STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455879	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Manor West	207 W Merritt St Marshall, TX 75670

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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 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** 49019 Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 4 residents (Resident #07) reviewed for resident rights in that: The facility failed to provide a catheter privacy bag for Residents #07 while sitting in main living room at facility with other residents on 11/5/2024. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings included: 1.Record review of a face sheet for Resident #07 dated 2/20/2024, indicated Resident #07 was a [AGE] year-old female who was readmitted on [DATE] with the diagnoses of encephalopathy (A medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion.), Intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently), dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), and conversion disorder with seizures (a condition where a mental health issue disrupts how your brain works). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #07 was rarely or never understood and BIMS score unable to be recorded indicating Resident #07 was severely cognitively impaired. Resident #07 was dependent for all ADL's (Activities of Daily Living). Record review of a care plan for ADLs, last updated 12/15/2017, indicated Resident #07 required max assist with all ADL's due to cognition related to mental retardation, unsteady gait/balance, daily bowel, and bladder incontinence. During an observation on 11/4/2024 at10:25 AM, Resident #07 was sitting up in wheelchair in her room with door open with catheter bag hanging below wheelchair without a privacy bag with yellow urine observed in the catheter bag. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/5/2024 at 10:13 AM, Resident #07 was sitting in the main living room on Hall C seated in her specialty wheelchair with catheter bag without a privacy cover hanging below her wheelchair. During the observation, staff and other residents were passing by and 1 other resident observed in the TV room with Resident #07. During an observation on 11/5/2024 at 10:43 AM, Resident #07 was sitting in the main living room on hall C in her wheelchair with catheter bag hanging below the wheelchair. The catheter bag was dated 10/31/2024 with urine facing the toward the front of the wheelchair. During an interview on 11/6/2024 at 11:07 AM, CNA A said residents who have a catheter should have a privacy cover over the catheter bag. CNA A said the nursing staff were responsible for keeping the catheter bags covered. She said if she observed a resident without a catheter bag cover, she would notify the nurse. CNA A said a resident may not feel comfortable if other residents were eating or drinking with a catheter bag exposed or make a resident feel bad if their catheter was exposed. During an interview on 11/6/2024 at 1:00 PM, LVN C said the facility has privacy covers for catheter bags. LVN C said if a resident comes from the hospital with a catheter, they sometimes do not have privacy covers. LVN C said she did not think you could change the catheter bags, but the staff could use a leg bag if a resident was up. LVN C said if a resident remained in their room and did not leave, they would still need a privacy bag. LVN C said a resident could be embarrassed if they did not have the proper cover over their catheter. LVN C said it could also bother other residents if they observed a catheter while eating or in a main room together. She said if a resident had a catheter that looked nasty, it could change a person's appetite. During an interview on 11/6/2024 at 1:24 PM, the ADON said the residents should have catheter covers on their catheter. The ADON said sometimes residents will go out to the hospital and they return with a different type of catheter. She said the facility nursing staff would change out the resident's catheter bag and place one from the facility's catheter bags with the privacy cover. The ADON said it was important to have the privacy covers on the catheters for privacy. She said a resident could be self-conscious if they had a catheter where other could see. She said if a resident was unable to voice their need for privacy bag, the staff should anticipate their need. During an interview on 11/6/2024 at 1:44 PM, the DON said she expected the nurses to change out the catheter bags to the facility's catheter bag with privacy cover. The DON said it depended on the resident, but it could be a dignity issue. She said she felt a reasonable person would feel embarrassed if their catheter bag was exposed. She said it may cause other persons in the public setting to lose their appetite. The DON said Resident #07 leaves her room, and she did have a new catheter bag after returning from hospital on 11/3/2024. During an interview on 11/6/2024 at 2:06 PM, the ADM said he expected the Resident #7 to have a privacy bag on her catheter. The ADM said it was the responsibility of the charge nurse to change out the catheter bags when a resident returns from the hospital. Review of a policy dated 9/2/2015 titled Indwelling Urinary Catheter Use revealed Purpose: A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 8. Catheter care: c. Utilization drainage bag holders/covers when resident is out of room to provide dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy dated July 1, 2002, titled Dignity: The Quality or State of being worthy, honored or esteemed revealed .a resident is treated with respect, consideration, and recognition as an individual. The facility now becomes the resident's home; therefore, remember each resident has a right to A dignified existence. The facility must promote care in a manner and environment that enhances each resident's dignity and respect in full recognition of his/her individuality.

