STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675008	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Rose Nursing and Rehabilitation	203 Gibbs Blvd Glen Rose, TX 76043

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview and record review, the facility failed to accommodate residents' needs and preferences for 3 of 19 (Resident #8, Resident # 21, and Resident #37) residents reviewed for accommodation of needs. The facility failed to ensure Resident #8, Resident #21, and Resident #37 call lights were within reach. This failure could place residents at risk of a diminished quality of life and lead to a loss of self-esteem and isolation. Findings included: Resident #8 Review of Resident #8's electronic face sheet dated 12/13/2024 revealed a [AGE] year-old female admitted on [DATE] and most recently admitted on [DATE] with following diagnosis: dementia, senile degeneration of brain (mental deterioration that is associated with old age), difficulty walking, unsteadiness on feet, lack of coordination, history of falling, and muscle weakness. Review of Resident #8's significant change MDS dated [DATE] revealed: BIMS score of 01 which indicated severe cognitive impairment. Section GG: Functional Abilities revealed Resident #8 needed partial to moderate assistance of staff for bed mobility, sitting to standing, and bed to chair transfer. Review of Resident #8's most recent comprehensive care plan reviewed on 12/13/2024 revealed: Resident #8 had a risk for falls with interventions that included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 07/02/2021. During an observation and attempted interview on 12/10/2024 at 8:30 a.m., Resident #8 was lying in bed. She did not answer questions, and no discomfort or distress observed. The call light was not in reach of the resident's bed and was on the other side of the room's privacy curtain. Resident #21 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #21's electronic face sheet revealed an [AGE] year-old female admitted on [DATE] and most recently admitted on [DATE] with the following diagnosis: muscle weakness, abnormalities of gait and mobility, and unsteadiness on feet. Review of Resident #21's quarterly MDS dated [DATE] revealed: BIMS score of 09 which indicated moderate cognitive impairment. Section GG: Functional Abilities revealed Resident #21 was dependent on staff for chair to bed transfers and for sitting to standing. Review of Resident #21's most recent comprehensive care plan reviewed on 12/13/2024 revealed: Resident #21 was at continued risk for falls with interventions that included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 05/25/2022. During an observation and interview on 12/10/2024 at 7:55 a.m., Resident #21 was lying in bed with the head of bed elevated and breakfast sitting on over the bed table. Resident #21 stated she would like more coke. She stated she did not think she had call light. The call light was hanging from the over the bed light down between headboard and mattress of bed and not within arm's length of resident. Resident #37 Review of Resident #37's electronic face sheet revealed a [AGE] year-old female admitted on [DATE] with the following diagnosis: dementia, weakness, unsteadiness on feet, and abnormalities of gait and mobility. Review of Resident #37's significant change MDS dated [DATE] revealed: BIMS score of 00 which indicated severe cognitive impairment. Section GG: Functional Abilities revealed Resident #37 was dependent on staff for chair to bed transfers and for sitting to standing. Review of Resident #37's most recent comprehensive care plan reviewed on 12/13/2024 revealed: Resident #37 was at risk for falls with interventions that included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 06/26/2022. During an observation and attempted interview on 12/11/2024 at 10:24 a.m., Resident #37 was lying in bed. She did not speak, and no distress observed. Resident breathing easily. The call light was not in reach of the resident's bed and was on the other side of the room's privacy curtain. During an interview on 12/13/2024 at 9:18 a.m., CNA F stated all residents should have a call light in reach. She stated Resident #8, Resident #21, and Resident #37 could not exit the bed safely without assistance of staff. She stated CNAs were responsible for making sure call lights were within reach and the charge nurses monitor that call lights were in reach. She stated not having call light in reach could cause residents to not be able to call for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/13/2024 at 9:22 a.m., RN G stated all residents should have a call light in reach. She stated Resident #8, Resident #21, and Resident #37 could not exit bed safely without assistance of staff. She stated CNAs were responsible for making sure call lights were within reach. She stated nurses monitored that CNAs were keeping call lights in residents' reach. She stated not having call light in reach could cause residents to not be able to call for help. During an interview on 12/13/2024 at 9:35 a.m., the DON stated her expectation would be for all residents to have call lights in reach. She stated in reach meant within residents' arm length, so residents were able to reach call light. She stated Resident #8 and Resident #37 would not be able to reach a call light that was across the room when they were lying in bed. She stated Resident #21 would not be able to reach a call light that was in between her mattress and headboard. She stated she felt residents being moved from another hall for unplanned construction may have led to call lights not being in reach. She stated everyone in the building were responsible for ensuring residents had access to call lights. She stated the CNAs, nurses, and department heads monitored call lights were within reach of residents. She stated not having a call light in reach could lead to resident not being able to call for assistance. During an interview on 12/12/2024 at 11:05 a.m., the ADMN stated her expectation would be for all residents to have call lights in reach. She stated in reach meant within arms distance. She stated that Resident #21 would not be able to reach