

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage House Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Pipeline Rd Sulphur Springs, TX 75482	
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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 3 of 3 kitchens (Kitchen #1, Kitchen #2, and Kitchen #3) reviewed for dietary services.1. The dietary staff failed to label and date all food items in Kitchen #1.2. The dietary staff failed to effectively reseal, label and date frozen and refrigerated food items in Kitchen #1.3. The dietary staff failed to put separate dented cans from undented cans in Kitchen #1.4. The facility failed to ensure CNA B and CNA C wore their hairnets properly during the lunch meal in Kitchen #2 on 07/21/2025.5. The facility failed to ensure Honey Nut and Crisp [NAME] cereal were not left unsealed in Kitchen #3.6. The facility failed to ensure 2 containers of tea in Kitchen #3 were dated.7. The facility failed to ensure a medicine cup was not left in the sugar container in Kitchen #3.8. The facility failed to ensure proper storage and labeling of food in airtight containers after opening.9. The facility failed to ensure that kitchen staff appropriately restrained their hair with the hairnet.10. The facility failed to monitor the temperature of the household dishwasher in Kitchen #2 and Kitchen #3.11. The facility failed to monitor the temperature of the food heated in the microwave in kitchen #3. These failures could place residents at risk for food contamination and foodborne illness. Findings included: 1. During observations with the Dietary Manager on 07/23/25 beginning at 9:33 am, the following observations were made in the kitchen refrigerator (1 of 2) in Kitchen #1: - (1) 3-liter container of spaghetti sauce had a prep date of 7/18/25 and no expiration date. - (1) 3-liter container of jalapeno peppers had an open date of 5/5/25 and no expiration date - (1) 2-gallon size bag of lettuce had an open date 7/18/25 and no expiration date. - (1) 1-gallon of sweet tea had a preparation date of 7/21/25 and no expiration date - (1) 1-gallon of unsweet tea had a preparation date of 7/21/25 and no expiration date. During observations with the Dietary Manager on 07/23/25 beginning at 9:38 am, the following observations were made in the kitchen refrigerator (2 of 2) in Kitchen #1: - (3) cups of prune juice had a preparation date of 7/21/25 and no expiration date. - (1) cup of apple juice had a preparation date of 7/21/25 and no expiration date. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dietary Manager stated she had 3 residents on puree diets. The Dietary Manager stated it was important because it's their home and that's how staff are to serve the residents; the food is supposed to look neat and not sloppy; residents should get their food how we want our food. During an interview on 7/23/25 at 9:49am., the Dietary Manager stated she had been employed at the facility since March 2025. The Dietary Manager stated the Administrator oversaw her. The Dietary Manager stated she walked thru the kitchen every day. The Dietary Manager stated all food items were to be labeled, dated with the receive date, open date and expiration date. The Dietary Manager stated staff had completed in-services on labeling and dating all food items back on April 17th, 2025. The Dietary Manager stated she had not completed in-services with staff on resealing refrigerated and frozen food items. The Dietary Manager stated since she had been the Dietary Manager the Administrator did not conduct walk throughs in the kitchen. The Dietary Manager stated the owner of the facility conducted walk throughs in kitchen. The Dietary Manager stated, it was important to ensure staff were labeling, dating and resealing refrigerated and frozen food items so that staff knew what needed to be discarded and what staff can and can not use. During an interview on 7/23/25 at 10:24am, the Administrator stated she had been the Administrator at the facility for 7 years. The Administrator stated she oversaw the Dietary Manager. The Administrator stated she conducted regular walk throughs in the kitchen monthly. The Administrator stated all food items in the kitchen were to be labeled, dated with receive date, open date and expiration date. The Administrator stated the dietary staff had completed in-services on labeling and dating in the past. The Administrator stated in-services on resealing refrigerated and frozen food items was conducted by the Dietary Manager this week of 7/21/25. The Administrator stated it was important to ensure staff were labeling, dating and resealing refrigerated and frozen food items so that staff did not use something that was expired. 