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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** 44933 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 2 of 6 residents reviewed for care plans. (Resident #6 and Resident #29) The facility failed to ensure Resident #6's vision impairment and use of eyeglasses were care planned. The facility failed to ensure Resident #29's hearing impairment was care planned. These failures could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings included: Record review of Resident #6's face sheet dated 11/06/24 indicated Resident #6 was a [AGE] year-old female admitted to the facility on [DATE] and 05/02/18 with diagnoses including dementia (is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), cognitive communication deficit (is a condition that makes it difficult to communicate due to a brain injury or other underlying cognitive issues), and age related physical debility (is weakness caused by an illness, injury, or aging). Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated Resident #6 was sometimes understood and sometimes understood others. Resident #6 had moderately impaired vision with use of corrective lenses. Resident #6 was rarely/never understood and was unable to complete the BIMS assessment. Resident #6 had short-and-long term memory problem and moderately impaired cognitive skills for daily decision making. Record review of Resident #6's care plan received on 11/06/24 did not reflect a care plan problem addressing moderately impaired vision with use of corrective lenses. During an observation on 11/04/24 at 12:45 p.m., Resident #6 was in the dining room eating lunch. Resident #6 did not have eyeglasses on. During an observation on 11/05/24 at 9:45 a.m., Resident #6 was in the facility's television room. Resident #6 was asleep in her wheelchair with no eyeglasses visualized. During an observation and interview on 11/05/24 at 3:00 p.m., Resident #6's was in the television room. Resident #6 was in her wheelchair with no eyeglasses visualized. Resident #6 answered basic questions but got confused when questioned about her vision. During an interview on 11/05/24 at 3:10 p.m., the DON said Resident #6 had several pairs of eyeglasses. She said Resident #6 did wear her eyeglasses but also liked to claim other people eyeglasses were hers. She said she found Resident #6's prescribed eyeglasses in her purse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #29's face sheet dated 11/06/24 indicated Resident #29 was an [AGE] year-old male admitted to the facility on [DATE] and 04/26/22 with diagnoses including dementia (is a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life), and retention of urine (is a condition that prevents the bladder from emptying completely). Record review of Resident #29's annual MDS assessment dated [DATE] indicated Resident #29 was understood and usually understood others. Resident #29 had moderate difficulty hearing and no hearing aids. Resident #29 had a BIMS score of 10 which indicated moderate cognitive impairment. Resident #29's care area assessment summary triggered communication. Record review of Resident #29's care plan provided on 11/06/24 did not reflect Resident #29's moderate difficulty hearing and no hearing aids. During an observation and interview on 11/04/24 at 1:45 p.m., Resident #29 was lying bed. Resident #29 did not understand the interview questions until the surveyor spoke loudly and slowed my speech. During an interview on 11/05/24 at 4:00 p.m., Resident #29 said he was hard of hearing but did not want hearing aids. During an interview on 11/05/24 at 4:05 p.m., LVN K said Resident #29 was hard of hearing. She said the facility had attempted to send him to a doctor for it, but he refused. During an interview on 11/06/24 at 11:05 a.m., the MDS Coordinator said she was responsible for resident's care plans. She said Resident #6 and Resident #29's vision and hearing deficit should be on their care plan. She said if the vision and hearing deficit was triggered on the MDS then it should be care planned. She said Resident #6 had vision problems and wore eyeglasses. She said she did not know Resident #29 was hard of hearing. She said social service normally handled resident's vision and hearing needs. She said she would communicate with social service to see what interventions needed to be added for Resident #29. She said a resident's care plan was important, so everyone was aware of the resident's needs. She said when things were not care planned, it placed residents at risk for not getting theirs needs met. During an interview on 11/06/24 at 11:58 a.m., the DON said the facility developed care plans by looking at the resident's history, talked to the family, assessment by facility staff, and the MDS. She said Resident #6 and Resident #29's vision and hearing deficit should be on their care plans. She said it was important to have a resident hearing problem on their care plan to know how to communicate with them and how the communicate with the staff. She said the vision problem needed to be on the care plan to know if the resident required special assistance due to decrease vision. She said it placed resident at risk for falls if their vision needs were not addressed. She said the MDS Coordinator and DON were responsible for the resident's care plan. She said the IDT should oversee the care planning process. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 2:19 p.m., the ADM said the DON and MDS Coordinator were responsible for the resident's care plans. He said Resident #6 and Resident #23's vision and hearing deficit should be care planned. He said it was important to care plan those problems to know how to interact with the residents. He said it was important because vision and hearing affected the resident quality of life and care. He said the DON and MDS Coordinator were also responsible for overseeing the care planning process. Record review of an undated facility's Care Planning-Resident policy indicated .each resident has a Resident Care Plan that is current, individualized, and consistent with medical regimen .a functional nursing assessment is conducted by using the Minimum Data Set (MDS) form .