STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on interview and record review, the facility did not ensure that the resident assessment accurately reflected the residents' status. Specifically, for 2 out of 38 sampled residents, the facility indicated on the resident assessment that the residents did not have a serious mental illness despite the residents' Preadmission Screening and Resident Review (PASRR) level II assessments that documented the residents had a serious mental illness. Resident identifiers: 45 and 68. Findings Included: 1. Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, paranoid schizophrenia, generalized anxiety disorder, post-traumatic stress disorder, and major depressive disorder recurrent moderate. Resident 45's medical record was reviewed on 3/17/25 through 3/20/25. Resident 45's admission Minimum Data Set (MDS) assessment dated [DATE], was reviewed. The response to Question A1500 on the assessment, which stated, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? was marked as no. Resident 45's PASRR level II dated 4/22/24, was reviewed. The PASRR level II evaluator indicated that resident 45 was seriously mentally ill. 2. Resident 68 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, anxiety disorder and schizoaffective disorder depressive type. Resident 68's medical record was reviewed on 3/17/25 through 3/20/25. Resident 68's admission MDS assessment dated [DATE], was reviewed. The response to Question A1500 on the assessment, which stated, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? was marked as no. Resident 68's PASRR level II dated 11/15/24, was reviewed. The PASRR level II evaluator indicated that Resident 68 was seriously mentally ill. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 3:36 PM, an interview was conducted with the MDS Coordinator. The MDS coordinator stated that a previous MDS coordinator had completed the assessments for the two residents and that she would need to review the assessments. The MDS coordinator stated that some examples of diagnoses that would indicate for her to mark that a resident had a serious mental illness on the resident's assessment included autism and epilepsy.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure residents received the appropriate treatment and assistive devices to maintain vision and hearing abilities. Specifically, for 2 out of 38 sampled residents, a resident with impaired vision had a referral sent to the eye doctor in January and the resident had not see the eye doctor. In addition, a resident with vision and hearing concerns . Resident identifiers: 2 and 63. Findings included: 1. Resident 63 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, type 2 diabetes mellitus without complications. On 3/17/25 at 11:12 AM, an interview was conducted with resident 63. Resident 63 stated the facility told her that someone would be in for the glasses but she had not heard anything. Resident 63 stated that she hoped she did not miss them because she needed new glasses. Resident 63 stated that she told someone that she needed new glasses but could not remember who. Resident 63's medical record was reviewed on 3/18/25 through 3/20/25. On 1/28/25 at 9:21 AM, a Social Service Note documented Note Text: Referral sent to [name redacted] vision and dental. Resident declined hearing services at this time. On 2/3/25 at 8:53 AM, a Minimum Data Set (MDS) Note documented Note Text: Resident assessed today for functional abilities. Resident has impaired vision with glasses. Resident has been added to the eye doctor list per her request, and social services has been notified to provider [sic] her with new glasses. On 3/19/25 at 8:32 AM, an interview was conducted with the Resident Advocate (RA). The RA stated if a resident requested that they wanted to see vision she would present them with two options. The RA stated the resident could either see the in-house vision provider or they could make an appointment with an outside optometrist. The RA stated if the resident requested to see an outside provider Transportation would schedule the appointment. The RA stated she was unsure if resident 63 was seen for vision and would need to check with the in-house vision provider to see what the recommendation was and or if the resident was seen. On 3/19/25 at 9:50 AM, a follow up interview was conducted with the RA. The RA stated that she confirmed with the in-house vision provider that they received the referral for resident 63. The RA stated that the in-house vision provider had not updated their data census which indicated who was on dental, hearing, and vision. The RA stated that she would send the referral and the in-house vision provider would come into the building. The RA stated when the in-house vision provider came back to the facility the provider would see who wanted to be on services. The RA stated that the in-house vision provider came to the facility on ce a quarter. The RA confirmed that it was not appropriate for a resident to wait a quarter to be seen if they needed glasses. 