STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455916	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Nursing and Rehabilitation	4511 Coronado Ave Wichita Falls, TX 76310

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14408 Based on interview and record review the facility failed to provide advance notice of change in services and charges not covered under Medicare for 1 of 3 residents (Residents #45) reviewed for Medicaid and Medicare Coverage Liability Notices. The facility failed to ensure Resident #45's representative was given a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN Form CMS-10055) when he was discharged from skilled services. This failure could place residents and their representatives at risk of not being fully informed about services covered by Medicare. The findings included: Record review of Resident #45's Admission Record, dated 5/17/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #45 had diagnoses which included: congestive heart failure (impairment in the heart's ability to fill with and pump blood); hypertension (high blood pressure); polycythemia vera (rare blood cancer with increased red blood cells that thicken the blood and increase risk for blood clots); anemia; hyperlipidemia (high cholesterol); cerebrovascular disease (condition affecting blood flow and blood vessels in the brain); neuropathy (nerve damage causing weakness, numbness, and pain in hands and feet); chronic atrial fibrillation (irregular heartbeat); hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (left sided weakness following a stroke); and joint pain. Record review of Resident #45's electronic health record census report reflected he was hospitalized from 1/28/2024 to 1/31/2024. Record review of the SNF Beneficiary Protection Notification Review worksheet for Resident #45 revealed he received Medicare Part A Services from 1/31/2024 through 2/19/2024. The resident remained in the facility. The form documented the resident's discharge from Medicare Part A services when benefit days were not exhausted had been voluntary. A SNF ABN, Form CMS-1005 was not provided. A hand-written note documented Resident is private pay and didn't want to go into co-pay days. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/15/24 at 9:51 AM, MDS Coordinator C stated she used the NOMNC and SNF ABN forms for notifying the residents and their responsible parties when skilled care services would end. She stated an IDT meeting was held to determine if skilled care was still needed and a resident's discharge from skilled services needed to be approved by the corporate office. She stated sometimes residents chose to be discharged from skilled services or chose hospice. In an interview on 5/17/24 at 10:57 AM, MDS Coordinator C stated Resident #45 was private pay and had used 20 days of Medicare Part A for skilled nursing care. She stated Resident #45's family member did not want to pay the copay for continued skilled care. She stated she did not have documentation from the conversation with Resident #45's family member. MDS Coordinator C stated she used the beneficiary notice guidelines from AAPACN decision tree. She stated the guidelines did not specify the use of the SNF ABN form when the resident initiated discharge from services and chose to remain in the facility. MDS Coordinator C stated she did not provide a SNF ABN to Resident #45 or his family member. She stated she would contact the corporate regional reimbursement nurse and ask if there was a policy and procedure for determining when and which notification form should be used. During an interview and record review on 5/17/24 at 2:13 PM, MDS Coordinator C stated her corporate regional reimbursement nurse said there was not a policy and procedure for use of the SNF ABN form, just the NOMNC form. She provided a company policy and procedure for NOMNC, which was not dated. The policy and procedure did not include information regarding the SNF ABN form. In an interview on 5/17/24 at 3:18 PM, MDS Coordinator B provided a copy of a policy and procedure for Advanced Beneficiary Notice NOMNC. She stated she was told to give it to the State Surveyor to review. In an interview on 5/17/24 at 3:21 PM, Resident #45 stated he received therapy services earlier this year. He stated the money ran out and he was told he had to stop services. Resident #45 stated he did not really want to stop therapy at that time. Record review of the facility's policy and procedure Advance Beneficiary Notice NOMNC, dated as revised 05/2024, reflected [in part]: ABN Notices are issued under the following circumstances: Part A only CMS 10055 1. On admission to SNF, the beneficiary has a 3-day hospital stay but does not require skilled care. 2. Part A stay will end because, SNF determines the beneficiary no longer requires daily skilled services. Resident has days remaining in benefit period. Resident will remain in facility (custodial care) . The above notices are to be delivered in writing far enough in advance to enable residents to make an informed decision.