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview, and record review the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers based on the comprehensive assessment for 1 of 2 Residents (Resident #12) whose record were reviewed for skin integrity. The facility failed to ensure Resident #12 received and/or documented wound care on the evening shift of 10/19/24 and 10/20/24. This failure could place residents at risk for developing pressure ulcers and could contribute to developing avoidable pressure ulcers. Findings included: Record review of Resident #12's face sheet dated 11/06/24 indicated Resident #12 was a [AGE] year-old female admitted on [DATE] and 10/18/24 with diagnoses including dementia (is a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life), pressure ulcer of sacral region (is a skin injury that forms on the sacrum, a bony area of the lower back and spine), and enterocolitis (is a condition that involves inflammation of the small and large intestines, or digestive tract) due to clostridium difficile (is a bacterium that can cause diarrhea, colitis, and other symptoms). Record review of Resident #12's annual MDS assessment dated [DATE] indicated Resident #12 was understood and usually understood others. Resident #12 had a BIMS score of 01 which indicated severe cognitive impairment. Resident #12 was at risk of developing pressure ulcer/injuries. Record review of Resident #12's care plan dated 10/21/24 indicated Resident #12 had a skin concern: Unstageable coccyx. Intervention included administer medication and supplements as needed. Record review of Resident #12's hospital discharge summary dated 10/18/24 indicated start Venelex ointment (is an ointment that's used on the skin to cover wounds). Apply topically two times daily. Record review of Resident #12's Medication Record dated October 2024 indicated Start Venelex ointment, apply topically 2 times daily. Use as directed. Dated 10/18/24. The medication record indicated Day which was highlighted, and Evening was not highlighted. No initials were noted for evening shift on 10/19/24 and 10/20/24. Record review of Resident #12's nurse's notes by LVN G, dated 10/19/24 at 12:10 a.m., indicated .this nurse [LVN G] makes weekend supervisor [RN H] aware of dressing to coccyx and bilateral heels .and that drsgs [dressings] looked fresh and intact .supervisor verbalized understanding and states 'we should leave them in place for now if intact to help .protect from any C.diff getting into wounds . Record review of Resident #12's nurse's notes by LVN M, dated 10/20/24 at 1:30 a.m., indicated .drsgs [dressings] intact to coccyx and bilateral heels . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #12's nurse's notes by LVN M, dated 10/20/24 at 5:10 a.m., indicated .tx [treatment] to coccyx and bilateral heels done per RN supervisor [RN H] . On 11/06/24 at 11:05 a.m., attempted to contact LVN M by phone. Unable to leave message. LVN M did not return call prior or after exit. During an interview on 11/06/24 at 11:09 a.m., WCN F said when a resident with a pressure ulcer was admitted the charge nurse was responsible to complete an assessment, call the PCP to relay findings and discuss treatment orders from the hospital. She said if the PCP approved of the treatment orders from the hospital, the charge nurse place the order on the TAR and physician order slip. She said Resident #12's treatment order was for twice a day. She said AM or days was done by the 6am-2pm shift and the evening was done by 2-10 pm shift. She said on the weekends, the weekend supervisor was responsible for dressing changes. She said the weekend supervisor usually arrived around midnight and completed dressing changes around 8-9 am. She said the weekend supervisor reviewed the treatment book and charge nurses informed him of wound dressing changes that were due. She said when a treatment was done, it should be charted in the nurse's notes and the MAR/TAR. She said it was important to document on the MAR/TAR when a treatment was done so everyone knew it was completed. She said on Resident #12's TAR, it appeared the treatment for her coccyx was only done once but the nurse's note said the dressing was clean, dry, and intact. She said it was important for Resident #12 to receive her treatment twice a day to decrease the risk of infection and help with wound healing. She said if Resident #12's coccyx dressing was not done as ordered, she was at risk for an infection and decreased healing. During an interview on 11/06/24 at 11:23 a.m., LVN G said she did not remember if Resident #12's wound dressing was changed on her shift. She said she worked the 2pm-10pm shift. She said when a treatment was done it was supposed to be charted on the resident's MAR/TAR. She said if the treatment order was scheduled for twice a day, it was supposed to be done on the morning shift and evening shift. She said the evening shift was 2pm-10pm shift. She it was important for Resident #12's wound dressing to be changed as ordered to control the drainage. She said if a resident's dressing was not changed as ordered then the wound could get infected and worsen. During an interview on 11/06/24 at 11:55 a.m., RN H said he was the weekend supervisor for the facility. He said he knew which treatments needed to be complete from reviewing the treatment book. He said when he completed the treatment, he placed his initials on the TAR/MAR. He said he normally completed the treatments after the residents got up in the morning. He said if Resident #12 had an order for a treatment he probably did it. He said he did not know why 10/19/24 and 10/20/24 were not initialed. He said if something was not documented then it was not done. He said Resident #12's treatment needed to be done twice a day because that was how it was ordered. He said it did not help the resident if the treatment