2. During an observation on 07/21/2025 at 11:35 AM, CNA B was plating the lunch meal and CNA C was standing right next to her while she plated the food in Kitchen #2. CNA B had a hair net on, but she had a piece of hair not contained in her hairnet. CNA B's strand of hair fell to her shoulder outside of the hairnet, while she was serving the lunch meal. CNA C was standing next to CNA B when CNA B was serving. CNA C was taking the uncovered plates to the dining table for the residents. CNA C's hairnet was not restricting the bottom half of CNA C's shoulder-length hair. During an interview on 07/22/2025 at 1: 56 PM, CNA B said when she was serving food her hairnet should restrict all her hair. CNA B said there should be no hair hanging out of the hairnet. CNA B said she did not realize her hair was hanging out of the hairnet. CNA B said it was important to wear the hairnets properly for it to be cleaner for the residents and so the hair did not get in the food. During an interview on 07/22/2025 at 2:00 PM, CNA C said the hairnet should restrict all of her hair not just the top half. CNA C said she was not wearing her hairnet properly because she was in a hurry. CNA C said hairnets should be worn properly to prevent hair from getting in the food. During an observation of the kitchen in Kitchen #3 with CNA G starting on 07/22/2025 at 2:27 PM, there were 35 oz bags of Honey Nut cereal and Crisp [NAME] cereal opened and not sealed. They were open to air. There were 2 pitchers of tea that were undated on the kitchen counter, and a container with sugar that had a plastic medicine cup inside of it. CNA G said the bags of cereal should be placed in a Ziploc bag and should not be left open to air. CNA G said they should be sealed so they did not get stale. CNA G said leaving it unsealed could result in contamination of the food and cause illness. CNA G said when tea was made it should be dated. CNA G said it should be dated to ensure (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	they did not serve tea that was bad. CNA G said they were not supposed to leave medicine cups in the sugar. CNA G said the medicine cup should not be left in the sugar because different people used it, and it could result in contamination and infections. 3. During an observation on 07/21/2025 at 11:35 AM., in Kitchen #3: 1 1/2 full tub of cottage cheese with no open date. 1 bag of opened pancakes with no open date and no use by date. 2 bags of opened sliced ham with no open date and no use by date. 1 bag of sausage patties with no open date and no use by date. 2 1/4 quarts of tea without use by date. During an observation and interview on 07/21/2025 at 01:35 PM, CNA G was putting the dirty dishes in the residential/household dishwasher. CNA G said she used the sanitize cleaning mode with Cascade Platinum dishwasher soap. CNA G said she was unable to verify a temperature to ensure proper sanitation. During an observation and interview on 07/21/2025 at 04:35 PM. CNA G was in Kitchen #2 serving food without a hairnet. CNA G was plating all the food for the residents without a hairnet. CNA G was heating the lunch food in the microwave and failed to take the temperature of the food prior to serving. CNA G said she should have taken the temperature and/or allowed the food to cool off before serving to the residents. CNA G said the microwaved heated food could have been too hot and burned a resident. During an observation on 07/22/2025 at 11:35 AM., in Kitchen #2: ^ 1 Ziploc bag of boiled shrimp not dated or labeled. ^ 1 1/2 full tub of cottage cheese with no open date. ^ a bag of opened pancakes with no open date and no use by date. crumbs and black crustlike substances in the microwave and oven. During an interview on 07/22/2025 at 02:35 PM., CNA G said staff should wear hairnets that covered hair appropriately while in the kitchen serving food. CNA G said all food once opened should be bagged, sealed and appropriately labeled with the date opened and expiration date. CNA G said it was important to follow appropriate food handling practices to keep the residents healthy and prevent cross contamination and food borne illness. CNA G said the appliances should be kept clean by wiping down after each use to prevent cross contamination. During an interview on 07/23/2025 at 3:58 PM, the Dietary Manager said she was not aware she was supposed to be checking Kitchen #2 and Kitchen #3. The Dietary Manager said she had just been focused on Kitchen #1. The Dietary Manager said when something was opened it should be dated. The Dietary Manager said cereal should be stored in a sealed bag once it was opened. The Dietary (continued on next page)		

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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** Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 21 residents (Resident #24) and 2 of 8 medication carts (Building #2 and Building #3 nurse medication carts) reviewed for drugs and biologicals. 1. The facility failed to ensure Resident #24's formoterol fumerate (inhaled medication to improve breathing) was properly stored and secured. 2. The facility failed to ensure LVN A did not leave Resident #24's budesonide and formoterol fumerate (inhaled medications) in the chamber of his nebulizer (chamber on the breathing machine that holds the liquid medication to be converted to a mist for inhalation) . 3. The facility failed to ensure a lock box inside the nurse medication cart for Building #2 with diazepam (anti-anxiety medication), hydrocodone/acetaminophen tablets (controlled pain medication), and tramadol (controlled pain medication) was permanently affixed. 4. The facility failed to ensure a lock box inside the nurse medication cart for Building #3 with alprazolam (anti-anxiety medication) acetaminophen/codeine tablets (controlled pain medication), and hydrocodone/acetaminophen tablets (controlled pain medication) was permanently affixed. 