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944 Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 3 of 7 residents (Residents #5, #15 and #50) reviewed for accuracy of assessments. 1. The facility failed to ensure Resident # 5's MDS accurately reflected the resident's weight gain. 2. The facility failed to ensure Resident # 15's MDS accurately reflected her weight loss or that she received hemo dialysis 3 times a week. 3. The facility failed to ensure Resident #50's MDS accurately reflected her weight loss. These failures could place residents at risk for not receiving care and services to meet their physical needs and promote feelings of well-being and quality of life. The findings include: 1. Record review of Resident #5's admission profile, dated 5/17/24, reflected a [AGE] year-old female who's most recent admitted was 06/16/21. Resident #5 had diagnoses which included: abnormal weight loss, edema (a condition in which fluid collects in the tissues of the body), and hypertension (high blood pressure). Record review of Resident #5's Quarterly MDS, dated [DATE], Section K reflected Resident #5 did not have a significant weight loss or gain of 5% in the last 30 days, or a 10% weight loss of gain within the last 180 days. Record review of Resident #5's care plan reflected the resident had the potential for unplanned weight loss or gain. The problem start date was 3/3/21, and a revision date of 9/6/23. Interventions included: monitor weight per facility protocol. Record review of Resident #5's weights reflected: On 10/03/2023, the resident weighed 134.6 lbs. On 04/01/2024, the resident weighed 147.4 pounds which was a 9.51 % Gain. Record review of nurse's progress notes dated 5/1/24 at 4:43 PM, reflected the following: Resident has weight gain since receiving dental work, resident currently on Lasix 40 mg of Lasix daily with 2+ edema noted to BLE. (Bilateral lower extremities) MD (physician) notified. No new orders. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/17/24 at 12:27 PM, MDS Coordinator B stated she did a Significant Change MDS on 5/16/24 for a weight gain of 13.8 pounds. She stated she must have made an error on the 4/1/24 Quarterly MDS because she just missed the weight change. MDS LVN B stated weight loss or change was communicated to her weekly by the Unit Manager and the DON through a written summary of the Standards Of Care Meeting. She stated she attended the Standards of Care meetings, but normally left the meeting after about 30 minutes into it because she had to go and supervise the smokers. She stated she did not feel her leaving the meeting had anything to do with the failure. She stated failure to document a weight loss or gain could result in the resident not receiving care. 2. Record review of Resident # 15's physician orders dated 5/16/24reflected a [AGE] year-old female who's most recent admitted was 6/9/23. Resident #15 had diagnoses which included: chronic kidney disease, end stage renal disease (condition in which the kidneys are not functioning properly and fail to filter waste and excess fluid from the body), and hypertensive heart disease (high blood pressure). Record review of Resident # 15's Quarterly MDS, dated [DATE], Section K reflected Resident # 15 did not have a significant weight loss or gain of 5% in the last 30 days, or a 10% weight loss of gain within the last 180 days. Section O reflected the resident did not receive hemodialysis or peritoneal dialysis. Record review reflected on 2/2/24, the resident weighed 179.8 lbs. On 3/5/24, the resident weighed 163.8 pounds which is a -8.90 % Loss. Record review of Resident #15's physician orders, dated 4/1/24, reflected: dialysis 3 times a week (3/5/24) and check shunt to left arm for signs and symptoms of infection, bleeding, bruising pulsation, or aneurysm (start date 3/1/24), weekly weight for weight loss (start date 2/29/24). Record review of Resident #15's care plan reflected the following: hemodialysis. Problem initiated 6/27/23. Intervention encourage resident to go for scheduled dialysis treatments. In an interview on 05/17/24 at 03:51 PM, MDS Coordinator B stated I cannot capture dialysis on the MDS without proof from dialysis center, and they will not provide documentation. She stated, We send a binder but 9 times out of 10 there is nothing there. She stated a Significant Change MDS was completed on 3/12/24 for Resident #15 for weight loss, but she should have caught the weight loss on 3/6/24. 3. Record review of Resident #50's admission profile, dated 5/17/24, reflected a [AGE] year-old female who's most recent admitted was 06/16/21. Resident # 5 had diagnoses which included: hypertension (high blood pressure), Protein calorie malnutrition and liver transplant. Record review of Resident #50's Quarterly MDS, dated [DATE], Section K reflected Resident #50 did not have a significant weight loss or gain of 5% in the last 30 days or a 10% weight loss of gain within the last 180 days. Record review of Resident #50's weights reflected: On 11/01/2023, the resident weighed 127.8 lbs. On 05/01/2024, the resident weighed 113.6 pounds which is a -11.11 % loss. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 50's physician orders, dated 5/17/24, reflected an order for Med Pass 2.0 (dietary caloric supplement) 60 cc three times a day. Order 12/29/23. Regular pureed diet pudding consistency 3 times a day. Record review of Resident #50's care plan reflected the following: potential nutritional problem related to dysphagia(difficulty swallowing) initiated 3/18/24. Problem initiated 6/27/23. Intervention monitor resident for signs and symptoms malnutrition, report weight loss or gain of more than 5 percent in one month, 7.5 percent in 3 months, and 10 percent in 6 months (initiated 3/18/24 . Last revised 3/18/24). In an interview on 5/16/24 at 1:00 PM Resident #50's family member stated she had trouble swallowing and was going to see the physician this week to see about getting a peg tube for nutrition. He stated she lost a lot of weight. Record review of the facility's, undated, policy titled MDS Data Accuracy Policy, reflected the following [in part]: The MDS coordinator will receive training to ensure competence in completing the assessment. Federal law requires the assessment accurately reflects the resident's status. Each individual responsible for a portion of the MDS must sign and certify their section of the assessment is accurate and complete. 50133

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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** 27938 Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 2 of 2 residents (Residents #19 and #183) reviewed for respiratory care. 1. The facility failed to ensure Residents #19 and #183's oxygen tubing was changed weekly. 2. The facility failed to ensure Residents #19 and #183's nasal cannula and nebulizer were kept in a bag while not in use. These failures could place residents at risk for infections and transmission of communicable diseases. The findings include: 1. Record review of Resident #19's face sheet, dated 05/17/2024, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. Resident #19 had diagnoses which included Hypertension (high blood pressure), Shortness of breath, Depression, Anxiety , chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe). Record review of Resident #19's MDS admission assessment, dated 05/17/2024, reflected a BIMS score of 06, which indicated severe cognitive impairment. Section I: Active diagnosis reflected chronic pulmonary disease, or chronic lung disease. Section O: Respiratory Treatments was marked for Oxygen Therapy. Record review of Resident #19's Physician Orders, dated 05/17/2024, reflected an order for Oxygen at 3 - 4 liters per minute via nasal cannula and nebulizer treatments two times daily. Change oxygen and nebulizer tubing weekly on Sunday. Record review of Resident #19's quarterly Care Plan, 05/09/2024 , reflected a care plan for has COPD (obstructive pulmonary disease) - Oxygen at 2- 4 liters per minute continuously to keep oxygen saturation above 92%. The Care Plan did not have an intervention regarding when oxygen tubing needed to be changed. In an observation on 05/15/2024 at 11:30 AM revealed Resident #19 was sitting in the dayroom in her wheelchair. Her nasal cannula was uncovered and hanging over the bed rail in her room with the nose prongs on floor . 2. Record review of Resident # 183's face sheet, dated 05/17/2024, reflected a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #183 had diagnoses which included dementia (memory loss), Hypertension (high blood pressure), Pneumonia (Inflammation of the air sacs in the lungs), Muscle wasting, Shortness of breath, Depression,(a group of conditions associated with the elevation or lowering of a person's mood) Anxiety , (A feeling of fear, dread, and uneasiness) chronic obstructive pulmonary disease (a lung disease that block airflow and make it difficult to breathe). (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 #183's MDS admission assessment, dated 05/17/2024, reflected a BIMS score of 99, which indicated severe cognitive impairment. Section I: Active diagnosis reflected chronic pulmonary disease, or chronic lung disease. Section O: Respiratory Treatments was marked for Oxygen Therapy. Record review of Resident #183's Physician Orders dated 05/17/2024 revealed an order for Oxygen at 2 liters per minute via nasal cannula and nebulizer treatments three times daily. Change oxygen and nebulizer tubing weekly on Sunday. Record review of Resident #183's admission Care Plan, dated 05/17/2024, reflected a care plan for [Resident #183] has COPD (obstructive pulmonary disease) - Oxygen at 2- 4 liters per minute continuously to keep oxygen saturation above 92%. The Care Plan did not have an intervention regarding when oxygen tubing needed to be changed. In an observation and interview on 05/14/2024 at 09:45 AM, during initial rounds, Resident #183 was lying in his bed receiving oxygen via nasal cannula at 2 liters per minute. His nebulizer was sitting on the nightstand uncovered. He could not recall when the oxygen tubing was last changed . 41944