was not done as ordered. During an interview on 11/06/24 at 11:58 a.m., the DON said she expected the nursing staff to follow the physician orders and document when treatments were done. She said nursing staff should document on the MAR/TAR and nurse's notes. She said the weekend supervisor or the resident's nurse were responsible for wound dressing changes. She said the treatments needed to be done as ordered to prevent infection and worsening of the wound. She said the WCN and DON should oversee that the wound care treatment orders were being followed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 2:19 p.m., the ADM said the charge nurse and weekend supervisor were responsible for wound dressing changes on the weekend and evening shift. He said he expected nursing staff to follow the physician orders and document when the treatment was done. He said nursing staff should document on the TAR and nurse's notes when the treatment was done. He said if the resident's treatments were not done as ordered, the wound could worsen. She said the WCN and DON should oversee that the wound care treatment orders were being followed. Record review of an undated facility's Pressure Ulcer Treatment policy indicated .residents with pressure ulcers receive necessary treatment and services to promote healing prevent infection and reduce the likelihood of new ulcers developing .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 1 of 4 residents (Resident #29) reviewed for indwelling urinary catheters (is a thin, hollow tube that is inserted into the bladder to drain urine). The facility failed to ensure Resident #29's foley catheter bag (is a device that drains urine (pee) from your urinary bladder into a collection bag outside of your body when you can't pee on your own) was changed as ordered on 10/15/24 (12am). The facility failed to ensure Resident #29's supra-pubic catheter (is a tube that drains urine from the bladder through a small incision in the lower abdomen) was changed as ordered on 10/16/24 (nights) Theses failures could place residents at risk for urinary tract infections. Findings included: Record review of Resident #29's face sheet dated 11/06/24 indicated Resident #29 was an [AGE] year-old male admitted to the facility on [DATE] and 04/26/22 with diagnoses including dementia (is a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life), retention of urine (is a condition that prevents the bladder from emptying completely), urinary tract infection (is a bacterial infection that affects the urinary tract, which includes the bladder, urethra, and kidneys), and obstructive (is a urinary tract disorder that occurs when urine flow is obstructed, either structurally or functionally) and reflux (is a condition where urine flows backward from the bladder into the ureters and sometimes the kidneys) uropathy. Record review of Resident #29's annual MDS assessment dated [DATE] indicated Resident #29 was understood and usually understood others. Resident #29 had a BIMS score of 10 which indicated moderate cognitive impairment. Resident #29 had an indwelling catheter. Record review of Resident #29's care plan revision date 11/05/24 indicated Resident #29 has a history of BPH (is a noncancerous condition that causes the prostate gland to enlarge) and now had a suprapubic catheter due to obstructive uropathy and was at risk for frequent UTIs, dislodgement, or other complications. Intervention included change foley catheter once a month and change bag twice a month. Record review of Resident #29's medication review report dated 11/06/24 indicated: *Change foley catheter bag twice a month at bedtime. Change foley catheter bag on the 15th and 30th of the month. Ordered date 11/30/20. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Supra-pubic catheter 16 french/10 cc bulb changed every 4 weeks, every night shift starting on the 16th and ending on the 16th every month. Ordered 04/26/23. Record review of Resident #29's Treatment Administration Record dated 10/01/24-10/31/24 indicated: *Change foley catheter bag twice a month at bedtime (12 am). Change foley catheter bag on the 15th and 30th of the month. Ordered date 11/30/20. The TAR did not reflect administration on the 15th but on the 20th (LVN J). *Supra-pubic catheter 16 french/10 cc bulb changed every 4 weeks, every night shift starting on the 16th and ending on the 16th every month. Ordered 04/26/23. The TAR did not reflect administration on the 16th but on the 20th (LVN J). Record review of the Nursing Staff assigned to Resident #29 on 10/15/24 and 10/16/24, provided by the DON on 11/06/24 indicated: *10/15/24: 2pm-10pm (LVN K), 10pm-6am (LVN J) *10/16/24: 2pm-10pm (LVN C), 10pm-6am (LVN L) During an observation on 11/04/24 at 1:45 p.m., Resident #29 was lying in bed. On Resident #29's wheelchair, bedside his bed, a catheter bag was hanging from it. On 11/06/24 at 10:33 a.m., attempted to contact LVN L by phone. A voicemail was left with contact information. A return phone call was not received prior or after exit. On 11/06/24 at 10:50 a.m., attempted to contact LVN K by phone. Unable to leave message. On 11/06/24 at 10:53 a.m., attempted to contact LVN C by phone. A voicemail was left with contact information. A return phone call was not received prior or after exit. During an interview on 11/06/24 at 10:43 a.m., LVN J said Resident #29 got his catheter bag changed more than twice a month. She said Resident #29's catheter bag leaked, or the resident messed the bag spout up when he tried to empty the bag himself. She said Resident #29's catheter and bag were changed on or around the 15th or 16th of October 2024. She said Resident #29's catheter and bag needed to be changed as ordered to prevent an infection. During an interview on 11/06/24 at 11:58 a.m., the DON said expected nursing staff to follow physician orders. She said she expected nursing staff to document if an order could not be completed, on the ordered day. She said if was important to change Resident #29's catheter and bag as ordered to prevent an infection. She said when the resident's catheter and/or bag was not changed as ordered, it placed the resident at risk for developing an infection. She said the DON was responsible for ensuring physician orders were being followed. She said she at the end of the month, she randomly reviewed resident's MAR/TARs to monitor medication and treatment administration. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 1:02 p.m., LVN K said she recalled helping another nurse change Resident #29's catheter. She said she could not remember the exact day Resident #29's catheter was changed. She said it was possible Resident #29's catheter did not get changed on the scheduled day because he refused sometimes. During an interview on 11/06/24 at 1:10 p.m., AS#1 said that the facility locked supplies like catheters and the catheter bags on the night shift and weekends. AS#1 said sometimes the facility did not have the supplies on hand to change the catheter and catheter bags on schedule. During an interview on 11/06/24 at 2:19 p.m., the ADM said the charge nurse was responsible for changing resident's catheter and bag. He said charge nurses should document on the MAR/TAR and nurse's notes when completed. He said research indicated indwelling catheter should not be changed often. He said he could not say the resident was at risk for an infection if it was not changed as ordered. He said the resident was at risk for an infection if the catheter was not changed for a long period of time. Record review on an undated facility's Indwelling Urinary Catheter Use policy indicated .a resident who enters the facility without an indwelling catheter is not catharized unless the resident's clinical condition demonstrates that catheterization was necessary . The policy did not address changing the bag or catheter.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45643 Based on observation, interview, and record review, the facility failed to ensure that the menu was followed for the lunch meal on 11/04/24 and 11/05/24 for 2 of 2 meals (the lunch service) reviewed for nutritional adequacy. The facility did not serve fried chicken, as planned, with the lunch meal on 10/04/2024 nor informed residents that a substitute would be used. The facility failed to serve Salisbury steak with the lunch meal on 10/05/2024 nor informed residents that a substitute would be used. These failures could affect all residents in the facility by placing them at risk of not receiving adequate nutritive food value needed to promote/maintain health. Findings included: Record review of a Sample Menu Substitution List dated 11/04/2024 to 11/05/2024 showed that on 11/04/2024 fried chicken was scheduled and substituted with fajita chicken. The Menu shows that on 11/05/2024 Salisbury steak was scheduled and substituted with steak. Record review of a facility food menu shows that on 11/04/2024 fried chicken was scheduled to be prepared. Shows that on 11/05/2024 that Salisbury steak was scheduled to be prepared. During an observation and interview on 11/05/2024 at 12:38 p.m., the Dietary Manager said that they would not have traditional Salisbury steak today. She said that they served an alternate provided by Sysco. She said that alternate is sliced beef. She said the box she was provided said Salisbury Steak. It was observed while testing a food tray that sliced roast beef was served as Salisbury steak. During an interview on 11/05/2024 at 12:50 p.m., Resident #50 stated that he did not like the food he was given today. He said he did not know what the meat was that was served. He said it was not any kind of Salisbury steak he has eaten before. During an interview on 11/05/2024 at 12:58 p.m., Resident #17 said she did not eat the meat on her plate. She said she didn't like the beef she was served. She said she likes the Salisbury steak that is made from a hamburger patty. She said that she didn't like what she was served today it was a tough piece of beef that had gravy on it. She said she ate the rest of her plate. During an interview and observation on 11/05/2024 at 1:02 p.m., Resident #47 said she did not try the roast beef to see if it was any good. She said that it did not look like what Salisbury steak normally looks like. She said it was a slice of beef and not a patty. She said if it doesn't look good it would not touch her lips. She said she ate the rest of her food, and it tasted fine. It was observed that Resident #47 did not eat any of her sliced beef. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/05/2024 at 1:04 p.m., Resident #4 said he enjoyed the food that he was served today but he would have preferred if it was the Salisbury steak that was on the menu. He said he ate everything but would have wanted to be informed if they did not have real Salisbury steak. During an interview on 11/05/24 3:20 p.m., the Dietary Manager, said the food supplier representative told her they were out of stock of the regular Salisbury Steak. She said they will order extra cases of Salisbury steak for this season since they would be serving it more often in the Fall/Wintertime. She said she had the conversation with the food representative last Monday October 28th, 2024. She said the food supplier delivered the sliced beef that was served today Tuesday October 29th, 2024. She said the kitchen served sliced roast beef today as Salisbury Steak. She said what they served today was delivered last Tuesday October 29th, 2024. She said they had a substitute menu list that shows steak as today's substitute. She said if an item was not available, and it will be substituted they do not tell the residents the substitute will be served. During an interview on 11/06/2024 at 10:50 a.m. with the Dietary Manager she said each morning she displays the daily menu on the walls in various locations for residents to see. She said that substitutions are not displayed. She said that residents would not be informed if a substitution will be used and the menu that is displayed is not updated to reflect that a substitution