a call light that was handing in between her mattress. She stated Resident #8 and Resident #37 would not be able to reach a call light on the other side of their room when they were in bed. She stated she did not know why call lights were not in reach but may have been due to unexpected construction and relocation of some residents. She stated that CNAs were responsible for making sure call lights were in reach and nurses were responsible for monitoring that call lights were in reach. She stated not having call light in reach could lead to residents not being able to call for help. She stated the facility did not have call light policy. Record review of the facility policy titled Resident [NAME] of Rights no date revealed: Dignity/Self Determination and Participation. You have the right to receive care from the facility in a manner and in an environment that promotes, maintains, or enhances your dignity and response in full recognition of your individually. You have the right to: a. Choose activities, schedules, and health care consistent with your interests, assessments and plans of care. b. Interact with members of the community both inside and outside the nursing facility. C. Make choices about aspects of your life in the nursing facility that is significant to you.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interview and record review the facility failed to ensure that a residents significant change in physical or mental condition was determined for 1 of 19 residents (Residents #47) reviewed for significant change. The facility failed to ensure Resident # 47 had a Significant Change Assessment completed after his admission to hospice. This failure could contribute to providing an inaccurate assessment of resident's most current medical condition and could lead to failure to not provide necessary care. Findings include: Record review of Resident #47's electronic face sheet revealed an [AGE] year-old male admitted to the facility 9/13/2024 with a most recent admission on 10/19/2024 with the following diagnosis: Traumatic subdural hemorrhage with loss of consciousness (head injury from trauma with brain bleed), sepsis (infection that has spread to the blood), respiratory failure, and Type 2 diabetes. Record review of Resident #47's admission assessment dated [DATE] revealed: Section C-Cognitive Patterns revealed Resident #47 had a BIMS score of 0 meaning severe cognitive impairment; Section O-Special Treatments and Programs revealed no evidence of hospice. Record review of Resident #47's hospice records revealed a physician order with a start date of 11/15/2024 after admit Resident #47 to hospice. Record review of Resident #47's electronic record on 12/12/2024 revealed no evidence of a Significant Change Assessment completed for Resident #47 when he was admitted to hospice; and no order to admit to hospice. During an interview on 12/12/24 at 2:10 PM the DON stated her expectation was a Significant Change Assessment should have been completed within after 14 days of Resident #47 being admitted to hospice. The DON stated the MDS nurse was responsible to complete the Significant Change and nursing was responsible to notify MDS with the change. The DON stated the affect on residents could have received incorrect services. The DON stated she did not know why the Significant Change was not completed stated possible miscommunication. The DON stated they did not have a policy for Significant Change Assessment that they followed the CMS's RAI Manual. During an interview on 12/12/2024 at 2:45 PM the RRN stated the MDS nurse was out of office on sick leave for the last 2 days, and she was responsible to complete the Significant Change Assessment. The RRN stated hospice should have triggered for a Significant Change Assessment to be completed and should have been completed when the order for hospice was completed. The RRN stated the MDS nurse was responsible to complete the MDS and the DON and the RRN monitors the completion. The RRN stated the effect on residents could have been plan of care not being updated and loss of revenue. The RRN stated what led to the failure was miscommunication, the nurse that received the order should have entered the order which would have triggered the Significant Change to be completed. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CMS'S RAI Version 3.0 Manual version 1.17.1 dated October 2019 revealed: The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

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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** 44722 Based on interviews and record reviews, the facility failed to develop a comprehensive person-centered care plan based on assessed needs with the ability to be evaluated or quantified to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #47) of 19 residents reviewed for comprehensive person-centered care plans. The facility failed to ensure Resident #47's comprehensive care plan addressed Resident #47 being on hospice. This failure could affect the residents by placing them at risk for not receiving care and services to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. Findings included: Record review of Resident #47's electronic face sheet revealed an [AGE] year-old male admitted to the facility 9/13/2024 with a most recent admission on 10/19/2024 with the following diagnosis: Traumatic subdural hemorrhage with loss of consciousness (head injury from trauma with brain bleed), sepsis (infection that has spread to the blood), respiratory failure, and Type 2 diabetes. Record review of Resident #47's admission assessment dated [DATE] revealed: Section C-Cognitive Patterns revealed Resident #47 had a BIMS score of 0 meaning severe cognitive impairment; Section O-Special Treatments and Programs revealed no evidence of hospice. Record review of Resident #47's hospice records revealed a physician order with a start date of 11/15/2024 after admit Resident #47 to hospice. Record review of Resident #47's Comprehensive Care Plan last updated on 11/07/2024 revealed no evidence of hospice. Record review of Resident #47's electronic records revealed no evidence of a physician order to admit to hospice. During