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42852 Based on observation, interview, and record reviews , the facility failed to provide food and drink that was palatable, attractive, and at a safe and appetizing temperature for one of one meal reviewed for palatable meals and preferred temperatures. The facility failed to ensure that the food was appetizing temperature, flavor, and texture. The deficient practice could affect the residents who received their meals from the kitchen by contributing to poor intake of nutrition, weight loss, and illness. This finding include: In an observation on 5/16/24 at 11:50 AM the holding food temperatures were as follows: Chicken corn casserole -154 F. Rice -158 F. Beans -148 F. Kool-aide with melted ice, a temperature was not obtained. In an observation on 05/16/24 at 01:27 PM of a sample test tray with Cook E present, revealed the following: Chicken corn casserole was at 110 degrees F, The warmth of the casserole was room temperature and not appetizing. The rice was gummy and not flavorful . The rice was difficult to swallow due to the texture. Kool-aide was room temperature and with melted ice. In an interview on 5/16/24 at 1:30 PM, Cook E said she had trouble with residents not liking the Kool-aide if the ice had melted and the drinks were watered down. In an interview on 05/14/24 at 10:04 AM, MDS Nurse B stated she had been working at the facility for [AGE] years. She said the food was consistently cold that was served down the halls. She said it had been an ongoing problem. In an interview on 05/17/24 at 11:15 AM with the DON she said the cold food and kitchen issues had been an ongoing issue and they were implementing things to improve cold food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/17/24 at 11:30 AM, the Regional Compliance Nurse said they have known about the problems with the food. She said this was addressed in the Resident Council and with other residents on the halls. She said they completed a training about using plate warmers and she said they needed to be more efficient during mealtimes. In an interview on 05/17/24 at 03:45 PM with the Administrator, she revealed the cold food was an ongoing issue. She stated she tried changing the order the hall meal tray carts were being sent from the kitchen so the Hall 400 residents would not feel they always came last. The Administrator mentioned in the Resident Council meetings the food was frequently a concern. In a record review of the facility's Dietary Services & Policy & Procedure Manual 2012: FP 00-10.0 reflected the following [in part]: Under section 4. Every attempt will be made to honor resident food preferences . Under section 8. The menu will reflect the needs of the resident population as well as input from residents and resident groups.

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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** 42852 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 in one of one kitchen reviewed for nutrition services. 1. The facility failed to ensure opened food were sealed in the nonperishable food storage room. 2. The facility failed to ensure temperature logs were kept for the refrigerator and freezer. 3. The facility failed to ensure the refrigerator had an internal thermometer. 4. The facility failed to ensure dishwashing logs were kept. 5. The facility failed to ensure staff followed proper hygiene during food prep and distribution. These failures could place residents at risk for decline in nutritional health status and foodborne illness. The findings include: In an observation and interview on 05/14/24 at 08:45 AM, during the initial tour of the kitchen, revealed the following: Trash can had a lid that did not fit, and hands had to be used to remove lid. There was a large, concentrated bag of orange Juice in a box on top of trash can lid. Dietary Aide G did not have all of her hair inside her hairnet. The temperature logs for two freezers had no temperature checks since 5/7/24 recorded. The refrigerator did not have a thermometer inside refrigerator and there was no log on the fridge. Cook E looked for an internal thermometer in the fridge and she could not find one. She said, there should be a thermometer inside the refrigerator and the temperature log should be hanging on the side of fridge. Dry Food Storage Pantry 1 bag of elbow macaroni which was opened in the dry pantry and was not sealed. Vienna [NAME] on the floor. Dish washing Machine Area (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dishwashing machine had no record of chemical usage checks. Cook E said there was no dishwashing