5. The facility failed to ensure LVN F secured the nurse medication cart keys for Building #3, when it was not in use on 07/22/2025. These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion. Findings included: 1. Record review of Resident #24's face sheet dated 7/23/2025 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs) and vascular dementia (condition caused by the lack of blood that carries oxygen and nutrients to a part of the brain and causes problems with reasoning, planning, judgment, and memory). Record review of Resident #24's Quarterly MDS assessment dated [DATE] indicated he was understood by others and was able to understand others. The MDS assessment indicated Resident #24 had a BIMS score of 9, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #24 required partial/moderate assistance with dressing, personal hygiene, and showering/bathing. The MDS assessment indicated Resident #24 had shortness of breath or trouble breathing with exertion and when lying flat. Record review of Resident #24's Order Summary Report dated 07/23/2025 indicated he had an order for: Budesonide Suspension 0.25 mg/2 ml inhale orally two times a day with a start date of 05/20/2025. Perforomist Inhalation Nebulization Solution 20 mcg/2 ml (Formoterol Fumarate) 20 mcg inhale orally via nebulizer every morning and at bedtime with a start date of 05/29/2025. Record review of Resident #24's care plan revised 06/17/2024 indicated he had impaired cognitive function and dementia, or impaired thought processes related to difficulty making decisions. Resident #24's care plan indicated he used his own nebulizer machine (machine used to turn liquid medication into a fine mist for inhalation into the lungs) per his choice to administer aerosol (liquid suspension used in an inhaler) or bronchodilators (medication that opens the airways to help breathe better) as (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordered and monitor/document any side effects and effectiveness. Record review of Resident #24's July 2025 MAR indicated his budesonide suspension 0.25mg/2ml and Performist Inhalation Nebulization Solution 20 mcg/2 ml were marked as administered by LVN A for the morning doses on 07/21/2025. During an observation and interview on 07/21/2025 at 2:23 PM, Resident #24 was in his room, he had 2 ampules of formoterol fumerate 20 mcg/ml nebulizer on his overbed table. Resident #24 said he brought them from home. There was clear liquid, approximately halfway full, in the chamber of Resident #24's nebulizer. Resident #24 said it was his breathing treatment, but he did not specify who left it there or how long it had been there. During an interview on 07/21/2025 3:19 PM, LVN A said she was Resident #24's nurse. LVN A said she had left Resident #24's breathing treatments (budesonide and formoterol fumerate) in his nebulizer that morning (morning of 07/21/2025). LVN A said she tried to tell Resident #24 to do his breathing treatments. LVN A said left the breathing treatments for him to do later in the day. LVN A said Resident #24 said he would do it later. LVN A said she should not have left Resident #24's breathing treatment in his nebulizer. LVN A said she should have stayed with Resident #24 until he completed his breathing treatment. LVN A said she did not know Resident #24 had 2 ampules of formoterol fumerate on his overbed table. LVN A said she had not given them to Resident #24. LVN A said he was not supposed to have them in his room because they had confused residents, and someone else could go in his room and get them. LVN A said she did not know of risks associated with leaving Resident #24's budesonide and performist in the nebulizer chamber. During an interview on 07/23/2025 at 3:36 PM, the ADON said they did not use self-administration for the residents. The ADON said they had several demented residents that could go in the rooms, and they did not have any residents who would qualify to self-administer medications. The ADON said Resident #24 should not have had ampules of formoterol fumerate on his overbed table. The ADON said the charge nurse, management, and the CNAs should report medications in the residents' rooms if they saw them. The ADON said Resident #24 had memory lapses and he was not able to administer medications to himself. The ADON said other residents could go in Resident #24's room and consume the medications, and they could have negative reactions. The ADON said Resident #24 could potentially get double dosed. The ADON said when a nurse administered a breathing treatment they should stay with the resident and make sure the residents were taking the medication. The ADON said if the resident did not want to complete the breathing treatment the nurse should document the medication as refused, but they should not leave it in the nebulizer chamber. The ADON said leaving the medication in the nebulizer chamber could result in Resident #24 not getting the full medication. The ADON said the residents could have respiratory issues if they did not get the full effect of the treatment and have a negative outcome. During an interview on 07/23/2025 at 3:45 PM, the DON said the residents should not have medications in their rooms. The DON said Resident #24 should not have formoterol fumerate in