STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675141	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Healthcare Residence	1400 Lake Shore Dr Waco, TX 76708

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** 44317 Based on observations, interviews, and record reviews, the facility failed to ensure residents received services within the facility with reasonable accommodation of the residents' needs and preferences for 4 of 12 residents (Resident #23, Resident # 57, Resident #83, and Resident #45) reviewed, in that: The facility failed to: 1) Ensure a call light was within reach for Resident #23 2) Ensure a call light was within reach for Resident #57 3) Ensure a call light was within reach for Resident #83 4) Ensure a call light was within reach for Resident #45 This deficient practice placed residents at risk for delayed care and a decreased quality of life. Findings Include: 1) Review of Resident # 23's quarterly MDS assessment dated [DATE], Section A (Identification Information) reflected a 74- year-old male admitted to the facility on [DATE]. Section C (Cognitive Patterns) Reflected a BIMS score of 15 indicating intact cognition. Section GG (Functional Abilities) reflected he was dependent on staff for personal hygiene, bathing and toileting. Section I (Active Diagnoses) reflects medically complex conditions, Other Hereditary and Idiopathic Neuropathies (a condition that causes gradual muscle weakness), Muscle Wasting and Atrophy (the wasting or thinning of muscle mass), Unspecified Lack of Coordination (a condition that affects balance), Schizophreniform Disorder (a mental health condition that causes hallucinations, delusions and disorganized speech), Spinal Stenosis Spinal Region (where the space inside the backbone is too small placing pressure on the spinal cord), Low Back Pain, Kissing Spine (a condition that causes pain, inflammation and nerve damage), Generalized Muscle Weakness, Abnormalities of Gait and Mobility (problems with walking or standing) and Aphasia (a condition that affects how you communicate with speech). (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 #23's care plan initiated 11/11/22 reflected a focus, Resident is bed bound due to his own decision and refuses to be transferred with a mechanical lift and is unable to move and sit in a wheelchair /geriatric chair. Interventions include, keep call light within reach of resident and keep resident belongings accessible and within reach. An observation and interview on 04/29/2024 at 01:15pm with Resident # 23, resident stated he can't reach call light and will usually ask his roommate for help to call for staff. Resident call light was not visible to surveyor nor to the resident. 2) Review of Resident # 57's quarterly MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female readmitted to the facility on [DATE]. Section C (Cognitive Patterns) Reflected a BIMS score of 15 indicating intact cognition. Section I (Active Diagnoses) Hypothyroidism (a condition that causes decreased thyroid hormones), Parkinson's Disease (a movement disorder that causes tremors or stiffness), Other Idiopathic Peripheral Autonomic Neuropathy (a condition that causes numbness, pain, and balance issues) and Schizophrenia (a condition causing hallucinations, delusions, confused thoughts and behavior). Review of Resident #57's care plan initiated 11/11/22 reflected a focus, Potential for falls related to Decreased mobility and noncompliance with using walker for ambulation. Resident has had falls due to not using walker. Interventions include, encourage resident to keep belongings within reach, provide a safe environment with floors free from spills, assist with removing room clutter, glare free lighting, reachable call bell etc. An observation and interview on 04/29/2024 at 10:05am with Resident #57, residents call light was not within reach. The call light was between the wall and the bed near the floor. 3) Review of Resident # 83's quarterly MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old male admitted to the facility on [DATE] 3. Section C (Cognitive Patterns) Reflected a BIMS score of 14 indicating intact cognition. Section GG (Functional Abilities) reflected resident is independent with activities of daily living. Section I (Active Diagnoses) reflected, Hyperlipidemia (a condition that causes high lipids or fat in the blood), Major Depressive Disorder (a condition that affects mood), Insomnia (a condition that causes trouble falling or staying asleep), Constipation (a condition that causes bowel movements less than three times per week), Hypothyroidism (a condition that causes decreased thyroid hormones), Bipolar II Disorder (also known as manic depression), Schizoaffective Disorder Bipolar Type (a condition causing hallucinations, delusions, confused thoughts and behavior) , Diabetes Mellitus without Complications (a condition that affects the way the body processes blood sugar), Disorder of Muscle and Schizophrenia (a condition causing hallucinations, delusions, confused thoughts and behavior). Review of Resident #83's care plan initiated 12/05/2023 reflected a focus, The resident has an ADL Self Care Performance Deficit. Interventions include, Encourage Resident to use bell to call for assistance before attempting any ADL's that resident cannot do independently. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 04/29/2024 at 10:12am with Resident # 83, the resident stated he can't reach his call light and asks his roommate to press the button for him. Resident call light was not visible to surveyor. When the surveyor asked resident to locate the call light, he could not see nor find the light. 4) Review of Resident #45's quarterly MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility 03/06/20. Section C (Cognitive Patterns) Reflected a BIMS score of 15 indicating intact cognition. Section GG (Functional Abilities) reflected she was dependent on staff for personal hygiene, bathing and toileting. She required substantial/maximal assistance with upper body dressing. She was dependent on staff and a mechanical lift for transfers to and from bed. Section I (Active Diagnoses) reflected, hemiplegia following cerebral infarct affecting left dominant side (paralysis of the left side of the body due to a stroke), diabetes mellitus (a condition that affects the way the body processes blood sugar), generalized muscle weakness, contracture of hand (permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen), and morbid (severe) obesity. Review of Resident #45's care plan initiated 11/11/22 reflected a focus, Alteration in musculoskeletal status related to contractures to left hand. Interventions included, Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. A focus initiated on 03/06/20 reflected, Resident has the potential for falls related to CVA . An intervention reflected, Place the resident's call light within reach and encourage the resident to use it for assistance as needed. An observation on 04/29/24 at 2:14 PM revealed Resident #45 sitting up in a bariatric wheelchair next to her bed. Her left side, with hemiparesis (a condition that causes weakness or the inability to move on one side of the body) and a hand contracture was closest to the bed. The string for the resident's call light was hanging down from the ceiling. A stuffed animal was tied to the end of the string. The Stuffed animal was hanging several inches above the bed. During an interview on 04/29/24 at 2:15 PM with Resident #45, she stated she wanted to get into bed, but she could not reach her call light, so she had to wait for staff. She stated she sometimes got her roommate to push her call light to get staff to the room. During an interview on 05/01/24 at 2:00 PM, LVN L stated call lights should be in reach, accessible to the residents. She stated if the call light was not within reach, the residents may not be able to get medications, toileted, or have any other needs met. She stated she was not working with Resident #45 today but she would check the call light placement. During an interview on 05/01/2024 at 2:15PM CNA F stated she checks on residents every thirty minutes during her shift, and she thought everyone had a call light string. She said there should not have been anyone that didn't have a string attached to their call light. She said she would notify her charge nurse if a resident didn't have a call light string, or she would go find a longer string herself. During an interview on 05/01/2024 at 2:45PM with DON, she stated nursing staff checked each resident every 2 hours and should have ensured they could reach the call light with a string attached. She said it was unacceptable for any resident to not have independent access to the call light. (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 05/01/2024 at 3:00PM with ADM, he stated that all residents should have a working call light and the CNAs are responsible to ensure the resident can access the call light. He said residents should not have had to ask their roommates for assistance. Review of facilities undated policy titled Answering Call Light, which states: Purpose The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines 4. Be sure the call light is plugged in and functioning at all times. 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, the shower and bathing facility and from the floor. 6. Report all defective call lights to the nurse supervisor promptly.