machine checklist , and there should have been a log hanging on the wall next to the dishwasher. Above the dish machine was a vent in the ceiling with thick white paint peeling and dropping down above the dishwasher. A cart for clean trays was dirty with food and had dried grime particles on the top self which held clean plates. Stove Area The stove had food and residue dried and caked onto the burners and grill. The vent a hood above the stove had a thick looking dark grease caked on. In an observation and interview of kitchen on 05/14/24 10:21 revealed: Food and grime caked on the counter that held clean dishes. Dietary Aide H pulled cups from clean side of dish washing machine that were full of discolored water, then dumped the fluid from the cups, then stacked them in the clean area. Dietary Aide I put the utensils that were stacked on each other and pulled the tray to the dirty side of dishwashing area that had pink residue sitting on all parts of sink next to dishwasher. In an interview on 05/14/24 at 10:25 AM, the Regional Dietician stated the facility had a new dietary manager who started that day. She explained they were in the process of addressing numerous kitchen issues. In an interview on 5/14/24 at 10:26AM, Dietary Aide I stated she thought she was responsible for checking breakfast and lunch dishwashing chemicals on the machine when she worked. In an observation on 5/14/24 at 11:00 AM revealed Dietary Aide G got supplies to serve lunch and there were food particles and grime dried on the clean rolling cart where clean utensils were being held. In an observation and interview on 5/16/24 at 11:15 AM , a cart behind the prep table where the puree was being processed had clean ladles on the cart which had food and grime dried on shelves and sides. The Dietary Manager said they were not meeting cleaning requirements and the cart holding the clean items was not considered clean . 05/16/24 11:20 AM in an interview with the Dietary Manager said the dish machine should be checked for sanitation chemicals before and after each meal. In an observation and interview on 5/16/24 at 11:30 AM , a daily cleaning schedule hanging on wall not signed for past week. Dietary Manager said the cleaning schedule did not have day or month and had not been signed since last dietary manager was let go 1 week ago. Dietary Manager did not consider the serving cart clean. She also said they had not been doing kitchen cleaning according to schedule that is on the wall. (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 observation on 05/16/24 at 12:38 PM Dietary Aide H pulled her cell phone out of her pocket and put it back in her pocket. Dietary Aide H did not wash her hands. Dietary Aide H started serving trays without gloves. In an observation on 05/16/24 at 12:40 PM revealed Dietary Aide G was handling food and utensils and had extremely long painted acrylic nails and did not wear gloves. In an observation on 05/16/24 at 12:48 PM revealed Dietary Aide H touched her nose and continued preparing trays and utensils with her bare hands without performing hand hygiene . In an interview on 05/16/24 at 12:50 PM with Dietary Manager, She said hand sanitation should always be performed after touching contaminated surfaces. In an observation on 05/16/24 at 12:53 PM Cook D lost her hair net which was slipping off over a 10-minute period. She picked the hair net up off floor and placed it on her head. Cook D did not perform hand hygiene and continued making sandwiches at prep table. In an observation on 05/16/24 at 12:57 PM revealed Dietary Aide H removed her gloves after washing dishes and did not perform hand hygiene and continued preparing meals for the halls. In an observation on 5/16/24 at 1:00 PM Cook D removed her gloves and placed them on the prep table. Cook D went into the walk-in fridge grabbed some supplies and re-gloved, while her last set of soiled gloves laid in the prep area. Cook D did not perform hand hygiene and was preparing sandwiches. In an observation on 5/16/24 at 1:03 PM revealed Dietary Aide H scratched her face and got applesauce. She wiped sauce that had gotten onto her hand onto her pants . In an observation on 05/16/24 at 1:16 PM revealed Dietary Aide H scratched her face and continued working without performing hand hygiene . In an interview on 5/16/24 at 01:35 PM with the Regional CDM, she said, If dietary staff have acrylic nails, they must be short. Nails were not to have polish on them She said They must wear gloves. Her expectation was that when gloves were removed, they should be placed in the trash and hand hygiene should follow. In an interview on 5/17/24 at 11:15 AM, DON said there had been an ongoing dietary issue. In an interview on 5/17/24 at 11:30 AM, the RN Compliance Nurse said hand hygiene should be performed when touching surfaces that were not clean including touching their face. In an interview on 05/17/24 at 03:45 PM, with the Administrator revealed hand hygiene for kitchen staff . should be common sense. She said At minimum when going from resident to resident, touching dirty areas and when changing gloves. In a record review of the facility's Dietary Services Policy & Procedure Manual 2012 Under Food Storage and Supplies (I-C 00-8.0) reflected [in-part]: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455916	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Nursing and Rehabilitation	4511 Coronado Ave Wichita Falls, TX 76310