was used. She said that residents do not make orders for their food choice and that if a substitute was desired by a resident the resident themself would need to request the substitution to the kitchen. She said that if a food became unavailable that was planned through their supplier residents would not be notified of that fact even though the menu remained the same. During an interview on 11/06/24 at 01:25 p.m., the Director of Nurses said she expects that kitchen staff follow menus and notify residents their options for substitutions. She said that residents would be placed at risk of losing weight and quality of life loss if they are given foods that were not appetizing to them and their choices. During an interview on 11/6/2024 at 1:50 p.m., the Administrator said he expects that kitchen staff notify residents when a substitution will be made to their menu. He said that it may be a quality-of-life issue for residents if they are receiving food they do not like. Requested a policy regarding menus and substitutions on 11/06/24. Facility provided policy did not have a section that specifically addressed notifications of meal substitutions.

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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. 45643 Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation in that: 1. Chicken, contained in plastic, was being thawed on a stovetop with hot water. 2. Tater Tots, shredded lettuce, iceberg lettuce, cheese, and an unknown food item was not labeled or dated. 3. Kitchen stove was not kept free of carbon buildup, grease, and food particles. These deficient practices could place residents who received meals from the kitchen at risk for food borne illness. The findings included: During an observation on 11/4/24 at 9:05 a.m . it was observed that tater tots, shredded lettuce, iceberg lettuce, cheese, and an unknown food item were not labeled and dated. It was observed that kitchen staff was thawing a large block of chicken in its plastic packaging inside a large pot with water. The water was simmering and appeared to be near boiling point. It was observed that the cooking stove top and the stainless-steel backing had grease and food particles layered on the surfaces. During an interview on 11/06/24 at 10:21 a.m., the Dietary Manager said that food should not be dethawed by placing it in boiling water while still in its plastic on the stovetop. She said the frozen chicken should have been placed on the bottom shelf of a refrigerator or placed in a sink underwater with water continuously flowing and agitating the water. She said that improper thawing could cause foodborne illness. She said food should be labeled and dated as it was placed into the refrigerator or freezer. She said that when food was opened and placed back into the refrigerator it should be labeled and dated as well. She said it was the responsibility of kitchen staff to ensure that food was labeled and dated. She said residents could be placed at risk of foodborne illness if they eat spoiled food. She said that the stove top should be cleaned regularly. She said that there should not be a buildup of food and grease in the stove top or the stove backing. During an interview on 11/06/24 at 01:25 p.m., the Director of Nurses said she expects that kitchen staff to thaw meat properly as meat that was prepared unproperly would place residents at risk for foodborne illness. She stated that kitchen staff should have labeled and dated the food items that were stored in the kitchen. She stated that she expects kitchen staff to clean the cooking surfaces in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/06/24 at 01:50 p.m., the Administrator said he expected that his kitchen staff thaw meat according to state regulations. He said that he expected staff to label and date food stored in the kitchen. He said that residents could be placed at risk for foodborne illness if they consumed meat that was not prepared or stored properly. He stated that the kitchen should be maintained and cleaned. He said that grease and food particles should be cleaned from cooking surfaces. Review of the facility document dated 2019, Meat and Vegetable Preparation provided by the Dietary Manager revealed: Meats and vegetables will be prepared to conserve maximum nutritive value, to develop and enhance flavor and appearance, and to prevent foodborne illness Meat will be defrosted using safe thawing methods (never at room temperature): In the refrigerator in a drip proof container, and in a manner that prevents cross contamination. In the sink, submerging the item under cold water (<70 F) that is running fast enough to agitate and float off loose ice particles. Review of the facility document dated 2019, General Sanitation of Kitchen provided by the Dietary Manager revealed: Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule Cleaning and sanitation tasks for the kitchen will be outlined in a written cleaning schedule. Tasks will be assigned to be the responsibility of specific positions. Frequency of cleaning for each task will be defined. Methods and materials/cleaning compounds to be used for cleaning/sanitizing will be written for each task. Employees will be trained on how to perform cleaning tasks.