an interview on 12/12/24 at 2:10 PM the DON stated her expectation was care plans should have been updated when there was a Significant Change Assessment completed. The DON stated admission to hospice should have been updated in the care plan. The DON stated the MDS nurse was responsible to update the comprehensive care plan when the significant change assessment was completed. The DON stated the effect on residents was they could have received incorrect services. The DON stated she did not know why the comprehensive care plan was not updated with hospice. The DON stated what led to failure was the Significant Change assessment was not completed. The DON stated they did not have a policy for Significant Change Assessment that they followed the CMS's RAI Manual. (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 12/12/2024 at 2:45 PM the RRN stated the MDS nurse was out of office on sick leave, and she was responsible to complete the Comprehensive Care Plan. The RRN stated hospice services should have been updated in care plan after the Significant Change Assessment was completed. The RRN stated the MDS nurse was responsible to complete the comprehensive care plan and the DON and the RRN were responsible to monitor the completion. The RRN stated the effect on residents could have been the plan of care not being updated and loss of revenue. The RRN stated what led to failure was miscommunication, the nurse that received the order should have entered the order which would have triggered the Significant Change to be completed which would have triggered the comprehensive care plan to be updated. Record review of facility policy titled, Comprehensive Care Planning without a date revealed, The comprehensive care plan will describe the following- The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . Any specialized services .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48883 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles, for 1 of 6 (C Hall) Medication Carts and 1 of 1 medication room. 1. The facility failed to ensure C Hall medication cart keys were not kept on unattended cart in binder labeled Narcotic Book C Hall. 2. The facility failed to ensure that all medications stored in C Hall medication cart were properly stored/labeled. These failures placed all residents at risk of harm or decline in health due to lack of potency of medications/biologicals or misappropriation of medications. The findings included: During an observation and interview on 12/10/2024 beginning at 10:33 a.m., the C Hall medication cart revealed MA D was administering medications. The top left drawer of C Hall medication cart stored 15 loose pills under one lock in a 3 clear medication cups with no label. MA D stated she had attempted to administer the medications earlier and those residents would not take them. She stated she stored them in the top of medication cart to attempt to give again. She stated she knew what medications were for Resident #1, Resident #17, and Resident # 28. She stated she was not supposed to store medications that had been popped out of the original containers on her cart. She stated there was no negative outcome from storing medications this way to the residents. She stated she was responsible for making sure the medications were stored properly on the medication cart she was responsible for. During an observation and interview on 12/10/2024 at 11:33 a.m., the C Hall medication cart was unattended outside of the nurses' station behind barrier half wall. Keys for C Hall medication cart were stored in three ring binder labeled Narcotic Book C Hall laying on top of C Hall medication cart. No loose medication found in top drawer. LVN E was sitting behind the nurses' station with a resident and was working on the computer. He stated keys should not be kept on the medication cart and should be kept on the person that was responsible for the medication cart. He stated he was not responsible for C Hall medication cart but would give keys to the appropriate nurse. He stated MA D had left the building on a break. He stated MA D should have given the keys to the nurse responsible for the hall when she left for her break. He took the keys and put them in his pocket. He stated he was not responsible for C Hall but would get the keys to an appropriate nurse. He stated MA D worked a split shift and that she would come back at 3 p.m. C Hall medication cart had heart medications including losartan, furosemide, metoprolol, amlodipine, and atorvastatin. Observed C Hall medication cart had psychotropic medications including risperidone, Zoloft, duloxetine, buspirone, Seroquel, Ativan, Ambien, and Clobazam. C Hall medication cart had nasal spray Flonase and narcotics including tramadol and methadone. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/2024 at 1:32 p.m., the DON stated her expectation would be for medications to be given when medication aide or nurse at door of resident. She stated if residents refuse medication, then medication should be discarded. The DON stated medication aides and nurses were responsible for ensuring medications were stored appropriately. She stated the charge nurse on that hall should be monitoring that medication aides stored medication appropriately. She stated the ADON, DON and consultant pharmacists were responsible for monitoring nurses store medications appropriately. The DON stated her expectation would be that keys to medication carts would remain on the person responsible for the medication cart. She stated her expectation during breaks would be for the medication aid to give keys to a nurse before leaving the building. She stated storing medications unlabeled in cart could lead to a medication error and put residents in danger by given wrong medications. She stated storing keys on top of medication cart in binder could give someone access to medication cart without them being a medication aide or nurse. She stated she did not know why loose medications were stored in medication cart, keys were left in binder on top of cart, and items were stored in refrigerator without open date or past use by date. She stated MA D did not come into work on the