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. Procedure: 4. Open packages of food are stored in closed containers with covers or in sealed bags. Equipment Sanitation (IC 00-6.0) [in-part]: We Will provide clean and sanitized equipment for food preparation. The facility will clean all food service equipment in a sanitary manner. Procedure: 1. Thermometers must be available in refrigerators . 2. Food carts will be cleaned and sanitized after each meal. 3. Grease filters should be cleansed routinely with detergent as needed to remove obvious grime. 4. Pots and pans: c. Effective concentration of a suitable detergent shall be used. e. All equipment and utensils shall be thoroughly rinsed free of detergent solution. 7. Facilities shall use an approved test kit to measure the parts per million of the chemicals . Records of test results should be kept on the temperature/chemical log. 8. Blenders and food processor bowls should be inverted after cleaning to drain dry on shelves or trays with vented slots or bar netting. Record review of facility policy labeled Hand Hygiene, not dated, [in-part]: 1. Hand Hygiene Hand hygiene continues to be the primary means of preventing the transmission of infection. When to perform hand hygiene . After blowing or wiping nose. . After touching garbage

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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** 42852 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 3 residents (Resident #60) reviewed for infection control. 1. The facility failed to ensure CNA A washed or sanitized her hands before feeding Resident #60. 2. The facility failed to ensure CNA A did not make contact with her own face, hair, and other objects while feeding Resident #60. These failures could place residents at risk of infections. The findings include: Record review of Resident #60's face sheet, dated 5/20/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #60 had diagnoses which included: cerebral palsy (a condition present a birth which leads to poor coordination, and stiff, loose or weak muscles), protein calorie malnutrition (a state in which a decrease in nutrients, proteins and calories leads to changes in body composition and function), intellectual disability (a term used to describe a person with certain limitations in cognitive functioning and other skills) and dysphagia (difficulty swallowing). Record review of Resident #60's MDS assessment, dated 2/8/2024, reflected in Section GG the resident was dependent with meals (helper does ALL of the effort. Resident does none of the effort to complete the activity.) During an observation on 05/14/24 at 12:26 PM revealed Resident #60 was sitting at the assisted feeding table and needed assistance with meal intake. CNA A was asked by the DON to feed Resident #60; CNA A did not perform hand hygiene. CNA A rubbed her nose and face before and during feeding Resident # 60, and never performed hand hygiene. CNA A grabbed her own hair and pulled it out of her face and continued to feed Resident #60 after she picked a napkin up off the table and wiped his mouth. During an interview on 05/14/24 at 12:40 PM, CNA A stated she washed her hands before feeding Resident #60, and she did not know of anything she did wrong while feeding the resident. She stated she did not know what negative outcome for the resident could occur if hand hygiene was not performed after touching her hair or face. She also stated she did not know when the last in-service on hand washing, or infection control was. She stated she did not normally carry or use sanitizer when feeding. During an interview on 05/14/24 at 12:45 PM, the DON stated her expectation was that hand sanitizer be used by all personnel as part of infection control when feeding and after touching faces, hair or other objects. She stated failure to do so could cause infection. Record review of the facility's policy titled Fundamentals of Infection Control Precautions, dated as revised 03/24, reflected the following [in part]: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hand hygiene continues to be the primary means of preventing the transmission of infection. Hand hygiene should be used in the following situations - before and after assisting a resident with meals, after blowing or wiping your nose, after handling soiled equipment or utensils, after performing your hand hygiene, after contact with resident's mucus membranes, after coming in contact with a resident's intact skin