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on record review and interview, the facility failed to inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate for 2 of 3 residents (Resident #300 and Resident #301), reviewed for changes made to charges or other items and services. The facility failed to ensure that Resident #300 and Resident #301 were provided a SNF ABN (SNF ABN document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility prior to covered days being exhausted. This failure could place residents at risk for not being aware of changes to provided services not covered by Medicare and their financial responsibilities. Findings included: Review of Resident #300's admission MDS assessment dated [DATE], Section A (Identification Information) revealed an [AGE] year-old female admitted to the facility 09/06/23. Section C (Cognitive Patterns) revealed a BIMS score of 8 indicating moderately impaired cognition. Section I (Active Diagnoses) reflected diagnoses including coronary artery disease (disease of the blood vessels of the heart), septicemia (infection in the blood), and cerebrovascular accident (stroke). Review of Resident #300's electronic medical record revealed no SNF ABN form. Review of Resident #301's admission MDS assessment dated [DATE], Section A (Identification Information) revealed a [AGE] year-old female admitted to the facility 11/10/23. Section C (Cognitive Patterns) revealed a BIMS score of 14 indicating intact cognition. Section I (Active Diagnoses) reflected diagnoses including cerebrovascular accident (stroke), encephalopathy unspecified (damage or disease that affects the brain), and urinary tract infection. Review of Resident #301's electronic medical record revealed no SNF ABN form. Review of the Medicare discharge list reflected Resident #300's Medicare benefit days started on 09/06/23 and ended on 11/16/23. Resident #301's Medicare benefit days started on 11/10/23 and ended on 11/25/23. During an interview on 04/30/24 at 2:56 PM, the ADM stated neither Resident #300 nor Resident #301 were provided with an ABN document. The ADM stated they did not have a policy regarding ABN notifications. He stated the facility had recently found the notices were not being provided and the staff were not sure of the process or who was responsible for providing the form to residents. He stated they recently started reviewing and monitoring Medicare days and potential changes in service during their daily meetings. The ADM stated he would be contacting the corporate office regarding a policy. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medicare Claims Processing Manual accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf, Chapter 30, section 70 reflected in part, If Medicare is expected to deny payment (entirely or in part) on the basis of one of the exclusions listed in S70 of this chapter for extended care items or services that the SNF furnishes to a beneficiary, a SNF ABN must be given to the beneficiary in order to transfer financial liability for the item or service to the beneficiary. The initiation, reduction and termination of such extended care items or services, that Medicare may not pay, are considered triggering events.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49048 Based on observations, interviews, and record reviews, the facility failed to provide a Safe/Clean/Comfortable/Homelike Environment for three of six residents (Resident #57, Resident #23, and Resident #66). The facility failed to ensure a safe/clean/comfortable/ homelike environment for Resident #57, Resident #23 and Resident #66. This failure could affect residents by placing them at risk for diminished quality of life due to the lack of a well-kept environment and placing residents at risk of living in an unsafe, unsanitary, and uncomfortable environment. Findings Include: 1) Review of Resident # 57's quarterly MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female readmitted to the facility on [DATE]. Section C (Cognitive Patterns) Reflected a BIMS score of 15 indicating intact cognition. Hypothyroidism (a condition that causes decreased thyroid hormones), Parkinson's Disease (a movement disorder that causes tremors or stiffness), Other Idiopathic Peripheral Autonomic Neuropathy (a condition that causes numbness, pain, and balance issues) and Schizophrenia (a condition causing hallucinations, delusions, confused thoughts and behavior). During observation and interview on 04/29/2024 at 10:05AM with Resident #57, the room appeared cluttered with items stacked haphazardly against the wall. Multiple items on the floor which could have been dropped. The residents room appeared messy; bed disheveled and trash can was full. Resident stated housekeeping does not sweep and mop like they should. 2) Review of Resident # 23's quarterly MDS assessment dated [DATE], Section A (Identification Information) reflected a 74- year-old male admitted to the facility on [DATE]. Section C (Cognitive Patterns) Reflected a BIMS score of 15 indicating intact cognition. Section GG (Functional Abilities) reflected he was dependent on staff for personal hygiene, bathing, and toileting. Section I (Active Diagnoses) reflects medically complex conditions, Other Hereditary and Idiopathic Neuropathies (a condition that causes gradual muscle weakness), Muscle Wasting and Atrophy (the wasting or thinning of muscle mass), Unspecified Lack of Coordination (a condition that affects balance), Schizophreniform Disorder (a mental health condition that causes hallucinations, delusions and disorganized speech), Spinal Stenosis Spinal Region (where the space inside the backbone is too small placing pressure on the spinal cord), Low Back Pain, Kissing Spine (a condition that causes pain, inflammation and nerve damage), Generalized Muscle Weakness, Abnormalities of Gait and Mobility (problems with walking or standing) and Aphasia (a condition that affects how you communicate with speech). During observation on 04/29/2024 at 10:12AM with Resident #23, the room appeared cluttered with multiple items stacked high on counters and bedside table. There were personal items and debris on the floor. The bathroom had a walker lying on the shower floor with soiled underwear and socks. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Review of Resident #66's MDS assessment dated [DATE] reflected a [AGE] year-old female originally admitted to the facility 09/23/22 with a readmission on 11/19/23. Her diagnoses included septicemia (infection in the blood), diabetes mellitus (a condition that affects the way the body processes blood sugar) and chronic obstructive pulmonary disease (a lung disease limiting air flow from the lungs). Her BIMS score was fifteen, indicating intact cognition. During observation on 04/30/2024 at 8:50AM with Resident #66, her room appeared cluttered with multiple boxes stacked and a piece of wood furniture sitting directly in front of the sink. The boxes in front of the sink protruded outward approximately 3-4 feet. There were dirty containers that appeared to have had food in them. On the privacy curtain near the resident's bed, there were different colored marks on the curtain, which appeared to have been drawn with a marker, by the resident. During an interview on 05/01/2024 at 1:52PM with HS , he stated the housekeepers swept and mopped the residents' rooms daily. He said that it was everyone's responsibility to pick up items off the floor when they observed it. He said resident rooms have clutter and that the facility had a deep cleaning scheduled soon. He said the clutter presented challenges for the housekeeping staff, making it difficult to sweep and mop around the items. During an interview on 05/01/2024 at 2:45PM with DON, she stated her expectation was that the resident rooms were swept and mopped daily, by housekeeping. She said excess personal items and boxes piled up in residents' rooms create clutter, a potential fire hazard, and issues with cleanliness. During an interview on 05/01/2024 at 3:00PM with ADM, he stated that he was aware of clutter is resident rooms. He said he had called some of the resident's family members in the past, to come pick up the extra items. He said the clutter caused issues with bugs, mildew, and mold when the boxes became wet, tripping hazards, and a fire hazard. He said the facility had another deep clean/declutter on the upcoming schedule. He acknowledged clutter was an ongoing issue within the resident's rooms. The surveyor requested a policy regarding personal items for residents and the facility did not have one.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observation, interview and record review the facility failed to ensure in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments, under proper temperature control and labeled in accordance with currently accepted professional principles for 1 (medication room [ROOM NUMBER]) of 2 medication storage rooms and 1 (medication cart #1) of 4 medication carts reviewed for medication storage that. Medication cart # 1 was left unattended and unlocked. An undated, opened and accessed, vial was stored in the medication room [ROOM NUMBER] refrigerator. The medication room [ROOM NUMBER] refrigerator temperature was not monitored daily. This failure could allow residents unsupervised access to prescription and over the counter medication and can result in the resident receiving ineffective medication due to lack of temperature management or proper labeling. Findings included: Observation on 4/29/2024 at 11:53 am revealed Medication cart # 1 was unlocked and unattended at the nurse's station not visible from the nurses sitting at the desk. Inspections of the contents revealed insulin pens and needles, prescription and over-the-counter medications. No nurses approached during the inspection. After approximately 4 minutes LVN A, who was sitting at the nurse's station, was asked about the cart. LVN A came around the desk and locked the cart. An observation on 05/01/24 at 8:12 AM revealed a multi-dose vial of Influenza Vaccine in the medication room [ROOM NUMBER] refrigerator. The vial which had been opened and accessed, was not labeled with the date the vial was opened. An observation on 05/01/24 at 8:15 AM revealed the medication refrigerator temperature log taped to the front of the refrigerator. The log was dated April 2024. The log did not have any entries for 4/2/24, 4/5/24, 4/6/24, 4/7/24, 4/15/24, 4/16/24, 4/19/24, 4/20/24, and 4/30/24. Interview of LVN A on 4/29/2024 at 12:00 pm stated that she was unaware the cart was unlocked and that it may have been unlocked for about 5 minutes. She stated she did see the surveyor going through the