50200 (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 2 was admitted to the facility on [DATE] with diagnoses which included, chronic obstructive pulmonary disease, heart failure, dysphagia, and cognitive communication deficit. On 3/17/25 at 10:37 AM, an interview was conducted with resident 2. Resident 2 stated she did not receive a vision assessment, new glasses, hearing aid evaluation, or dental care during her stay at the facility. Resident 2's medical record was reviewed. On 1/15/25 at 12:21 PM, a Minimum Data Set Note documented, Resident assessed today for functional abilities. Resident reports she has difficulty hearing with background noise and would like hearing aids. Resident reports she has lost her glasses and would like new ones to be able to read. Social services notifiedof [sic] resident's request for hearing aids and glasses. Resident is able to speak clearly and understand others. Social services notified of request. On 3/20/25 at 8:53 AM, an interview was conducted with the RA. The RA stated that a different social worker handled referrals when resident 2 was admitted . The RA stated she was unaware of the request and had not submitted a referral for services. The RA stated that dental services visit monthly, based on resident needs, and optometry and hearing services visit quarterly. The RA stated she would look to see if resident 2 had the referrals sent in. On 3/20/25 at 9:41 AM, a follow-up interview was conducted with the RA. The RA stated resident 2 had not yet been referred. The RA stated she typically submitted referrals immediately once informed but noted the previous social worker was responsible to do this at the time. The RA stated she would now follow through to ensure resident 2 was referred for services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 1 out of 38 sampled residents, a resident that was a high fall risk did not have interventions implemented to prevent future falls. Resident identifier: 81. Findings included: Resident 81 was admitted to the facility on [DATE] with diagnoses which included, dementia, rheumatism, chronic pain syndrome, and essential hypertension. Resident 81's medical record was reviewed on 3/17/25 through 3/20/25. An admission Morse fall risk assessment was performed on 12/16/24. Resident 81's Morse score was 90. A score of 45 and higher indicated a high-risk for falling. A review of resident 81's care plan interventions for falls revealed: a. Answer call lights promptly. Date initiated: 2/15/25. b. Clean up spills immediately. Date initiated: 2/15/25. c. Educate resident to use wheelchair. Date initiated: 3/12/25. d. Encourage resident to stay in common area while during awake hours. Date initiated: 3/5/25. e. Ensure resident was in the center of bed during rounds. Date initiated: 3/15/25. f. Ensure resident was not seated too close to edge of bed prior to transfers. Date initiated: 3/17/25. g. Visible sign to the back of the door to remind resident to use his call light or call for assistance. Date initiated: 2/15/25 and revised on: 2/17/25. On 3/17/25 at 10:05 AM, an observation was made of resident 81. Resident 81 was observed ambulating in his room without a walker. His pant legs were under his shoes, and he repeatedly tried to pull up his pants while walking. No staff were observed in the hallway at the time. Resident 81 had purplish-yellow discolorations under both eyes. There was no signage indicating that the resident should use his call light for assistance. On 3/18/25 at 7:50 AM, an observation was made of resident 81 in the dining area of the unit. Resident 81 was observed to stand up out of his wheelchair and ambulate to a dining room chair without assistance. There were no staff present in the dining room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 1:08 PM, an observation was made of resident 81 ambulating in his room without a walker. Resident 81 was observed to be wearing pants with the pant legs under his shoes. No staff were observed to be in the hallway. There was no signage indicating that the resident should use his call light for assistance. A review of the facility's incident reports revealed the following: a. On 2/15/25, an incident report documented, . Patient was in room with CNA [Certified Nursing Assistant]. CNA reports trying to organize room and prepare resident for cares. Patient's son was outside of room and prompted to keep door shut for cares. CNA reports resident was in room and wheeled over to door and tried to open the door. Resident reached to open the door and fell out of wheelchair. Patient suffered swelling and abrasion to left eyebrow and orbital area. Patient has abrasion to nose and medial part of forehead. Patient has abrasion to right tibia. Interventions put in place after the fall: Place sign reminding resident to use call light and ask for assistance. b. On 3/2/25, an incident report documented, . Resident in bedroom & [and] while standing next to his w/c [wheelchair] he reached to get the tissue box that was on the w/c seat & then lost his footing & fell down on his buttock first then on his left side and arm as went backwards to then being in laying position. No injuries noted & V/S [vital signs] stable & Neuro [neurological] check WNL [within normal limits] of baseline. Assisted by staff onto recliner chair in bedroom. States that Lt [left] lateral upper arm sore. Interventions put in place after the fall: Intervention was to keep resident in common areas while awake as able. c. On 3/12/25 an incident report documented, . Resident was found on the floor on his left side between the bed and his bedside table. He stated that he was