his room. The DON said the department heads should be making rounds weekly to check for medications in the residents' rooms. The DON said medications in the residents' rooms could cause medication errors. The DON said the nurses should not leave the breathing treatments in the nebulizer chamber. The DON said the nurses were supposed to stay with the residents during their breathing treatment and rinse the chamber after the treatment. The DON said leaving the medication in the chamber could result in the residents getting too much or too little. (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 07/23/2025 at 4:33 PM, the Administrator said the residents should not keep medications at the bedside. The Administrator said nursing was responsible for ensuring this did not happen. The Administrator said it was important for the residents not to keep medications in their rooms because they had not been approved to give themselves medications. The Administrator said if the nurse left medication in the chamber of the nebulizer, they should be following up with the resident to ensure the breathing treatment was completed. The Administrator said if medication was left in the nebulizer chamber, it placed residents at risk to self-administer medications or they could drink it. 2. During an observation and interview on 07/22/2025 01:55 PM, LVN F entered the building and opened the unlocked desk drawer at the nurse station and took out the keys to Building 3's medication cart. LVN F proceeded to unlock the Building 3's medication cart and removed the locked box of narcotics and sat it on top of the medication cart. LVN F said she normally counted down the medication cart with the other nurse on duty and gave the medication keys to her before exiting the building. LVN F said the medication cart keys had not been placed in a locked secured place and could place the resident's medications at risk of misappropriation or a drug diversion. LVN F said she was not aware of the need for an affixed locked narcotic box on the medication cart. LVN F said the box not permanently affixed could result in the entire box being stolen and could put the residents at risk of not having medications. During an observation and interview on 07/23/2025 at 09:14 AM, LVN N opened Building #2's medication cart and removed the locked narcotic box of narcotics and sat it on the top of the medication cart. LVN N said she was not aware the medication cart locked narcotic box was supposed to be permanently affixed to the medication cart. LVN N said a drug diversion would occur if the locked narcotic box was taken. During an interview on 07/23/2025 at 09:40 AM, the ADON said he was not aware that it was necessary to have permanently affixed locked narcotic box on the medication carts. The ADON said he expected the staff to ensure the medication cart keys stayed always secured to prevent any drug diversions. During an interview on 07/23/2025 at 12:30 PM, the DON said she was not aware that it was necessary to have a permanently affixed locked narcotic box on the medication carts. The DON said she expected all staff to ensure the medication cart keys stayed secured by whoever was assigned to the cart to prevent misappropriation and/or a drug diversion. The DON said it was important to ensure the residents had their medication readily available for their needs. The DON said she and the ADON conducted random rounds daily to check to ensure the medication carts were secured. The DON said the nurses were responsible for ensuring the medication carts were locked. During an interview on 07/23/2025 at 1:30 PM, the Administrator said there was a system in place to check the medication carts. This system included the clinic staff and the pharmacy consult checking the medication carts to ensure everything was secured and dated. The Administrator said it was important to ensure the resident's medications were secured to prevent any misappropriation and eliminate the potential of any drug diversions. The Administrator said a drug diversion could place the residents at risk of not having needed medications readily available. Record review of the facility's policy, titled, Medication Labeling and Storage, revised February 2023, indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.7.controlled (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Carriage House Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Pipeline Rd Sulphur Springs, TX 75482	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	substances are separately locked in permanently affixed compartments, except when using single dose drug distribution systems. Record review of the facility's policy, titled Controlled Substances, revised November 2022, indicated, 3. The charge nurse on duty maintains the keys to controlled substance containers.