drawers and did not see an issue with it. She stated that if a resident had been opening the drawers she would have intervened. She stated that most of the resident would not be at risk for the cart being unlocked because they were oriented and did not go thru things. Interview with DON on 4/29/2024 at 12:30 pm she stated her expectation was the medication carts be locked when not attended. She stated that residents and visitors could have access to prescription and over-the counter medications and that could put them at risk for possible overdose and medication side effects. (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 05/01/24 at 8:16 AM, the DON stated, anything opened, including multi-dose vials, were dated when opened. She stated the nurse who opened the vial or bottle was responsible for dating the medication. She stated vials were good for 30 days once opened. She stated expired medications may not have been effective and then residents may not receive the desired effect. She stated the medication room refrigerator temperature was supposed to be monitored daily. She stated some medications were stored in the refrigerator to maintain their effectiveness. She stated it did not meet her expectations that 9 of 30 days were not monitored. Record Review of the policy titled Storage of Medications, undated, states 6. Compartments (including, but not limited to, drawers, Cabinets, rooms, refrigerator, carts, and boxes) containing drugs and biological are locked when not in use. Unlocked medications are not left unattended. and 7. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medication is stored separately from food and are labeled accordingly. Record Review of the policy titled Medication, vaccine refrigerator temperature monitoring, updated January 2024, states Daily logs: The temperature will be checked and recorded by designated staff.

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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 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. 49048 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food storage and sanitation, in that: 1) The facility failed to ensure the kitchen prep area was free of personal items. 2) The facility failed to ensure food and beverages in refrigerator #1 and #2, and the freezer, were covered, labeled, and dated. These deficient practices could cause cross contamination and place residents at risk of foodborne illness. Findings include: 1.) Observation of the kitchen food prep table #1 on 04/29/2024 at 8:28am revealed a pink travel cup. Observation of the kitchen food prep table #2 on 04/29/2024 at 8:28am revealed car keys on a Miami Beach key chain and a white cell phone charger sitting next to a box of sandwich bags. Observation of kitchen Refrigerator #1 on 04/29/2024 at 8:31am revealed a Styrofoam drink container with a red straw and what appeared to be a red liquid inside the container. The drink container was on the bottom shelf of Refrigerator #1, next to a gallon of milk. Interview with DA #1 on 5/1/2024 at 2:05pm, she stated personal items should be kept in the DM's office. She said it was not okay to have personal drinks in the kitchen refrigerator. Interview with DA #2 on 05/01/2024 at 2:10pm, she stated personal items should be kept in the DM's office and it was not okay for a drink to have been in the refrigerator. Interview with DM on 05/01/2024 at 2:25pm, she stated all personal items should be kept in her office and personal drinks should be kept in the staff refrigerator in her office. Surveyor requested policy for storing personal items and the facility does not have one. 2.) Observation of the kitchen Refrigerator #1 on 04/29/2024 at 8:31am revealed an unsealed and unlabeled storage bag with contents that resembled sliced cheese (yellow/orange squares). Observation of the kitchen Refrigerator #1 on 04/29/2024 at 8:31am revealed an unlabeled storage bag containing an opened, bag of Whipped Topping. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675141	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Healthcare Residence	1400 Lake Shore Dr Waco, TX 76708

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the kitchen Refrigerator #2 on 04/29/2024 at 8:34am revealed with a rolling cart and two gray tubs with small drinking glasses containing a white liquid that resembled milk. The white plastic lids were ajar and not placed securely on the drinking glasses. Observation of the kitchen Refrigerator #1 on 04/29/2024 at 8:35am revealed a white box labeled Peeled and Cooked Eggs. Inside the box were multiple sealed bags of eggs. The box was not labeled with an opened on and use by date. Observation of the kitchen Freezer on 04/29/2024 at 8:37am revealed a blue storage bag tied in a knot. The bag contained what resembled frozen kernels of corn. The bag was not labeled with an opened on and use by date. Interview with DA #1 on 5/1/2024 at 2:05pm, she said all items in the refrigerator and freezer should have been placed in a plastic bag with