afternoon of 12/10/2024. She stated MA D had clocked out at 11:20 PM on 12/10/2024. During an interview on 12/11/2024 at 1:40 p.m., the ADMN stated her expectation would be for medications to have identification on them when stored. She stated she expected keys for medication carts to be kept on the person or given to the nurse and not stored on top of medication cart in binder. She stated storing medications incorrectly could cause negative effects by residents having access to medication carts or possibly receiving wrong medications. She stated the nurses and medication aides were responsible for storage of medications. She stated the ADON and DON were who monitored that medications were stored correctly. She stated she did not know why medications were stored inappropriately. The ADMN who is a LVN stated the medications that were stored in medication cups on C Hall medication cart could have been: Vitamin D3 a supplement Keppra a medication for seizure prevention Metformin a medication to reduce blood sugar Multivitamin a supplement Biotene a supplement Wellbutrin a medication for depression Eliquis a medication that interferes with blood clotting Pepcid medication for indigestion Finasteride a medication to help enlargement of prostate Lisinopril a medication for blood pressure reduction Modafinil a medication to treat narcolepsy (a disorder that effects sleep) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Montelukast a medication used to treat asthma Protonix a medication to reduce acid in stomach Tamsulosin a medication to help enlargement of prostate Zyrtec a medication to reduce seasonal allergies Aspirin a medication that interferes with blood clotting Cetirizine a medication to reduce seasonal allergies Cyanocobalamin a supplement Fluoxetine a medication for depression Metoprolol a medication to reduce blood pressure Myrbetriq a medication for overactive bladder Strattera a medication used for attention deficit disorder Topiramate a medication used to reduce headaches Vitamin C a supplement Cilostazol a medication used to dilate blood vessels Divalproex sodium a medication used for preventing seizures Levetiracetam a medication used for preventing seizures During a telephone interview on 12/13/2024 at 10:41 a.m., the CP stated her expectation would be for medication carts to be locked and keys stored on medication aides and nurses that were responsible for those carts. She stated it was best practice to not store medications in unlabeled medication cups in top drawer of medication carts. She stated her expectation would be that medications be discarded if resident would not take medication. She did not know why keys were stored on top of medication cart in binder or why medications were stored in unlabeled medication cups. She stated medication aides and nurses were responsible for medications being stored appropriately on their medication cart. She stated she does spot checks when she was in the building and the DON and ADON should be monitoring that medications are stored appropriately as well. She stated storing medications in unlabeled cups was discouraged because there could be confusion later who medication should be administered to. She stated storing keys in binder on top of cart could lead to more than just the nurse or medication aide having access to medication cart. She stated in a hypothetical situation these failures could lead to misappropriation of medication but could not state if this instance led to misappropriation of medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled Storage of Medications dated 2003 revealed: The provider pharmacy dispenses medication in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. Only a pharmacist completes transfer of medications from one container to another. Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medication (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked and attended by persons with authorized access. Record review of the facility policy titled Medication Labeling dated 2003 revealed: Medications dispensed by a pharmacy: All legend patient medications regardless of source shall be properly labeled as required in State regulations for Long Term Care Facilities. Medications provided other than by a Pharmacy: Non-prescription drugs obtained from health food stores, or sources other than the provider pharmacy must be in the original manufacturer's container.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44722 45458 Based on observation, interviews, and record review, the facility failed to ensure the menus met the nutritional needs of residents in accordance with established guidelines and were followed for 1 of 1 meal (lunch meal on 12/10/2024) reviewed for menus being followed. The facility did not prepare or serve the posted items included on the menu as recommended by the licensed dietician. This failure could affect all residents who ate the food prepared for the lunch meal on 12/10/2024, by placing them at risk of not receiving adequate nutritive value and calorie intake needed to promote and maintain good health. Findings include: During an observation on 12/10/2024 at 8:10 a.m., the menu on the bulletin board posted in the dining room outside the kitchen door was set up in cycles which set the meals in five-week rotation of meals. The menu for the lunch meal dated 12/10/2024 was: Grilled steak with onions, baked potatoes, sauteed broccoli, honey kissed rolled, margarine, sour cream, cheese, cheesecake with fruit topping and tea. During an interview on 12/10/2024 at 10:25 a.m., [NAME] I said she said she did not follow or use recipes because the facility did not have the item that was on the menu. She said she was substituting Grilled steak with onions with Salisbury steak, and she was not sure if she was serving baked potatoes. [NAME] I said the facility did not have broccoli so she was substituting mixed vegetables and thought she would serve garlic, parmesan mashed potatoes. She said the kitchen would serve green Jell-O with fruit instead of cheesecake. [NAME] I said when the kitchen did not have an item, she would substitute a dish as close as possible to the item she was substituting. During