STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675672	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Nursing & Rehabilitation	3922 W River Dr Corpus Christi, TX 78410

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on interview and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, for 1 (Resident #39) of 8 residents reviewed for abuse and neglect, in that: LVN A did not implement facility abuse policy related to reporting allegations of abuse to Resident #39's RP when CNA C was alleged to have abused Resident #39 on 10/22/24. This failure could place residents at risk of abuse and neglect. The findings included: Record review of Resident #39's face sheet dated 10/29/24 revealed a [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included Unspecified Dementia and Major Depressive Disorder. Record review of Resident #39's care plan dated 10/29/24 revealed no information regarding the reporting of abuse allegations. Record review of Resident #39's Quarterly MDS Assessment section C, Cognitive Patterns, dated 09/09/24 revealed a BIMS score of 6 (severe impairment). (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the provider investigation report dated 10/30/24 revealed the alleged abuse occurred on 10/22/24 at 11:00 PM. Further review revealed the alleged victim was Resident #39 and alleged perpetrator was CNA C. Further review revealed the incident category was Abuse. Further review revealed the following investigation summary, On October 22, 2024 at approximately 11:30pm [ADM] was notified by [DON] that our night shift charge nurse [LVN A] was bringing an allegation of Abuse and Neglect. LVN [A] states that she heard a resident yelling on the 200 hall and entered rom 209. She noticed [Resident #39] and [CNA C] in the resident's bed area. LVN [A] states that she heard the CNA [C] and resident yelling at each other and that the CNA [C] told the resident to 'Shut Up'[.] LVN [A] also stated that she observed the CNA [C] cover the resident mouth. The CNA [C] stated that she did not tell the resident to shut up but instead stated [Resident #39] please be quiet, there are people sleeping. Also stated she did not cover the resident's mouth but was actually attempting to to[sic] take paper out of her mouth. The LVN [A] and another [LVN B] assessed the resident for any injuries or concerns, they assessed her mouth and oral cavity and did not identify any concerns, or discoloration. Resident's physician notified. [ADM] interviewed the resident, unfortunately she did not remember or provide any information. She was in good spirits and she had no concerns. The CNA [C] was immediately suspended that night and it was decided to terminate the CNA [C] on 10/29/24. In an interview with the RP of Resident #39 on 10/28/24 at 1:18 PM, the RP stated Resident #39 did well at the facility. The RP stated Resident #39 was stubborn, but not combative. The RP stated she was not aware of any allegation of abuse made that involved Resident #39 being abused by CNA C at the facility. In an interview with the ADM on 10/28/24 at 1:43 PM, the ADM stated the DON contacted him at home around 11:30 PM on 10/22/24 to tell him LVN A may have witnessed potential abuse by CNA C. The ADM stated he had not called the RP to notify her of the abuse allegation. The ADM stated when there was an allegation of abuse, the doctor and RP should have been notified immediately by one of the nurses working at the time. In an interview with LVN A on 10/29/24 at 12:14 PM, LVN A stated she observed what she believed to be CNA C abusing Resident #39. LVN A stated she had only been working in the facility for a few weeks and was not sure of the process for reporting the abuse. LVN A asked LVN B for help and LVN B walked LVN A through the process of filing a complaint. LVN A stated the only person she called was the DON. LVN A stated she did not know if anyone called the RP of Resident #39. LVN A stated she performed an assessment on Resident #39 after the incident and did not find any injuries or markings. In an interview with LVN B on 10/29/24 at 2:37 PM, LVN B stated LVN A told her she had witnessed a CNA potentially abusing a resident. LVN B stated she called the NP to inform them about the potential abuse. LVN B stated she did not call the RP of Resident #39. In an interview with the DON on 10/29/24 at 1:10 PM, the DON stated she talked to LVN A on the phone immediately after the incident and told her to call the family of Resident #39 and document the incident. The DON stated she did a follow-up call with the RP of Resident #39 on 10/28/24 and learned at that time that LVN A never called the RP. The DON stated she usually made follow-up calls to the RPs within 3 to 5 business days after an allegation was made to inform them of the investigation results. The DON stated they should notify the RP as soon as possible after an allegation of abuse was made involving a resident. The DON stated the charge nurses on shift were the ones supposed to call the RP after an incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow-up interview with the RP of Resident #39 on 10/30/24 at 1:48 PM, the RP stated the DON called her sometime after this surveyor did on 10/28/24 to inform her of the incident. In an interview with Resident #39 on 10/30/24 at 3:30 PM, Resident #39 was unable to recall the incident with CNA C allegedly abusing her. Resident #39 stated the nurses were always nice to her and she had never had any issues with any of them. Record review of the facility policy Abuse Guidance: Preventing, Identifying and Reporting dated 02/17 and revised 10/22 revealed the following: Investigative Procedures Related to Allegations of Abuse, Neglect or Exploitation . Investigation should include, but is not limited to: Immediate notification of the alleged victim's practitioner and the family or responsible party.