going to turn down the temperature in his room, when he lost balance and he slipped. He complained of pain in his left forearm, it is red, but no other obvious injury. He hit his left ear, it is red and has a tear around the base of the outer ear next to the scalp. Nurse tried to clean it and apply bacitracin but he refused. VS within his normal range. Nurse was able to assist him up and back into his chair. He refused to come to the day, but the nurse then asked PT [physical therapy] to help and got him back into his chair so we can watch him better. He is not happy about staying in the dayroom. Interventions put in place after the fall: Educate the resident to use wheelchair instead of ambulating by himself. d. On 3/15/25 an incident report documented, . CNA was assisting resident getting ready for the day. Resident slid out of bed and landed on buttocks. Bed was in the lowest position possible. Patient has a small abrasion to right lower extremity by knee and hip. First aide [sic] was applied. Patient did not hit head or back. Patient rates pain 0/10 post fall. Patient's vitals were WNL. Interventions put in place after the fall: Ensure the resident was not sitting on the edge of the bed prior to transfers. On 3/19/25 at 8:55 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that resident 81 was a fall risk and needed to be checked on often. RN 2 stated that resident 81 needed to stay in the common area, but was independent and preferred to be in his room. RN 2 stated that resident 81 walked with a shuffling gait and required assistance when he was ambulating. RN 2 stated she often walked behind resident 81 when he used his walker to ensure that he did not fall down. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 9:46 AM, an interview was conducted with CNA 2. CNA 2 stated that staff were expected to remain in the hallway to monitor resident 81 and watch for his call light. CNA 2 stated resident 81 needed checks every 5 to 10 minutes due to his high fall risk. CNA 2 stated resident 81 was unsteady and did not use his walker and had fallen multiple times. CNA 2 stated staff tried to keep resident 81 in the common area for closer supervision, but he often returned to his room on his own. On 3/20/25 at 8:13 AM, an interview was conducted with RN 3. RN 3 stated that resident 81 walked with a shuffle or like his feet overlapped. RN 3 stated that resident 81 was supposed to use a walker when walking, but liked to walk around his room without it. RN 3 stated that resident 81 should be in the common area during the day. On 3/20/25 at 11:21 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 81 had fallen since arriving at the facility. The DON stated he was unsteady and required a walker. The DON stated a sign in his room reminded him to use the call light for assistance. The DON stated staff encouraged resident 81 to stay in the common area during the day. The DON stated there were two CNAs on the unit but planned to increase to three due to a rise in resident falls. On 3/20/25 at 11:27 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated that she had educated the CNA's on the need to monitor residents in their rooms and round frequently. ADON 1 stated that the facility had added a shift for an extra CNA for the day due to increased falls from resident 81. It should be noted that the nursing administration staff did not know that resident 81 did not have a sign hanging in his room to use his call light.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on interview and record review, the facility did not ensure that the resident's drug regimen was free of unnecessary drugs without adequate monitoring. Specifically, for 1 out of 38 sampled residents, nursing staff administered blood pressure lowering medications to the resident when the resident's blood pressure was outside of the parameters specified by a physician's order. Resident identifier: 40. Findings Included: Resident 40 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, essential primary hypertension, type 2 diabetes mellitus with hyperglycemia, mixed hyperlipidemia, and severe morbid obesity due to excess calories. Resident 40's medical record was reviewed on 3/17/25 through 3/20/25. A physician's order with a start date of 11/26/24, stated, HydroCHLOROthiazide Oral Tablet 25 MG [milligrams] (Hydrochlorothiazide) Give 100 mg by mouth one time a day for HTN [hypertension] Hold for SBP [systolic blood pressure] < [less than]110 or HR [heart rate] < 60. A physician's order with a start date of 1/3/25, stated, Metoprolol Succinate Oral Capsule ER [extended release] 24 Hour Sprinkle 25 MG (Metoprolol Succinate) Give 50 mg by mouth two times a day for HTN Hold for SBP <110 or HR <60. The Medication Administration Record was reviewed for March 2025. a. On 3/1/25 at 8:00 PM, the SBP was measured as 90. Resident 40 received the 50 mg dose of metoprolol succinate. b. On 3/16/25 at 8:00 PM, the SBP was measured as 101. Resident 40 received the 50 mg dose of metoprolol succinate c. On 3/16/25, the SBP was measured as 101. Resident 40 received the 100 mg dose of hydrochlorothiazide. On 3/20/25 at 8:51 AM, an interview was conducted with Registered Nurse (RN) 4 and RN 5. RN 4 and RN 5 stated that they would not administer a blood pressure lowering medication if a resident's blood pressure was below the number specified in a physician's order. RN 4 and RN 5 stated that if a resident's blood pressure was outside the parameters specified by a physician's order, they would hold the medication and notify the physician. On 3/20/25 at 2:42 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that if a resident's blood pressure was outside of the parameters established by a physician's order for blood pressure lowering medications, then she would expect the nurses to hold the medication and notify the physician of the blood pressure.