot foods are not meeting temperature of 140 degrees Fahrenheit or above - food needs to be reheated at 165 degrees Fahrenheit for 15 seconds until it reached ideal temperature. Temperature Logging When taking food temperatures, please ensure: 5. ALL foods (hot and cold) have temperatures recorded in food temperature log prior to meal service.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on observations, interview, and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 3 residents (Resident #36) reviewed for medication administration. Resident #36's Medication Administration Record (MAR) and Treatment Administration Record (TAR) reflected the administration of oxygen was not accurately documented, the order was not reconciliated or recorded and administration of oxygen was completed and not accurately documented. The deficient practice placed resident #36 and 2 additional residents who receive medications from facility staff at risk for less than therapeutic benefits, and/or not receiving ordered medications/treatments due to inaccurate documentation. The findings included: Record Review of Order Summary for Resident #36 dated 07/30/24 reflected the last order review was 04/19/24 and there is no active order for oxygen on resident profile. Record review of the admission record for Resident #36 reflected Resident #36 was readmitted to the facility on [DATE], was a [AGE] year-old female with diagnoses that included Chronic respiratory failure, Hypercapnia, chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), iron deficiency anemia(a condition in which blood lacks adequate healthy red blood cells.), sleep apnea(sleep disorder in which breathing repeatedly stops and starts) and other pulmonary embolism without acute cor pulmonale (blood clot that blocks and stops blood flow to an artery in the lung but does not cause sudden enlargement of the right ventricle of the heart) Record review of Resident #36's Care Plan with admitted [DATE] and last revised 03/14/24 stated the resident has congestive heart failure, at risk for activity intolerance, edema, fluid overload, OXYGEN SETTINGS: O2 prn as ordered. The care plan also stated the resident has oxygen therapy r/t CHF, ineffective gas exchange, respiratory illness, OXYGEN @3L/min via NC at HS and PRN at bedtime for the relieve [sic]of s&sx of hypoxia r/t SOB. AND as needed for relive [sic] of sign and symptoms of hypoxia. The care plan also noted that the resident has altered respiratory status/difficulty breathing r/t CHF, OXYGEN SETTINGS: O2 as ordered. Record review of Resident #36's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15, indicating intact cognition. Section O Special Treatments, Procedures, and Programs: Respiratory Treatments has an X on C1 selecting Oxygen Therapy. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Nurse's Note for Resident #36 by LVN F dated 07/18/24 stated Resident readmit from [hospital] via [ambulance company] stretcher. Alert x 4. Was admitted pain/SOB and Rt arm pain. Resident states has a Fx Rt arm is wearing a wrapped cast, from voice pain with movement. Has multiple bruising to bi-lat arms/legs abd., yeast under ab and groin area. Remains on routine o2 at 3L per N/C with stats at 98%. Is on 1200 cc flu F/U appt. with cardiologist. Did not receive D/C med list from hospital sent Dr. [NAME] for now pending fax. Observation on 07/29/24 at 09:04 AM revealed Resident #36 was observed in bed with oxygen via NC at 2. 5L/min. Interview on 07/30/24 at 02:02 PM with Resident #36, she stated that she had always had oxygen on since return from hospital and prior to going to hospital. It was observed that resident# 36 had oxygen via NC at 2. 5L/min. Interview on 07/30/24 at 02:02 PM with CNA A, stated she thought Resident #36's oxygen wass usually at 3L. Interview on 07/30/24 at 02:11 PM with LVN B without reviewing chart stated Resident #36 was on oxygen at 3L via NC. When asked for order LVN B could not find an order for oxygen for Resident #36. LVN B stated that there should have been an order for Resident #36's oxygen, and it must have been overlooked. LVN B stated that order should have been on there, if O2 was on prior orders. LVN stated that when a resident returned from the hospital they call the doctor, reconcile orders with the physician or fax orders. LVN B stated that a negative outcome for giving a treatment without an order for Resident #36 could be shortness of breath. LVN B stated that MDS Nurse reviews resident orders for interventions residents are receiving and accuracy. Interview on 07/30/24 at 02:56 PM with MDS Nurse, she stated that she pulled out orders for care plans or orders are discussed during morning meetings with IDT made up of morning floor nurse, ADON, DON, Rehabilitation, Social Worker, MDS nurse, Dietary and Administrator; however, if order wass not written then the IDT will not be aware of it but should have been noted during rounds but for Resident #36 they must have not caught it. MDS nurse questioned if she care planned it and checked and stated she did care plan it but must have went by Resident #36's primary diagnosis and not reviewed the orders. MDS nurse stated that if something was care planned then there should be an order. MDS nurse stated that in Resident #36's case if they had a history and go to the hospital for COPD , respiratory failure and with O2 on, when they come back it is a continuation of care, and yes there should be an order. MDS nurse stated that if no order staff should question and should renew as per physician orders. MDS nurse stated for Resident #36 there would be no negative outcome because the major diagnosis is COPD, but that nurses should flag and verify orders for residents that are on oxygen. MDS nurse stated that anything on a patient even if a Band-Aid, requires a physician order because there can be negative outcomes in any situation if treatment is given with no order. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/30/24 at 03:34 PM DON stated that resident orders are reconciled on admission when they come. DON stated that there was nursing discretion for applying oxygen and then notifying the physician and then write the order later like within 24 hours. or late entry, but as soon as possible. DON stated that there was an order because the hospital order stated oxygen. DON stated that the procedure for transferring hospital orders to facility orders was, the nurse reviews hospital orders and notifies the MD, and the MD will continue hospital orders until he reviews or discontinues orders. DON stated that he and ADON review new orders, new admits, with floor nurse as part of morning meeting. DON stated that the order most likely was not reactivated because it was ordered before, but he stated again there was a hospital order. DON stated that upon Resident #36's return on 7/18/24 the facility should have inputted orders that day. DON stated they would have reviewed Resident #36's admission and orders the next day but obviously they had a break in chain of process to ensure there was an order. DON stated there was no negative impact to Resident #36 because she was on oxygen, and she is cognitively able to inform her needs. The order for oxygen for Resident #36 despite audits and rounds was missed and slipped by . Interview on 07/31/24 at 10:44 AM with LVN F stated she started the admission for Resident # 36 on 07/18/24 but did not finish because another nurse relieved her since patient arrived during shift change and then she was off and did not return until 3 days later. LVN F stated that she had reviewed the chart upon her return but missed that there was no oxygen order because she did look through the orders to make the appointments necessary for Resident #36. LVN F stated that she missed the order was not entered because Resident #36 has been on oxygen continuously at the same rate before, and hospital report also stated that she was at same rate of oxygen. LVN F assumed there was a facility order for oxygen and no treatment should be given without an order. If a medication that is not ordered is given there could be a negative outcome . Record Review of Order Summary and order details on 07/30/24 after staff interviews, noted physician order with start date 07/30/24 at 15:41 (3:41pm) Oxygen @ 3 L/pm via NC continuous to relieve s/s of hypoxia r/t COPD was noted in resident #36's point click care (electronic health record) profile. Observation on 07/30/24 at 03:54 PM revealed Resident #36 was observed in bed with oxygen via NC still set at 2.5L/min. Observation on 07/31/24 at 10:18 AM revealed Resident #36 was observed in bed with oxygen via NC at 3L/min. Record Review of the facility's oxygen administration policy dated October 2010, reflected Oxygen therapy is administered by way of an oxygen nasal cannula, and/or nasal catheter. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. Check the tubing connected to the oxygen cylinder to assure that it is free of kinks. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on observation, interview, and record review, the facility failed to 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 one Resident (Resident #44) of four residents observed for infection control practices during personal care, in that: 1.) The facility failed to ensure LVN D performed hand hygiene for 20 seconds or greater after wound care for Resident #44. This failure could place residents that require assistance with personal care at risk for healthcare associated cross-contamination and infection. The Findings included: Record review of Resident #44's face sheet dated 7/31/24 reflected a [AGE] year-old-male with an original admitted [DATE]. Diagnoses included type two diabetes (insufficient insulin production in the body), chronic obstructive pulmonary disease (chronic inflammatory lung diseases that causes obstructed air flow from the lungs), and dementia (general decline in cognitive abilities that affects a person's ability to perform everyday tasks). During an observation on 07/31/24 08:21 AM LVN D performed wound care on Resident #44 as ordered. After wound care, LVN D removed her gloves and performed hand hygiene for 15 seconds. Record review