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 1 of 3 meals (7/22/2025 Lunch) and for 5 of 5 residents reviewed for palatability, attractiveness, and appetizing (Resident #'s 63, 33, 10, 54, and 88). The dietary staff failed to provide food that was palatable and appetizing temperature for 1 of 3 meals observed on 7/22/25 (lunch) meal in Kitchen #1. The facility failed to ensure Resident #'s 63, 33, 10, 54 and 88 food was not served bland and lacking flavor. These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: Record review of the menu indicated the lunch meal items on 7/22/25 included BBQ brisket, potato salad, fried okra, sliced bread and vanilla [NAME] pie dessert. During an interview on 07/21/2025 at 09:55 AM Resident #63 stated the food was bland. During an interview on 07/21/2025 at 10:53 AM Resident #33 stated the food was bland. During an interview on 07/21/2025 at 2:34 PM, Resident #10 said, They do not know how to cook; it doesn't look or taste good. During an interview on 07/21/2025 at 2:20 PM, Resident #54 said the food did not taste good. During an interview on 07/23/2025 at 12:49 PM Resident #88 said the food was often cold because it was brought in from the main building and by the time the residents got the food it was cold which made the food taste bad. During observation and tasting of the lunch meal on 7/22/25 at 12:09 p.m., the Dietary Manager and [NAME] H stated the BBQ was warm, the fried okra was not warm, the potato salad tasted like potato salad and the vanilla [NAME] dessert pie crust was hard. During observation and tasting of lunch meal on 7/22/25 at 12:09 p.m., the surveyors stated the BBQ was not warm and was salty, the fried okra was not warm, the potato salad tasted like potato salad and the vanilla [NAME] dessert pie crust was hard. During an interview on 7/22/25 at 12:00 pm, [NAME] H stated she had been the [NAME] at the facility for 20 years. [NAME] H stated the facility had 3 residents on a puree diet. [NAME] H stated she did not understand the question when asked why it was important to the residents for the cold food to be served at 41 degrees Fahrenheit and below for cold foods and for the hot foods to be served at least 135 degrees Fahrenheit and above at the steam table. [NAME] H stated the potato salad was to be served as a cold food item. During an interview on 7/23/25 at 9:40 am the Dietary Manager stated she had been the dietary manager since March of 2025. The Dietary Manager stated the Administrator oversaw her at the facility. The Dietary Manager stated she tasted the foods. The Dietary Manager stated she tasted the foods from the newer cooks more often than the older cooks. The Dietary Manager stated the last in-service on following recipes had not been completed on staff since she had been the dietary manager. The Dietary Manager stated she would in-service staff on following the recipe. The Dietary Manager stated she had 3 residents on puree diets. The Dietary Manager stated it was important because it's their home and that's how staff are to serve the residents; the food is supposed to look neat and not sloppy; residents should get their food how we want our food. During an interview on 7/23/25 at 10:14am the Administrator stated she had been the administrator for 7 years. The Administrator stated she oversaw the Dietary Manager. The Administrator stated she would eat at the facility. The Administrator stated her last test tray was completed about 3 months ago at the facility. The Administrator stated the food complaints were tricky because a lot of times the residents had issues with food preferences. The Administrator stated the residents had not complained about cold food to her recently. The Administrator stated she handled food complaints by letting the Dietary Manager know about the food complaint and having the Dietary Manager talk to the resident to address all food complaints issues. The Administrator stated she did not know if the staff had completed in-services on following the recipes recently. The Administrator stated it was important to ensure the food was palatable, attractive and appetizing to the residents because, the food was the one of the main things the resident had looked forward everyday. Record review of the food preparation and service policy dated October 2017 indicated, (1) the danger zone for food (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature is between 41 degrees and 135 degrees. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. (3) The longer food remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41 degrees or above 135 degrees. Potentially hazardous food held in the danger zone for more than 4 hour (if being prepared from ingredients at room temperature) Or 6 hours (if cooked and then cooled) may cause foodborne illness.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to make a comprehensive assessment of each residents' needs, strengths, goals, life history, and preferences within 14 calendar days after admission for 1 of 21 residents (Resident #43) reviewed for accuracy of assessments. The facility failed to complete Resident #43's admission MDS assessment, with an ARD of 06/03/2025, within 14 days of admission. This failure could place residents at risk of not having their needs met. Findings included: Record review of a face sheet dated 07/23/2025 indicated Resident #43 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease (progressive disease that destroys memory and other important mental functions) and dementia in other diseases classified elsewhere, severe, with other behavioral disturbance (deterioration of memory, language, and other thinking abilities with behaviors). Record review of Resident #43's Comprehensive MDS assessment with an ARD of 06/03/2025 indicated in