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure the residents were free of any significant medication errors. Specifically, for 1 out of 38 sampled residents, a resident's physician order for oxycodone was transcribed to the wrong resident's Medication Administration Record (MAR) and that resident received five doses of the medication. Resident identifier: 60. Findings included: Resident 60 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, osteomyelitis of vertebra, cauda equina syndrome, stimulant abuse, and discitis. On 3/17/25 at 2:45 PM, an interview was conducted with resident 60. Resident 60 stated that she had not had her pain medications since 3/4/25, because her pain medications were not available. Resident 60's medical record was reviewed on 3/18/25 through 3/20/25. The March 2025 MAR was reviewed. The following documentation was related to pain. a. A physician's order dated 3/4/25 at 4:00 PM, documented oxyCODONE HCl [hydrochloride] Oral Tablet 5 MG [milligrams] (Oxycodone HCl) Give 1 tablet by mouth every 4 hours for aching pneumonia for 5 Days. Resident 60 received four doses prior to the physician's order being discontinued on 3/5/25 at 9:13 AM. b. A physician's order dated 3/5/25 at 1200 PM, documented oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 4 hours for aching pneumonia for 5 Days Crush Narcotics and verify they are swallowed. Resident 60 received one dose prior to the physician's order being discontinued on 3/5/25 at 12:42 PM. On 3/20/25 at 8:20 AM, an interview was conducted with Assistant Director of Nursing (ADON) 2. ADON 2 stated the Nurse Practitioner would email the facility the physician orders. ADON 2 stated the initial oxycodone physician order on 3/4/25, was the wrong order. ADON 2 stated she spoke with the Medical Director (MD) on 3/5/25, and the physician order was discontinued. ADON 2 stated the nurse on the night of 3/4/25, called her and was worried that resident 60 was not taking the oxycodone and might be diverting the medication. ADON 2 stated that was why a crush physician order was put in place on 3/5/25. ADON 2 stated she spoke to the MD on 3/5/25, regarding changing the physician order from every four hours to three times daily (TID). ADON 2 stated the TID order was never implemented because she realized the physician orders got mixed up with another resident's physician orders. ADON 2 stated resident 60 was not supposed to be on oxycodone. ADON 2 stated that she spoke to resident 60 about the mistake when it happened. ADON 2 stated when the physician orders were emailed to the facility, herself and the other ADON would split the physician orders and enter them into the resident's MAR but now only one of them would input the physician orders to prevent mistakes. ADON 2 stated when the physician orders were emailed on the day of the mistake there were three pages and page two and three got out of order.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview, and record review, the facility did not provide or obtain outside resources for routine or emergency dental services to meet the needs of the resident. Specifically, for 1 out of 38 sampled residents, a resident was not provided dental services for missing teeth. Resident identifier: 2. Findings included: Resident 2 was admitted to the facility on [DATE] with diagnoses which included, chronic obstructive pulmonary disease, heart failure, dysphagia, and cognitive communication deficit. On 3/17/25 at 10:37 AM, an interview was conducted with resident 2. Resident 2 stated she had not received a vision assessment, new glasses, hearing aid evaluation, or dental care during her stay at the facility. On 1/15/25 at 12:21 PM, a Minimum Data Set Note documented, Resident assessed today for functional abilities. Resident reports she has difficulty hearing with background noise and would like hearing aids. Resident reports she has lost her glasses and would like new ones to be able to read. Social services notifiedof [sic] resident's request for hearing aids and glasses. On 3/20/25 at 8:53 AM, an interview was conducted with the Resident Advocate (RA). The RA stated that a different social worker handled referrals when resident 2 was admitted . The RA stated she was unaware of the request and had not submitted a referral for services. The RA stated that dental services visited monthly, based on resident needs, and optometry and hearing services visit quarterly. The RA stated she would look to see if resident 2 had the referrals sent in. On 3/20/25 at 9:41 AM a follow-up interview was conducted with the RA. The RA stated resident 2 had not yet been referred. The RA stated she typically submitted referrals immediately once informed but noted the previous social worker was responsible to do this at the time. The RA stated she would now follow through to ensure resident 2 was referred for services.