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 6 resident personal refrigerators reviewed for food safety. (Resident #47). The facility failed to inspect and remove expired foods from Resident #47's personal refrigerator on [DATE]. This failure could place resident at risk for food borne illnesses. Findings included: Record review of a face sheet dated [DATE] indicated Resident #47 was an [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses including chronic ischemic heart disease (occurs when blood flow to your heart is reduced, preventing the heart muscle from receiving enough oxygen), Chronic pain (Chronic pain is long standing pain that persists beyond the usual recovery period or occurs along with a chronic health condition, such as arthritis.), Diabetes (a condition that happens when your blood sugar (glucose) is too high. It develops when your pancreas does not make enough insulin or any at all, or when your body isn't responding to the effects of insulin properly), Major Depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and acquired absence of left leg (refers to an amputation). Record review of a Quarterly MDS dated [DATE] indicated Resident #47 understood others and made herself understood. The MDS indicated Resident #47 cognition was intact with a BIMS score of 13. The MDS indicated Resident #47 was independent with most ADL's (activities of daily living). Record review of a care plan for Resident #47 revised ,d+[DATE]//2024 indicated Resident #47 tends to hoard food, clothes, and other items in her room and often refuses to let staff organize or store items appropriately. The care plan indicated Resident # 47's room was often cluttered and smelled as well as Resident #47 went out on pass shopping with family or with staff and frequently purchases items that are not allowed to be used in the nursing facility. Resident #47 had intervention in place for staff to remove old food and trash daily. During an observation and interview on [DATE] at 10:06 a.m., Resident #47 said the surveyor could inspect her personal refrigerator and was observed with the following expired foods: two small cartons of milk with expiration date of [DATE] and [DATE] on cartons. Resident said she cleans out her refrigerator sometimes the staff remove expired food and drinks. Resident #47 had her refrigerator filled with multiple food items and condiments without dates located on packaging. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] 11:07 AM CNA C said the Hospitality Aide was responsible for cleaning out resident's personal refrigerators. CNA C said she would open Resident #47's personal refrigerator and get milk out for her. CNA A said she would look at the dates first to make sure it is still good. She said if the milk were expired, she would throw it away. CNA A said if a resident opened or consumed milk that was expired, it could make the resident sick. CNA A said the Hospitality aide checks the personal refrigerators every day. CNA C said Resident #47 never complained if the staff went through her refrigerator. During an interview on [DATE] at 11:25 AM, the Hospitality Aide B said she had been at the facility for 2 years and in the role of the hospitality aide for approximately 1 year. Hospitality Aide B said she checks resident's refrigerators for expired food and keeps a log of the temperature logs at the nurse station in a notebook. She said she would go through the refrigerators daily. Hospitality Aide B said were residents who refuse her to clean or look in their refrigerator. Hospitality Aide B said there was only two residents who refused to allow her to look in his refrigerator. Hospitality Aide B said Resident #47 did not have a problem with her cleaning out expired food or drinks. She said a resident could get sick or get an infection if they consumed expired food or drinks. Hospitality Aide B said the residents were not responsible for cleaning out refrigerator. She said if a resident refuses, she would notify the DON have her talk with the residents about their refrigerator. During an interview on [DATE] at 1:08 PM, LVN C said housekeeping was responsible for keeping the resident's refrigerator cleaned out. She said expired condiments, food, milk, or juices should not be kept in a resident's room. LVN C said she was not sure how often the resident's refrigerators should be cleaned out. LVN C said she personally does not go into a resident's stuff but would let a resident know if an item requested from their refrigerator was expired. LVN C said a resident could get food poisoning, stomach sickness if the resident consumed or drank something that was expired. During an interview on [DATE] at 1:21 PM, the ADON said the Hospitality Aid was responsible for cleaning out the resident's refrigerators. The ADON said the nurse aides could also clean out the refrigerator. The ADON said she was not sure how often the Hospitality aid was supposed to clean the refrigerator. She said it was not ok for a resident to have expired condiments, milk, or food in refrigerator. The ADON said the resident could get sick if they ate or drank food that was expired. The ADON said she expected the Hospitality Aid and CNAs to remove the expired food and drinks from resident's personal refrigerators. During an interview on [DATE] at 1:44 PM, the DON said the Hospitality Aid was supposed to clean out personal refrigerators. She said expired food and milk should be removed from refrigerator. The DON said Resident #47 did not like her refrigerator to be touched. She said the facility had it care planned. The DON said Resident #47 refused for her refrigerator to be cleaned out on [DATE] but there was no documentation of the attempt or refusal. The DON said Resident #47 wanted to have control over her life and whatever solutions had been present was never good enough. During an interview on [DATE] at 2:06 PM, the ADM said Resident #47 hoards food. The ADM said he expected expired food to be removed from the refrigerator if expired. He said the Hospitality Aid was responsible for removing expired food from resident's personal refrigerator. The ADM said the Hospitality Aide should attempt to remove expired food. The ADM said there should be documentation of attempts and refusals to remove or clean refrigerator and if not successful, notify family in attempt to talk with resident. The ADM said if a resident consumes expired food from their personal refrigerator, there was a potential for food born illness. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled, Personal Refrigerator undated revealed .The purpose was to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Procedure: IV. The refrigerator will be cleaned once weekly and as needed. VI. The facility staff will check for expired food and drinks and remove them daily .