Section A0310 it was an admission assessment (required by day 14). The MDS assessment for Resident #43 indicated in Section A1600 an entry date of 05/22/2025. The MDS assessment in Section Z0500B was signed completed on 06/13/2025, which indicated the MDS assessment for Resident #43 was completed 9 days late. During an interview on 07/23/2025 at 3:15 PM, MDS Coordinator D said she was responsible for completing Resident #43's admission MDS assessment. MDS Coordinator D said the admission MDS assessment should be completed within 14 days of admission. MDS Coordinator D said she tried her best to complete them within the 14 days. MDS Coordinator D said she kept a calendar to keep track of the MDS assessments that needed to be completed. MDS Coordinator D said she completed Resident #43's admission MDS assessment late because she was working on the floor. MDS Coordinator D said not completing the admission MDS assessment by the required timeframes could affect the way they got paid. During an interview on 07/23/2025 at 4:29 PM, the Administrator said the MDS Coordinators should be completing the MDS assessments per the requirements. The Administrator said she did not know how it could affect the residents, but it could affect the way they got paid. Record review of the facility's policy revised July 2017, titled, MDS Completion and Submission Timeframes, indicated, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 updated October 2023 indicated, For the admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600).		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 3 residents reviewed for respiratory care. (Resident #33) The facility failed to administer Resident #33's oxygen as ordered on 07/22/25. This failure could place residents who receive respiratory care at risk for developing respiratory complications. Findings included: Record review of Resident #33's face sheet dated 07/22/25, indicated a [AGE] year-old male who readmitted to the facility on [DATE] with diagnoses which included heart failure (chronic condition in which the heart doesn't pump blood as well as it should) and acute respiratory failure with hypercapnia (condition where the lungs cannot adequately remove carbon dioxide from the blood, leading to dangerously high levels of carbon dioxide). Record review of Resident #33's quarterly MDS assessment dated [DATE], indicated he was able to be understood and understood others. Resident #33 had a BIMS score of 9 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #33 received oxygen therapy. Record review of Resident #33's comprehensive care plan revised on 09/10/24, indicated Resident #33 had oxygen therapy related to ineffective gas exchange. The care plan indicated Resident #33 received oxygen via nasal cannula at 2 liters per minute for shortness of breath and oxygen saturation 90%. Record review of Resident #33's order summary report dated 07/22/25, indicated he had an order for oxygen 2 liters as needed to maintain oxygen saturation greater than 90% with an order start date of 05/29/25. The order indicated to obtain oxygen saturation every shift and mark Y if oxygen was applied with the amount and to mark N if oxygen was not applied. Record review of Resident #33's medication administration record dated 07/01/25-07/31/25, indicated on 07/22/25 in the AM Resident #33 was administered oxygen at 2 liters by LVN M. During an observation on 07/22/25 at 09:07 AM Resident #33 was in his bed. He received oxygen at 3.5 liters per minute via nasal cannula. During an observation and interview on 07/22/25 at 1:47 PM, Resident #33 was in his bed and received oxygen at 3.5 liters per minute via nasal cannula. He said he started using the oxygen about a week ago and was unsure of what the oxygen was supposed to be set at. He said the nurse handled the oxygen setting. During an observation and interview on 07/22/25 at 4:29 PM, the MDS Coordinator went to Resident #33's room and observed his oxygen setting. She said Resident #33's oxygen was set at 4 liters per minute. She went to review his orders and said Resident #33 had an order for oxygen at 2 liters per minute. She said the oxygen task had been marked completed by LVN M that morning. She said the nurse making the morning rounds was responsible for ensuring the oxygen was set at the ordered rate. She said failure to check the oxygen rate could place the resident at risk for receiving too much oxygen or not enough which could cause them to have trouble breathing. The MDS Coordinator went and checked Resident #33's oxygen saturation and it read 90% which she said could have been the reason the oxygen was titrated up. She said the nurse should have made a note or notified the doctor when the oxygen was increased. During an interview on 07/23/25 at 2:17 PM, the DON said she strongly believed oxygen was a nursing intervention. She expected the orders and care plan to reflect the amount of oxygen the resident received. She said every resident in the facility should have had an order for oxygen at 2-4 liters per minute and the nurse who placed Resident #33's order should have never written it for 2. She said the nurse should have known to write the oxygen orders for 2-4 liters per minute. She said there were no risks for Resident #33 not receiving his oxygen at the ordered