an interview on 12/10/2024 at 10:29 a.m., the Regional Certified Dietary Manager said the staff should follow the menu because substitutions would change the overall calorie intake of the meal and have a negative effective on the resident's diet. The Regional Certified Dietary Manager said [NAME] I did not follow the facility's policy and the change could have affected the resident's negatively by changing the overall daily nutritional value and intake. During a follow-up interview on 12/10/2024 at 1:18 p.m., the Regional Certified Dietary Manager said the reason the facility did not serve steak was because the facility had an abundant supply of beef patties. The Regional Certified Dietary Manager said prior to the new facility Dietary Manager, who started her position three (3) weeks prior, no one completed inventory. The Regional Certified Dietary Manager said [NAME] I, who had prepared the lunch meal, was defiant and the fact that she did not follow the menu did not meet her expectations. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/2024 at 1:20 p.m., [NAME] H said knew she was required to follow the menu and if she needed to substitute any item, she would ask the manager. During an interview on 12/12/2024 at 1:35 p.m., the Dietary Manager said her expectations were for the cooks to follow the menu. The Dietary Manager said the substitution log was blank and the previous logs were missing. The Dietary Manager said she was responsible to ensure the menu items were ordered and available and to provide oversight and supervision of the dietary staff. The Dietary Manager said she was responsible to ensure dietary staff followed the menu. Record review of the substitution logs for December 2024 revealed the logs were blank. Record review of the facility's policy, Resident Menus, dated 2012, revealed the facility will strive to assure the resident's nutritional needs are provided based on the RDA. The standard menu will ensure nutritional adequacy of all diets, offer a variety of food in adequate amount at each meal, and standardize food production. Alternates for noon and evening meal will be planned and recorded. Alternates shall be of comparable nutritive value and the alternate food shall come from the same food group. If any meal served varies from the planned menu, the change and reason for the change shall be noted on the substitution log. 48883

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45458 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 1 of 1 kitchen reviewed for service safety, in that: 1. The facility failed to ensure staff practiced appropriate hand hygiene during meal prep. 2. The facility failed to label open food items with date opened food in the refrigerator and freezer. 3. The facility failed to ensure staff appropriately cleaned and sanitized the thermometer prior to testing food temperatures. These failures could place residents at risk of food borne illness and cross contamination. Findings include: During an observation on 12/10/2024 at 8:31 a.m., revealed four (4) sealed bags and one (1) open bag of cabbage were with no label identifyng items and dates opened. A medium size container of brown pudding and a medium size of orange pudding had lids that sat on top of the containers but were not sealed. During an observation on 12/10/2024 at 8:44 a.m., revealed five (5) bags of small pita bread were located in the up-right refrigerator with no date of when the items were open or expiration date on the packages. Each package contained six (6) pieces of bread. During an interview on 12/10/2024 at 8:45 a.m., the Dietary Manager said the bags of pita bread came out of a large box that was dated at the time the food order came in and the bags did not come with a pre-printed use by date. The Dietary Manager said she did not know how long the bread had been in the refrigerator. During an observation on 12/10/2024 at 10:20 a.m., [NAME] H approached the kitchen door and entered. [NAME] H approached the stove and engaged in conversation with [NAME] I and proceeded to the prep table. [NAME] H picked up Styrofoam containers of Jell-O and stacked on food trays. [NAME] H was not observed to wash her hands. During an observation on 12/10/2024 at 11:05 a.m., [NAME] I placed a thermometer into the vegetables on the holding station and did not sanitize the thermometer prior. During an interview on 12/10/2024 at 11:12 a.m., [NAME] I said she obtained the thermometer used to take temperature of the vegetables from a red plastic basket on the counter by the holding station. [NAME] I said she did not know if the thermometers were sanitized or not. [NAME] I said she did not use alcohol wipes to sanitize the thermometers because she did not agree that she should put alcohol in the food she cooked. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/10/2024 at 11:20 a.m., [NAME] I put on gloves and picked up two (2) pieces of cook hamburger patties and placed the patties in the food processor. [NAME] I removed the gloves and turned the food processor on. [NAME] I picked up the second container of the food processor and scooped the mechanical meat into a metal pan. [NAME] I picked up a used paper towel and lifted the lid of a 30-gallon trash can and threw the used paper towel into the container. [NAME] I put on oven mitts and put the mechanical meat on the holding station. [NAME] I did not wash her hands. [NAME] I put on gloves and moved the puree meat that she scooped out the container of the food processor and place on the holding station. [NAME] I removed the gloves and placed two (2) bags of potatoes mix on the counter and took a plastic pitcher and fill with water and seasoning. [NAME] I put gloves on and opened a zip lock bag of an open bag of potato mix and then removed the gloves and began mixing the potato mix with water without washing her hands. During an observation on 12/10/2024 at 11:46 a.m., [NAME] I removed a pan of rolls from the oven and placed on the counter and removed the oven mitts. [NAME] I scratched her head on the left side, picked up a spoon and stirred the mash potatoes. During an observation on 12/10/2024 at 11:47 a.m., [NAME] H put on gloves, removed