a label and date. She said this task is the responsibility of all kitchen staff. Interview with ADM On 5/1/2024 at 2:00 Surveyor requested policy for storing personal items and the facility does not have one. Interview with DA #2 on 05/01/2024 at 2:10pm, she stated food in the refrigerator should be labeled and in storage bags. She said the kitchen staff were responsible for the labels and dates and the DM came behind them to ensure it was completed. Interview with DM on 05/01/2024 at 2:25pm, she stated her expectation was for items to be wrapped or placed in a storage bag, labeled with the contents and the date. She said this task was everyone's responsibility and she completes rounds to ensure it was done correctly. Review of facility policy titled Food Receiving and Storage, MED-PASS, Inc. Revised November 2022 states the following: Policy Statement Foods shall be received and stored in a manner that complies with safe food and handling practices. Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). 7. Refrigerated foods are labeled, dated and monitored so they are labeled by their use by date, frozen or discarded. Record review of Federal Drug Administration Food Code 2022 indicated [(C) PACKAGED FOOD shall be labeled as specified in LAW, including 21 Code of Regulation 101 FOOD Labeling, 9 Code of Regulation 317 Labeling, Marking Devices, and Containers, and 9 Code of Regulation 381 Subpart N Labeling and Containers, and as specified under S 3-202.18.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47795 Based on observation, record review and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 29 of 29 (Resident's # 75,70,92, 73,8,58,7,60,81,32,59,88,36,80,19,49,10,78,21,34,25,26,43,71,61,2,9,and 43) residents by 5 (DON,ADON, LVN C, CNA D and CNA E) of 5 staff passing lunch trays that were reviewed for infection control and transmission-based precautions policies and practice, in that: The facility failed to ensure DON, ADON, LVN C, CNA D and CNA E did not grab resident's cups by the rim with bare hands, contaminating the tops of the rims, during the lunch meal serving process. This failure could place residents at risk for infection through cross contaminations of pathogens. Findings include: During the lunch observation on 4/29/2024 at 12:15pm DON, ADON, LVN C, CNA D and CNA E were observed touching the rims of the Resident's cups (Resident's # 75,70,92,73,8,58,7,60,81,32,59,88,36,80,19, 49,10,78,21,34,25,26,43,71,61,2,9,and 43) covered with plastic lids that did not fit properly with bare hands during the meal service. Hand hygeine was preformed between residents, however the lids of the cups were touch once to place on the tray , the tray deliver to the resident then removed from the tray to place in front of the resident. Interview with CNA D on 4/29/2024 at 1:00 pm he stated he did not even realize he was grabbing the cups by the rims and will start grabbing by the sides. He was not sure what harm could come to the resident, but he would not want to drink from a cup someone had grabbed from the rim. Interview with CNA E on 4/29/2024 at 1:05 pm she stated that she was not aware she was supposed to grab the cup from the side, and the way they have them on a tray it is hard to always grab from the side when you are trying to get the residents served their meals. Interview with ADON on 4/29/2024 at 1:15 pm she stated that the cups should be grabbed by the side, but lunch was a little late today and they were in a hurry to get the residents their meal. She stated that grabbing the cups by the rim could potentially cause cross contamination. She also stated employees are encouraged to use hand sanitizer between delivery of resident trays and there is some available in the dining room. Interview with LVN C on 4/29/2024 at 1:25 pm she stated that it is hard to grab the cups by the side for the first several residents as the drinks are pre poured and are on a tray . She stated that after she thought about it, grabbing by the side makes sense to help with cross contamination. Interview with DON on 4/29/2024 at 1:30 pm she stated that she did not realize the lids did not cover the entire drinking area of the cup. She stated that cups should be grabbed by the side of the cups to prevent cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with ADM on 4/29/2024 at 2:00 pm he stated that his expectation is that the infection control and hand hygiene policies be followed. He stated anytime it is not followed it puts the resident at risk for infection from cross contamination. Record review of the facility's infection prevention and control program policy, undated, stated: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development of transmission of communicable disease and infection as per accepted national standards and guidelines. Record review of the facility's Hand Hygiene policy, undated, stated: Hand washing with either soap and water or hand sanitizer is the best way to stop the spread of infection, Before and after Assisting a resident with meals.