rate. During an interview on 07/23/25 at 2:40 PM, the Administrator said administration of oxygen was a nursing function and to be used as an intervention. She said she expected orders to be obtained and the residents orders to be updated accordingly. She said she expected the nurse to check the oxygen rate during their morning rounds. She said she was unsure of the risks for setting the oxygen at the wrong rate. During an interview on 07/23/25 at 4:22 PM, LVN M said when she marked the oxygen order on Resident #33 MAR, his (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen was set at 2 liters per minute. She said the nurse was responsible for ensuring the oxygen was set at the ordered rate. She said there were no risks to the resident as he was set at the correct rate when she had worked that morning. Record review of the facility's policy Oxygen Administration revised October 2010, indicated . The purpose of this procedure is to provide guidelines for safe oxygen administration.1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 7 residents (Resident #35 and Resident #88) and 2 of 2 staff (CNA K and CNA G) reviewed for infection control. 1. The facility failed to ensure CNA K changed her gloves and performed hand hygiene when she provided incontinent care to Resident #35 on 07/22/2025. 2. The facility failed to ensure CNA G followed enhanced barrier precautions related to a wound while assisting Resident #88 with the use of a urinal on 07/23/2025. These failures could place residents and staff at risk for cross-contamination and the spread of infection. Findings included: 1. Record review of Resident #35's face sheet dated 07/22/25, indicated a [AGE] year-old female who admitted to the readmitted to the facility on [DATE] with diagnoses which included dysphagia (difficult swallowing) and protein-calorie malnutrition (inadequate intake of protein and calories in diet). Record review of Resident #35's quarterly MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. Resident #35's BIMS score was a 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #35 was totally dependent on facility staff with toileting, showering, dressing and personal hygiene. Resident #35 was always incontinent of bowel and bladder. Record review of Resident #35's comprehensive care plan revised on 12/09/24, indicated she had bowel and bladder incontinence. The care plan interventions included to clean peri-area with each incontinent episode. During an observation on 07/21/25 at 10:09 AM, revealed CNA K and CNA L entered Resident #35's room to transfer the resident to the shower chair. CNA K and CNA L observed Resident #35 to have an incontinent episode of bowel. CNA K proceeded to provide incontinent care to Resident #35. CNA K unfastened Resident #35's brief and tucked it underneath her. CNA K then removed clean linen from the trash bag and placed them on the bed while wearing the same dirty gloves. CNA K failed to change her gloves and perform hand hygiene. CNA K then completed providing incontinent care to Resident #35. CNA K removed the dirty brief and placed it in a plastic bag. CNA K removed her gloves and applied the mechanical lift pad underneath Resident #35. CNA K failed to perform hand hygiene after removing her gloves. CNA K and CNA L transferred Resident #35 to the shower chair using the mechanical lift. CNA K and CNA L performed hand hygiene after completion of transfer. During an interview on 07/21/25 at 12:11 PM, CNA K said she should have changed her gloves after she touched Resident #35's dirty brief and before touching the clean linen. She said she did not do that. She said she should have also performed hand hygiene when she removed her gloves. She said failure to change dirty gloves and perform hand hygiene placed residents at risk for infection. She said she was responsible for maintaining infection control protocols when providing incontinent care. During an interview on 07/23/25 at 2:17 PM, the DON said she expected staff to change their gloves when going from dirty to clean and when they removed their gloves. She said failure to do so placed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents at risk for infection. She said the CNA providing the incontinent care was responsible for ensuring infection control was maintained during incontinent care. During an interview on 07/23/25 2:40 PM, the Administrator said she expected gloves to be changed when going from dirty to clean and when removing gloves. She said failure to change gloves or perform hand hygiene placed the residents at risk for infection. She said the CNA providing the incontinent care was responsible for ensuring infection control was maintained during incontinent care. 2. Record review of a face sheet dated 07/23/2025 indicated Resident #88 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing (care provided after a hip fracture). Record review of Resident #88's electronic medical record on 07/23/2025 indicated his admission MDS assessment was in progress and had not been completed. Record review of Resident #88's Order Summary Report dated 07/23/2025 indicated he had an order for enhanced barrier precautions related to a surgical incision and wounds to monitor staff for PPE use and make sure the room was stocked with a start date of 07/18/2025. Record