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on observation and interview, the facility did not provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Specifically, surveyors observed two meals that were served late, multiple residents complained of late meals during the initial pool, and there were grievances filed by residents about late meals. Resident identifier: 2 and 44. Findings Included: The posted facility meal times posted outside of the main dining room were as follows: Breakfast: 7:30 to 8:30 AM Lunch: 11:30 AM to 12:30 PM Dinner: 4:30 to 5:30 PM The facility serves residents who eat in their rooms first and then serves residents who choose to eat in the dining room after. On 3/17/25, an observation was made of the breakfast meal service at the facility. The facility did not finish serving residents in the dining room until 8:52 AM. The last breakfast tray for the Colonial hall was not served until 8:48 AM. On 3/18/25, an observation was made of the dinner meal service at the facility. The facility did not begin plating and loading meal trays onto the delivery carts until 4:52 PM. The facility did not finish serving residents in the dining room until 5:53 PM. The last dinner dray for the Cambridge hall was not served until 5:40 PM. The last dinner tray for the Colonial hall was not served until 5:57 PM. On 3/13/25 at 8:25 AM, an interview was conducted with the Ombudsman. The Ombudsman stated there had been some continuing concerns at the facility including the quality of food and dining times. The Ombudsman stated that residents had complaints about the food quality, not enough food, and the food tasting bad. The Ombudsman stated that several residents have reported that the meals were served late, especially dinner. The Ombudsman stated that she had been told that dinner was not served to some residents until 7:00 PM. On 3/17/25 at 10:37 AM, an interview was conducted with resident 2. Resident 2 stated that the kitchen was understaffed and she had to wait until after 5:30 PM, to receive dinner. On 3/17/25 at 12:45 PM, an interview was conducted with resident 44. Resident 44 stated that she had no concerns about the food served at the facility other than the food timing. Resident 44 stated the facility was pressed to get the food out and there was not enough workers. (continued on next page)

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	465117	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24, a resident at the facility filed a Grievance/Complaint Report. The report stated, [Resident name redacted] expressed that he received a bagged lunch (sandwich and chips) for lunch on the weekend instead of a hot lunch. He was told it was due to kitchen being short handed. On 2/10/25, two residents at the facility filed a Grievance/Complaint Report. The report stated, Residents feel that dinner has been served late and the food was cold. On 2/18/25, a resident at the facility filed a Grievance/Complaint Report. The report stated, Dinner is coming out late impacting ability to attend family home evening. On 3/19/25 at 7:31 AM, an interview was conducted with the Administrator. The Administrator stated that the facility used to have three staff members working in the kitchen at night, but the facility census dropped and the extra staff had nothing to do. The Administrator stated that the facility was trying to staff the kitchen higher. The Administrator stated the facility should start plating meals 15 minutes prior to a meals starting time. On 3/19/25 at 9:35 AM, an interview was conducted with the Dietary Manager (DM). The DM stated when dietary staff at the facility were hired, they completed a three day training program with another dietary staff member. The DM stated that after the three day training was completed, the new dietary staff member completed a post training checklist. The DM explained the process the kitchen used to ensure meals that were served on time at the facility. The DM stated that the cook was responsible for following the spreadsheet on the tray table to ensure that meals were served timely. The DM stated that the facility recently lost two kitchen staff members, including one who had worked at the facility for over [AGE] years. The DM stated that staff in the kitchen had been stretched thin due to an increase in the facility census. The DM stated that after recently hiring additional evening kitchen staff, she felt that the facility had enough dietary staff. The DM stated that the facility has had difficulties with potential employees accepting job offers, but then not showing up on their start date. The DM stated that meals were served late because steps were missed in the training program for new kitchen staff. The DM stated that there was usually one cook and two dietary aides working in the kitchen in the evening. The DM stated that timeliness was the missing piece of the puzzle to ensuring that meals were served on time. On 3/20/25 at 7:29 AM, an additional interview was conducted with the Administrator. The Administrator stated that breakfast was served late on 3/17/25 because the cook scheduled to work the shift did not show up. 50200 33215