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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** 44933 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #12) reviewed for infection control. 1. The facility failed to ensure Resident #12 had signage to identify the resident was on EBP and PPE used for Enhance Barrier Precaution (EBP) due to pressure ulcer on her coccyx, on 11/04/24 and 11/05/24. 2. The facility failed to ensure WCN F followed the Enhanced Barrier Precautions (EBP) (interventions to prevent spread of infection in high-risk residents) policy of wearing a gown during Resident #12's pressure ulcer wound care to her coccyx on 11/05/24. These failures could place residents at risk for cross-contamination, increased risk of infection and the spread of infection. Findings included: Record review of Resident #12's face sheet dated 11/06/24 indicated Resident #12 was a [AGE] year-old female admitted on [DATE] and 10/18/24 with diagnoses including dementia (is a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life), pressure ulcer of sacral region (is a skin injury that forms on the sacrum, a bony area of the lower back and spine), and enterocolitis (is a condition that involves inflammation of the small and large intestines, or digestive tract) due to clostridium difficile (is a bacterium that can cause diarrhea, colitis, and other symptoms). Record review of Resident #12's annual MDS assessment dated [DATE] indicated Resident #12 was understood and usually understood others. Resident #12 had a BIMS score of 01 which indicated severe cognitive impairment. Resident #12 was at risk of developing pressure ulcer/injuries. Record review of Resident #12's care plan dated 10/21/24 indicated Resident #12 had a skin concern: Unstageable coccyx. Intervention included administer medication and supplements as needed. During an observation and interview on 11/04/24 at 10:24 a.m., Resident #12 was lying in her bed with her eyes close. Resident #12 only mumbled unintelligible words when greeted. Resident #12 was not interviewable. Resident #12 did not have signage and/or PPE outside her door. During an observation on 11/05/24 at 9:20 a.m., Resident #12 did not have signage to identify the resident was on EBP and/or PPE outside her door. WCN F performed wound care to Resident #12's coccyx without gown. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 11:09 a.m., WCN F said when a resident was on EBP, signs and PPE were placed on and by the resident's door. She said residents with chronic wounds, indwelling catheters, and MDROs were placed on EBP. She said it was important to follow the EBP guidelines and were a gown and glove during care and treatments. She said the gown and gloves helped not spread an infection to the resident and facility. She said EBP was to protect the resident from receiving an infection from the staff. She said when EBP was not used on high-risk resident, it increased the probability of getting an infection. She said the DON was responsible for placing the EBP signage and supplies at the resident's door. During an interview on 11/06/24 at 11:58 a.m., the DON said residents with indwelling catheters, tube feedings, wounds, tracheostomies, and MDROs were placed on EBP. She said Resident #12 had just gotten off contact isolation for C.diff so she removed everything. She said she forgot to place Resident #12 on EBP for her wound. She said staff were supposed to wear a gown and gloves for high contact care. She said EBP was important to prevent the spread of MDROs to the resident. She said when EBP was followed, it placed the resident at risk for getting a MDRO. During an interview on 11/06/24 at 2:19 p.m., the ADM said he expected staff to follow the EBP policy and guidelines. He said a gown and gloves should be worn when in contact with the resident. He said EBP was important to prevent the spread of an infection to the resident. He said the DON was responsible for identifying which residents needed to be placed on EBP and setting up the supplies and signage. He said the DON and ICP should be ensuring staff followed the EBP guidelines and signage and supplies were at the resident's bedside. Record review of a facility Enhanced Barrier Precaution policy and procedure dated 03/27/24 indicated . expand the use of PPE and refer to the use of gowns and gloves during high-contact resident care activities to prevent opportunities for transfer of MDROs to staff hands and clothing .the facility will apply EBP to all residents with any of the following .wounds and/or indwelling medial [sp]devices .post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) .the facility will make the required EBP PPE available near residents' rooms .the staff will wear the required PPE prior to the high contact care activity .the facility will use gowns and gloves for those residents who are on EBP during the following high-contact resident care activities .wound care: pressure ulcers requiring dressing changes .