review of Resident #88's care plan revised 07/21/2025 indicated he required enhanced barrier precautions related to his surgical incision and wounds. Resident #88's care plan indicated staff would wear gloves and gowns for the following high contact care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. During an observation on 07/22/2025 starting at 11:08 AM, on the doorway entrance, next to Resident #88's name were the letters EBP on bright pink paper. Resident #88 was in his bed and requested to use the urinal. CNA G put on gloves and did not put on a gown. CNA G went to Resident #88 while he was in the bed, leaned her body against the bed, and helped him by uncovering him and lowering his pants and brief. CNA G helped Resident #88 with holding the urinal in place while he attempted to use it. During an interview on 07/22/2025 at 11:23 AM, CNA G said she was not aware Resident #88 required enhanced barrier precautions. CNA G said usually when residents required special precautions, they had a cart outside their door with the PPE required, and they had a sign on the door. CNA G said PPE should be worn when necessary to prevent germs from getting on the resident and prevent them getting germs from the resident. During an interview on 07/22/2025 at 11:28 AM, LVN F said Resident #88 required enhanced barrier precautions because he had a wound. LVN F said the staff should be wearing PPE when providing care to him such as with transfers and incontinent care. LVN F said when assisting Resident #88 with the urinal the staff should wear gown and gloves. LVN F said the charge nurses were responsible for ensuring the CNAs knew the residents who required enhanced barrier precautions. LVN F said it was important for enhanced barrier precautions to be followed to prevent the transfer of germs. During an interview on 07/23/2025 at 3:31 PM, the ADON said Resident #88 required enhanced barrier precautions due to his wound. The ADON said ensuring the CNAs knew to use enhanced barrier (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS discharge assessment was electronically completed and transmitted to the CMS System within 14 days after completion for 1 of 1 resident (Resident #86) reviewed for discharge MDS assessments. The facility failed to ensure Resident #86's discharge MDS assessment was completed within 14 days of discharge. This failure could place residents at risk of not having records completed and submitted in a timely manner as required. Findings include: Record review of a face sheet dated 07/23/2025 indicated Resident #86 was an [AGE] year-old female admitted to the facility on [DATE] and discharged on 04/26/2025. Resident #86 was admitted with diagnoses which included acute respiratory failure with hypoxia (condition where there is not enough oxygen in the blood) and fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing (fracture of the thigh long bone). Record review of Resident #86's Nursing Home Discharge Item Set with an ARD of 04/26/2025 indicated Resident #86 discharged home/community on 04/26/2025. The Nursing Home Discharge Item Set was signed completed on 05/15/2025 by MDS Coordinator E., which indicated it was completed 5 days late. During an interview on 07/23/2025 at 3:07 PM, MDS Coordinator E said she was responsible for completing Resident #86's discharge assessment. MDS Coordinator E said they had the discharge day plus 14 days to complete the discharge assessments, and Resident #86's discharge assessment was completed a couple days late. MDS Coordinator E said it was hard to complete the discharge assessments in a timely manner because they were swamped with other MDS assessments, and the discharge assessments were not a priority. MDS Coordinator E said MDS Coordinator D helped her to complete the discharge assessments to try to keep them up to date. MDS Coordinator E said it was important to complete the discharge assessments timely for CMS to be aware the residents had been discharged from the facility. During an interview on 07/23/2025 at 3:15 PM, MDS Coordinator D said Resident #86's discharge assessment was probably not completed in a timely manner. MDS Coordinator D said their priority was the admission MDS assessments and the skilled MDS assessments. MDS Coordinator D said she did not know the required timeframes for completion of the discharge assessments. MDS Coordinator D said it was important to complete the discharge MDS assessments because that was how they got paid. During an interview on 07/23/2025 at 4:32 PM, the Administrator said the MDS Coordinators were responsible for completing the discharge assessments. The Administrator said she expected for them to be completed per the requirements. The Administrator said not completed the discharge assessments per the requirements could affect their reports. Record review of the MDS Final Validation Report, submission date 05/15/2025, indicated, Resident #86's Nursing Home Item Discharge Set was completed more than 14 days after the ARD. Record review of the facility's policy titled, MDS Completion and Submission Timeframes, revised July 2017 indicated, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11 dated October 2023, indicated, Discharge Assessment-Return Not Anticipated must be completed discharge date plus 14 calendar days.		