a serving tray, and placed the tray on the cart. [NAME] H rolled a fork, spoon and knife into a napkin and placed on the serving tray. [NAME] H removed her gloves and picked up a used napkin and lifted the lid of a 30-gallon trash can and threw the used paper towel into the container. [NAME] H picked up a tea glass an put on the serving tray with no gloves or washing her hands. During an observation on 12/10/2024 at 11:55 a.m., [NAME] I placed a thermometer into the Salisbury steak and took the temperature. [NAME] I removed the thermometer and immediately placed the thermometer into the mash potatoes to take the temperature without cleaning or sanitizing. During an interview on 12/10/2024 at 1:18 p.m., the Regional Certified Dietary Manager said the fact that [NAME] I did not wash her hands during meal prep did not meet her expectations. The Certified Dietary Manager said [NAME] I was very defiant during meal prep. The Regional Certified Dietary Manager said the fact that she did not wash her hands could negatively affect the residents and anyone who ate out the kitchen by spreading germs and causing food borne illness. During an interview on 12/12/2024 at 1:20 p.m., [NAME] H said she knew she was required to wash her hands when she first entered the kitchen, before and after using gloves, after using the restroom, and if she touched her face or picked something of the floor. [NAME] H said not washing her hands could spread germs. During an interview on 12/12/2024 at 1:35 p.m., the Dietary Manager said her expectations were for all food to be labeled with the date cooked or opened and the date of expiration. The Dietary Manager said if the food was not labeled it could be old and spoiled which could cause the residents who are susceptible to illness more vulnerable. The Dietary Manager said she expected the cooks to clean and sanitize the thermometers before and after taking the temperature of each food item to prevent the spread of germs and cross contamination. The Dietary Manager said not washing hands was the main way of spreading germs and causing infections, especially with COVID currently in the building. On 12/12/2024 at 2:01 p.m., an attempt was made to contact [NAME] I by phone. There was no answer. A message was left to return call prior to survey exit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Infection Control, Dietary Services Policy & Procedure Manual 2012, revealed the facility will ensure all employees practiced infection control in the Dietary Service Department, and maintain sanitary food preparation. All dietary service employees will follow Infection control Policies as established and approved by the Infection Control Committee. Careful handwashing by personnel will be done in the following situations: - Prior to entering the work area and reporting to the workstation. - Between handling of dirty dishes, boxes, or equipment and handling clean food or utensils. - After going to the restroom, after breaks or after smoking. - Between handing cooked and uncooked food. - After each instance of coughing, sneezing, touching face and/or hair. - Prior to returning to the food production area. Record review of the facility's policy, Hand Washing, dated 2012, revealed the facility would ensure proper hand washing procedures would be utilized. Employees are to frequently perform hand washing. Record review of the Food Code U.S. Food and Drug Administration 2022 Food Code, dated 01/18/2023, revealed - Food employees shall clean their hands and exposed portions of their arms for at least 20 seconds, using a cleaning compound in a handwashing sink. Record review of the facility's policy, Daily Food Temperature Control, dated 2012, revealed there is a thermometer available for use in the department to test the temperature of food which is sanitized between food testing.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interview, and record review the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, that were complete and accurate for 1 (Resident #47) of 19 residents reviewed for resident records. The facility failed to ensure Resident #47's clinical record included an order to admit to hospice. The order was only located in the hospice records. This failure could place residents at risk of having errors in care and treatment. The Findings included: Findings included: Record review of Resident #47's electronic face sheet revealed an [AGE] year-old male admitted to the facility 9/13/2024 with a most recent admission on 10/19/2024 with the following diagnosis: Traumatic subdural hemorrhage with loss of consciousness (head injury from trauma with brain bleed), sepsis (infection that has spread to the blood), respiratory failure, and Type 2 diabetes. Record review of Resident #47's admission assessment dated [DATE] revealed: Section C-Cognitive Patterns revealed Resident #47 had a BIMS score of 0 meaning severe cognitive impairment; Section O-Special Treatments and Programs revealed no evidence of hospice. Record review of Resident #47's hospice records revealed a physician order with a start date of 11/15/2024 after admit Resident #47 to hospice. Record review of Resident #47's Comprehensive Care Plan last updated on 11/07/2024 revealed no evidence of hospice. Record review of Resident #47's electronic records revealed no evidence of a physician order to admit to hospice. During an interview on 12/12/24 at 2:10 PM the DON stated her expectation was that the nurse that received a physician order was to enter the order into the electronic medical records when it was received. The DON stated the effect on residents could have been residents received incorrect services or had services missed. The DON stated she did not know why the comprehensive care plan was not updated with hospice. The DON stated what led to the failure was the charge nurse forgot to transcribe the record. Record review of facility policy titled, Physician Orders dated 2015 revealed Written orders by the Physician or Nurse Practitioner 1. Nurse will review the order and if needed contact the prescriber for any clarifications. 2. The nurse will enter the order into {electronic charting system} for the resident.