of Resident #44's MD orders dated 7/2/24 stated: Apply Santyl External Ointment 250 UNIT/GM to left lateral (to side) lower leg topically one time a day for arterial ulcer. Clean with normal saline, pat dry with 4x4 gauze (fabric that allows fluids from the wound to be absorbed), apply Santyl (used to treat severe skin ulcers in adults) and moistened Hydrofera Blue (antibacterial foam that promotes healing), cover with dry dressing daily and as needed. Record review of Resident #44's care plan with a revision date of 5/7/24 stated: Resident #44 was at risk for pain r/t diabetes mellitus, Parkinson's, pressure ulcer, arterial ulcer, diabetic ulcers. Interventions included: Administer analgesia as per orders. Give half hour before treatments or care as needed prior to wound care. -Monitor/record/report to nurse any s/s of non-verbal pain: Changes in breathing (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notify physician if interventions are unsuccessful or if current complaint was a significant change from residents past experience of pain. -Provide nonpharmacological interventions for pain In an interview on 07/31/24 at 08:42 AM LVN D stated it was important to wash hands appropriately as to clean hands and to prevent the spread of infections to residents. LVN D sated she thought she counted to 20 seconds while lathering hands but thought she may have counted too fast. LVN D stated she was nervous and could not remember when the last handwashing in-service was conducted as she usually works nights and could have missed the in-services that were provided. In an interview on 07/31/24 10:44 AM the DON sated all staff are expected to wash hands for 20 seconds or greater between glove changes and after removing gloves as it is part of the infection prevention process. The DON stated the wound care nurse should have lathered her hands for the allotted time of 20 seconds or greater. The DON stated by not washing hands as per CDC guidelines it could cause cross contamination and the goal of the facility is to stop the spread of germs and infections. The DON stated he could not recall when the last in-service was, but in-services are done annually and as needed. The DON stated an in-service on hand hygiene was going to be conducted immediately. Record review of facility's Handwashing/Hand Hygiene policy dated revised 08/2019 documented: The facility considers hand hygiene the primary means to prevent the spread of infections . -Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents d. Before performing any non-surgical invasive procedures g. Before handling clean or soiled dressings, gauze pads, etc. j. After contact with blood or bodily fluids k. After handling used dressings, contaminated equipment, etc. m. After removing gloves. www. cdc.gov guidelines states: Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs. Follow these five steps every time. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Scrub your hands for at least 20 seconds. Need a timer? Hum the Happy Birthday song from beginning to end twice.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Senior Care of Corpus Christi		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Fortune Dr Corpus Christi, TX 78405	
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on observation and interview the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 3 halls (Hall 200) reviewed for environment. 1) The facility failed to keep the soiled linen utility closet containing dirty linens locked when not in use. 2) The facility failed to keep the oxygen storage room containing empty and full oxygen canisters locked when not in use. 3) the facility failed to keep the central supply storage room containing approximately 40 individual shaving razors locked when not in use. These failures could result in injury for residents who come into contact with sharp implements or hazardous materials. The findings included: During an observation on 07/29/2024 at 10:53 AM, the soiled linen utility closet on hall 200 across from resident room [ROOM NUMBER] was noted to be partially ajar. The sign on the door read Authorized Personnel Only. Inside the room was soiled linens and trash. During an observation on 07/29/2024 at 3:03 PM, the oxygen storage room and central supply storage rooms at the end of hall 200 were unlocked. The signs on the oxygen storage room read Danger Flammable Gas and Danger Gas Cylinder Storage Area. Inside the oxygen storage room were approximately 50 oxygen canisters in racks. Half of them were in the section labeled O2 full and the other half were in the section labeled O2 empty. The door to central supply storage room had a locking mechanism with buttons for input, but the door could be opened without inputting any combination. Inside the central supply storage room were various hygiene supplies, including approximately 40 individual shaving razors in a basket on a shelf. In an interview with CNA C on 07/31/2024 at 2:29 PM, CNA C stated that the locking mechanism on the door to the central supply storage room stopped working about a year ago. CNA C stated that she was not certain if the oxygen room had ever been locked because she had never been in that room. CNA C stated that she had never seen a resident by the storage rooms at the end of hall 200. CNA C stated that she did not think any residents on the 200 hall would grab a razor in the central supply storage room and hurt themselves or others. CNA C stated that she was not sure whether or not the oxygen storage room should be locked, but that the central supply storage room should probably be locked. CNA C stated that it should be the responsibility of whoever stocks the supply rooms to inform the DON or administrator that the doors are unlocked. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN E on 07/31/2024 at 2:42 PM, LVN E stated that the oxygen storage room is usually locked at other facilities he has worked. LVN E stated that it was possible for a resident to go into the central supply storage room, grab a razor, and then hurt themselves or others. LVN E stated that if a resident walked into the central supply storage room and fell it could take a while before anyone would notice that the resident had fallen and injured themselves. In an interview with the DON on 07/31/2024 at 3:15 PM, the DON stated whether or not storage rooms should be locked depends on what is being stored. The DON stated that the soiled linens closet should be secured when not in use. The DON stated that he was fine with the oxygen supply room being unlocked because they are in racks. The DON stated that he was fine with the central supply door being unlocked as long as nothing dangerous was in there. The DON stated that shaving razors do not belong in the central supply storage room at the end of hall 200. The DON stated that there was potential for residents to harm themselves or others with the razors in the room. The DON stated that it was possible, but not likely, that a resident could go into the central supply storage room and fall causing them to injure themselves. On 07/31/2024 at 4:01 PM, a policy was requested from the DON and ADM covering the expectations for a safe, homelike environment but none could be located.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49157 Based on observation, interview, and record review the facility failed to maintain an effective pest control program so that the facility was free of pests in one of one kitchen reviewed for pests. 1. There were multiple live flies and gnats in the kitchen. 2. There were multiple live flies in the dining room. These failures could put residents who consumed food from the kitchen and who ate in the dining room at risk for infection and/or food contamination. The findings included: Observation of the facility's kitchen dry storage area on 07/29/24 at 09:10am revealed 2 flies and approximately 10 gnats that were flying around in the area. Observation of the facility's kitchen food preparation and cooking area on 07/29/24 at 09:45am revealed multiple flies were flying around in the kitchen area and had landed on multiple food preparation surfaces. Observation on 07/29/24 at 11:45am of the facility's dining room revealed multiple flies in the dining room. One resident was noted to have a fly swatter on the dining room table that she was sitting at. In an interview on 07/30/24 at 1:43pm, the DM stated that they had ordered and received an air curtain for the dining room door to help keep the flies and gnats outside and they were waiting on an electrician to fix the electrical issue so that it could be installed. The DM stated the electrician should be out next week. In an interview on 07/31/24 at 10:36am, the ADM stated that the MS was out of the facility to get foggers to spray outside. The ADM stated they would be spraying outside at least weekly during peak seasons to help control the flies. The ADM stated the MS was also looking for fly traps for the kitchen. The ADM stated pest control was contracted for 2 times a month; one time to spray the inside and the next time outside, but that they could call them anytime to come in for additional treatment if needed. The ADM stated that pest control should be coming out today (07/31/24). In an interview on 07/31/24 at 11:24am, MS stated pest control came out 2 times a month and as needed. MS stated pest control had been out on 7/25/24 and 7/20/24. MS stated pest control should be out by about 1:00 pm today and that he was going to discuss how to control the flies in the facility and what recommendations or remedies the pest control company had. Record review of the facility's pest control request log on 7/31/24 at 10:50am revealed 13 entries dated 6/26/24 through 7/29/24. 12 of 13 entries were related to roaches and 1 of 13 entries was related to ants. There were no entries related to flies or gnats for any area of the facility. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's pest control invoices on 7/31/24 at 11:26am revealed the pest control company had been out on 7/20/24 and 7/25/24 and had treated for roaches and ants, but there was no mention of treating for flies inside or outside the facility.		