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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. 47432 Based on observation and interview, the facility did not ensure that each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature. Specifically, surveyors sampled a test tray and found it to not be palatable, there were concerns about the palatability of the food served at the facility identified during the initial pool interviews, and there were grievances filed by residents about the food served at the facility. Resident identifiers: 2, 26, 40, 63, and 72. Findings Included: On 3/17/25 at 10:41 AM, an interview was conducted with resident 2. Resident 2 stated that most of the time the food served at the facility tasted bad. On 3/17/25 at 11:01 AM, an interview was conducted with resident 40. Resident 40 stated that sometimes the food was not so bad, but other times it was so bad he would rather not eat. Resident 40 stated that the food served at the facility was worse on the weekends. On 3/17/25 at 11:08 AM, an interview was conducted with resident 63. Resident 63 stated the food was normally good but every once in awhile it was on the yuck. On 3/17/25 at 1:20 PM, an interview was conducted with resident 26. Resident 26 stated the food served at the facility was not the best. Resident 26 stated on Christmas day she was served cold cheese pizza. Resident 26 stated that all of the soups served at the facility were watered down. On 3/18/25 at 8:38 AM, an interview was conducted with resident 72. Resident 72 stated that the potato soup served at the facility tasted like potato and water. On 11/4/24, a resident at the facility filed a Grievance/Complaint Report. The report stated, [Resident name redacted] expressed that colonial [name of unit at facility] often does not get full menu item [sic], english muffins are hard, kitchen freq. [frequently] out of coffee. On 2/10/25, two residents at the facility filed a Grievance/Complaint Report. The report stated, Residents feel that dinner has been served late and the food was cold. On 3/18/25 at 5:53 PM, surveyors sampled a test tray of the dinner served at the facility. The meal consisted of chicken tenders, onion rings, pickled beets, and a fruit cup. The onion rings were soggy. The beets were not pickled as described on the menu. The beets were very wet and beet juice had dripped onto the onion rings. On 3/19/25 at 9:35 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that food complaints were addressed in the facility food council and that she provided frequent training to the kitchen staff. The DM stated that kitchen staff should follow the instructions left on a spreadsheet to prepare meals. The DM stated that each resident had a tray card that listed their diet order, diet texture, and any other pertinent information.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program to prevent the development and transmission of communicable diseases. Specifically, for 1 out of 38 sampled residents, a resident's feeding tube was observed to be on the floor and not capped while not in use. Additionally, facility staff did not wear Personal Protective Equipment (PPE) while providing high contact care on Enhanced Barrier Precautions (EBP). Resident identifier: 238. Findings included: Resident 238 was admitted to the facility on [DATE] with diagnoses which included, encephalopathy, acute kidney failure, and adult failure to thrive. On 3/17/25 at 8:47 AM, an observation was made of resident 238's room. There was an EBP sign posted on the door. On 3/18/25 at 10:36 AM, an observation was made of Certified Nursing Assistant (CNA) 1 coming out of resident 238's room with a used brief in a disposable trash bag. On 3/18/25 at 10:57 AM, an observation was made of resident 238. Resident 238's tube feed was disconnected and the tubing was laying on the floor with no cap. On 3/18/25 at 5:54 PM, an observation was made of resident 238's feeding tube uncapped and hanging on an Intravenous (IV) pole. On 03/20/25 at 8:01 AM, an observation was made of resident 238's tube feed that was not running and the end of the tubing was not capped and was hanging from an IV pole. A physician's order with a start date of 3/16/25, documented that resident 238 was on EBP related to the feeding tube. On 3/18/25 at 11:04 AM, an interview was conducted with CNA 1. CNA 1 stated she had recently changed resident 238's brief before the resident went to physical therapy. CNA 1 stated she was unsure if resident 238 had EBP precautions, as she was new to the facility. CNA 1 stated the EBP sign on the door may have been for the previous resident in the room. On 3/18/25 at 11:14 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated night shift changed the tubing for tube feeds. RN 1 stated physical therapy requested that resident 238 be disconnected from her tube feed. RN 1 stated that she wore gloves when caring for the tube feed. RN 1 stated when the feeing tube was not in use she would leave the tubing with the feed because it was good for 24 hours. RN 1 stated she had not capped the feeding tube when it was disconnected. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/25 at 11:32 AM, an interview was conducted with the Director of Nursing (DON). The DON stated if a feeding tube needed to be unhooked for any reason the tube should be capped and hung up on an IV pole. The DON stated staff should be wearing PPE when providing care for feeding tubes or when changing the resident.