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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** 48883 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 reviewed for 2 of 4 halls (B Hall & C Hall) reviewed for infection control. 1. The facility failed to ensure staff (CNA B) wore appropriate PPE providing direct care services for Resident #46 (on B Hall) who was placed on Transmission Based Precautions due to having contracted COVID-19. 2. The facility failed to ensure Resident #46 wore appropriate PPE when being transported to shower room on B Hall. 3. The facility failed to ensure LVN C performed hand hygiene when obtaining blood sample for glucose reading (on C Hall). These deficient practices could affect residents that reside in the facility and place them at risk of infection. Findings included: Resident #46 Record review of Resident #46's electronic face sheet dated 12/13/2024 revealed she was a [AGE] year-old female admitted to facility on 6/14/2023 with diagnoses to include cerebral palsy (disorder of abnormal movement and paralysis caused by abnormal function of the brain). Record review of Resident #46's electronic physician orders dated 12/9/2024 revealed Resident requires transmission-based precautions (contact & droplet), because of active infection of COVID-19. Record review of Resident #46's annual MDS dated [DATE] revealed: Resident #46 had absence of words and rarely or never understood others. Further review of MDS revealed she needed substantial assistance with hygiene and was dependent on staff for showers. Record review of Resident #46's care plan dated 12/13/2024 revealed she required isolation precautions specifically related to active COVID-19 infection date initiated: 12/09/2024 with interventions: please encourage me to cover my mouth and nose when coughing or sneezing. Ensure that good infection control measures and personal potective equipment is used when working with me. Date initiated 12/9/2024. Please ensure I stay in my room, away from other people as much as possible. (Contact and Droplet Precautions) Date Initiated: 12/09/2024. Further review of care plan revealed Resident #46 requited staff assistance to complete ADL care in place. Date Initiated: 06/16/2023 Revision on: 06/23/2023. With interventions: Bathing: requires staff x 1 assistance Date Initiated: 06/16/2023 .The resident requires a lift for all transfers Date Initiated: 06/16/2023 .Transferring: requires staff x2 for assistance Date Initiated: 06/23/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/10/2024 at 9:32 a.m. revealed, Resident #46's door to room had signage stating droplet and contact precautions. Observed CNA B exiting Resident #46's room wearing surgical mask and gown but no gloves or face shield. CNA B was pushing Resident #46 in a wheelchair and entered the hall with Resident #46 taking her to the shower room. Resident #46 did not have mask on during transportation. CNA B came out of the shower room wearing no gown but had the same surgical mask on. During an interview on 12/10/2024 at 10:04 a.m., CNA B stated it was her first day to work at the facility. She stated she was supposed to be shadowing another staff member but could not remember that staff member's name. She stated she did not know if Resident #46 had active COVID infection but stated Resident #46 should have had a mask on. CNA B stated no one had told her which residents had an active COVID infection. She stated she had training on infection control. During an observation on 12/11/2024 at 5:12 p.m., LVN C observed performing hand hygiene and putting on gloves prior to entering Resident #28 to obtain FSBS with glucometer. She had supplies lying on wax paper and placed them on cleaned bedside table. LVN C cleansed resident's finger with alcohol swab and then used lancet to stick resident's finger. LVN C was unable to get sufficient blood on test strip for glucometer and went back to medication cart to get more supplies without removing gloves or performing hand hygiene. She got another glucometer test strip out of bottle, another lancet, and another alcohol swab before closing and locked medication cart. She then went back to resident, sanitized his finger with alcohol and used lancet to stick finger and obtain blood sample for glucometer. After getting FSBS reading, she went back to the medication cart and prepared insulin aspart flex pen by sanitizing rubber tip with alcohol swab prior to placing needle onto it, primed needle and twisted end to how many units would be administered. She brought insulin flex pen over to the resident with another alcohol swab and administered insulin to cleansed abdominal skin. She took supplies over to the medication cart and disposed of needles into sharps container. She placed insulin flex pen cap back onto pen then put into bag and placed in top drawer of cart. She documented medication administration onto laptop then removed her gloves and performed hand hygiene using ABHG. During an interview on 12/11/2024 at 5:22 p.m., LVN C stated she never removed gloves or performed hand hygiene in between obtaining FSBS using glucometer and administering insulin. She did not see any issue with reusing the same gloves if both occurred on the same patient. During an interview on 12/12/2024 at 9:48 a.m., the DON stated she expected nurses to perform hand hygiene after the nurse handled blood sample using glucometer. She stated she expected hand hygiene to be done prior to the nurse going back into the medication cart for more supplies. She stated not performing hand hygiene and replacing gloves could lead to cross contamination infections. She stated she did not know why the nurse did not perform hand hygiene appropriately and stated staff had been in-serviced on infection control. She stated nurses were responsible for performing hand hygiene when providing care and nurse management monitored that the nurses and CNAs performed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/2024 at 10:35 a.m., the DON who was also the IP stated negative COVID residents should not share room with positive COVID residents unless they chose to after being notified of the risks for not changing rooms. She stated her expectation would be for COVID exposed residents to not leave their room without wearing a N95 mask or a droplet precautions appropriate mask if he was at open room door. She stated the surgical masks that the facility provides were droplet precautions appropriate masks as they say so on the mask box. She stated her expectation would be that COVID positive residents wear mask when being transported in hallway from their room into shower room. She stated CNAs were notified of which residents had active COVID infection when they started their shift by the nurse or herself if she was present in the building. She stated signage on door alerted staff members of what precautions to follow when taking care of residents. She stated she expected staff to wear PPE including droplet precautions appropriate mask, gloves, gown, and face shield when providing care to COVID positive residents including transporting them into shower room. She stated she expected for mask to be changed after caring for COVID positive resident upon leaving the room. The DON stated she expected for staff performing shower to a COVID positive resident to wear PPE including mask, face shield, gown, and gloves. She stated not wearing appropriate PPE could lead to spread of infection. She stated nurses and upper management monitored that staff and residents follow appropriate precautions, but everyone should be able to correct anyone not wearing appropriate PPE. She stated she did not know why staff did not have full PPE on when caring for COVID positive residents. She did not know why COVID positive resident was transported out in hall with no mask on, or why resident exposed to COVID was out in dining room with no gown on or if his wheelchair had been sanitized. During a telephone interview on 12/12/2024 at 11:20 a.m., the MD stated staff wearing a mask caring for residents with active COVID infection would be sufficient as long as the staff were washing their hand after care. He stated he would expect staff to wear gown, gloves, and mask if they were toileting residents with active COVID infection. He stated best practice would be for staff to wear gown, gloves, and mask when showering a resident with active COVID infection. The MD stated he did not feel staff not wearing face shields would cause COVID infection to spread. He stated he would expect for residents with active COVID infection to wear mask when outside of their room in public area but if they were not allowed to stop and converse with anyone or touch anyone then infection would not be spread from them not wearing mask. He stated he was notified of COVID infection in building and residents being sent to hospital. He stated he had not gotten report from hospital on how those residents were doing. He stated normally the hospital would fax over information to his office and information was relayed to him. Record review of the facility policy titled Fundamentals of Infection Control Precautions dated 3/2024 revealed: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: Before and after performing any invasive procedure (e.g., fingerstick blood sampling) .Upon and after coming in contact with a resident's intact skin, (e. g., when taking a pulse or blood pressure, and lifting a resident) .After completing duty. Record review of the facility policy titled Subcutaneous Injection Administration dated 2003 revealed: 2. Wash your hands and put on clean disposable gloves . 12. Dispose of the needle and syringe in a sharps container. 13. Remove and dispose of gloves and wash hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled Covid Response Plan no date revealed: Source control options for HCP include: . A well-fitting face mask .If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on droplet precautions), they should be removed and discarded after the patient care encounter and a new one should be donned .Source control is recommended for individuals in healthcare settings who: Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure .Duration of Empiric Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection In general, asymptomatic patients do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These patients should still wear source control and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section .Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods. Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative. If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms .Personal Protective Equipment: HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) .Environmental Infection Control: Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection. All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before used on another patient.