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on record reviews and interviews, the facility failed to ensure a PASRR evaluation was completed on newly admitted residents prior to admission or after admission for 2 (Residents #48 and #25) residents of 5 residents reviewed for PASRR screenings. 1. The facility failed to ensure Resident #48 had an accurate PASRR Level 1 screening 2. The facility failed to ensure Resident #25 had an accurate PASRR Level 1 screening These failures placed residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require. Findings included: 1. Record review of Resident #48's face sheet dated 11/08/22 revealed an [AGE] year-old male with an admitted [DATE]. Diagnoses including unspecified dementia, severe, with psychotic disturbance, Parkinsonism, bipolar disorder, current episode depressed, moderate 02/25/22, and generalized anxiety disorder 06/07/22. Record review of Resident #48's clinicals dated 11/04/22 received from the sending nursing facility listed diagnoses including bipolar disorder 11/8/2022, current episode depressed, moderate 02/25/22, Dementia 06/07/22, generalized anxiety disorder 06/07/22, mood (affective) disorder 07/01/21, anxiety disorder 05/01/21, Parkinson's 05/01/21. Record review of Resident #48's quarterly MDS dated [DATE] indicated Resident #48 had a BIMS of 0 (severely impaired cognition). Resident #48 did not display any behaviors during the assessment period. The assessment indicated active diagnoses of non-traumatic brain dysfunction, non-Alzheimer's dementia, anxiety disorder, bipolar disorder, unspecified dementia, severe, with psychotic disturbance, and Parkinsonism. Record review of Resident #48's comprehensive care plan dated 10/15/22 reflected o I require psychotropic medications and I am at potential risk for side effects r/t my medication regimen. Medication regimen is required r/t targeted behavior/behaviors: Antianxiety, Antidepressant, and Antipsychotic medication regimen Date Initiated: 10/28/2024. o I require anti-depressant, anti-anxiety medication r/t Dx: Bipolar Disorder w/Depression and Anxiety Disorder Date Initiated: 09/19/2024 Created on: 09/19/2024 Revision on: 09/19/2024. o I require anti-psychoticmedication: Dementia w/psychotic disturbance, Bipolar Disorder Date Initiated: 07/18/2023 Created on: 07/18/2023 Revision on: 09/19/2024. Record review of Resident #48's November 2024 physician orders reflected Anti-Depressant, Anti-manic, Antianxiety, and Antipsychotic side effect monitoring: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Order summary: Carbidopa-Levodopa four times a day related to Parkinson's disease. Clonazepam three times a day related to anxiety disorder. Fluoxetine one time a day for depression. Oxcarbazepine one time a day related to bipolar disorder. Oxcarbazepine at bedtime related to bipolar disorder. Seroquel at bedtime related to bipolar disorder. Trazodone one time a day for depression. Trazodone at bedtime for depression. Record review of Resident #48's progress notes dated 9/7/2024 at 5:53 am: Resident became combative hitting and kicking. Staff attempted to redirect resident and unable to. Staff exited room to allow resident time to self soothe. 09/28/2024 at 9:58 am: Resident hitting, kicking, at staff. Hitting/kicking the door to memory care unit, not allowing staff to enter or exit the unit. Record review of Resident #48's PASRR dated 11/08/22 revealed #2 Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness? No. 2. Record review of Resident #25's face sheet dated 08/01/24 revealed a [AGE] year-old female with an admitted [DATE]. Diagnoses included metabolic encephalopathy, unspecified dementia, unspecified severity, with anxiety, epilepsy, generalized anxiety disorder, and schizoaffective disorder, bipolar type. Record review of Resident #25's quarterly MDS dated [DATE] indicated she had a BIMS of 10 (moderate cognitive impairment). The assessment indicated active diagnoses of medically complex conditions, non-Alzheimer's dementia, seizure disorder (epilepsy), anxiety disorder, and metabolic encephalopathy. Medications she was taking included antipsychotics, antianxiety, antidepressants, and opioids. Record review of Resident #25's comprehensive care plan dated 08/22/24 reflected: I have chronic health conditions & co-morbid conditions that have affected my physical function and may further affect my quality of life: Epilepsy, schizoeffective disorder, bipolar type. Date Initiated: 09/06/2024 Revision on: 09/06/2024 o I require psychotropic medications and I am at potential risk for side effects r/t my medication regimen: Antianxiety, Antidepressant, and Antipsychotic. Date Initiated: 10/28/2024 Created on: 10/28/2024. Record review of Resident #25's October 2024 physician order summary reflected Anti-Depressant, Anti-manic, Antianxiety, and Antipsychotic Side Effect Monitoring. Clonazepam every 12 hours for anxiety. Divalproex three times a day for seizures. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Doxepin at bedtime for Depression. Seroquel at bedtime for psychosis. Record review of Resident #25's PASRR dated 07/24/24 revealed #2 Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness? No. In an interview with the MDS nurse on 10/29/24 at 12:15 PM, she stated she would look into the 1012 for the PL1 dated 11/08/22. She said she was responsible for making sure residents had the correct PL1. The MDS nurse said she had since been re-educated on PASRR by the RDCR on what they should be looking for and not what a facility or entity provided. She said she had worked at the facility for a while. In an interview with the RDCR nurse on 10/30/24 at 2:23 PM, she said they did not have a 1012 for Resident #48 and never had one, but they had one signed by the doctor to be faxed to [NAME] (Local Intellectual and Developmental Disability Authorities) today. She said it was important for the residents because otherwise they would not get the services and or the benefits they deserved. She said improper screenings could be detrimental if the residents suffer a delay of care and or treatments. In an interview with the RDCR nurse at 10/30/24 at 2:32 PM, she stated Resident #25 should have had a positive PL1 for schizoaffective disorder and bipolar disorder. She said she would be submitting another form for R#25. Specific PASRR/L1 & L2 referral was requested, but not received. Record review of the facility's policy titled, Comprehensive Assessments revised January 2024 reflected, Compliance guidelines: Pre-admission screening determines whether the community can provide the level and scope of services required by the resident's medical and mental condition. This assessment is important because it is the initial source of information that will ultimately determine the resident's comprehensive care plan. Pre-admission screening and resident review (PASRR) screen is required of all individuals with mental illness (MI) or mental retardation (MR}. These screenings are provided within fourteen days of the resident's admission to the community, when there has been a significant change in the resident's condition, quarterly, and annually (every twelve months). PASRR preadmission screens: Residents with mental illness or mental retardation: The community coordinates resident assessments with pre-admission screening to maximize the resident assessment process. The community does not admit new residents with mental illness (MI) or mental retardation (MR) unless approved by the appropriate state mental health or mental retardation agency. Preadmission screening is required of all individuals with MI or MR.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observations, interviews, and record reviews, the facility failed to ensure that the comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, for 1 (Resident #140) of 8 residents whose care plans were reviewed for timing and revision. Resident #140's care plan was not revised after self-removal of her tracheostomy tube. Resident #140's care plan was not revised after her tracheostomy sutures were removed. Resident #140's care plan was not revised after pleasure feeding was discontinued and changed to a pureed diet. Resident #140's care plan was not revised after enteral feedings were discontinued. These failures could place residents at risk for inadequate care. The findings included: Record review of Resident #140's face sheet dated 10/12/24 reflected a [AGE] year-old female admitted on [DATE]. Diagnoses included nontraumatic stroke with subsequent right sided paralysis, anoxic (no oxygen) brain damage, vascular dementia, tracheostomy (breathing tube), and gastrostomy (feeding tube). Record review of Resident #140's MDS dated [DATE] reflected Resident #140 had a BIMS score of 01 indicating severe cognitive impairment. She was incontinent of bladder and bowel. Her active diagnoses included stroke, non-Alzheimer's dementia, hemiplegia (paralysis on one side of the body), respiratory failure, gastrostomy, and tracheostomy. J2710 involving the respiratory system including .trachea, J2910 involving the gastrointestinal tract . including creation of ostomies or percutaneous feeding tubes, K0520 Nutritional approaches-check all that apply: 1. On admission-Assessment period is days 1 through day 3 of the SNF stay starting with A2400B, column 2 while a resident/B. Feeding Tube, K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B, L0200-oral care, M1040 was checked for Surgical wounds, M1200-surgical wound care, Section N medications/High risk, were blank. Record review of Resident #140's care plan dated 10/12/24 and revised on 10/15/24 did not reflect any gastrostomy care, dietary changes, or tracheostomy. Enhanced Barrier Precautions practices as clinically indicated. Date Initiated: 10/12/2024. Drinking by Mouth: NPO (Nothing by Mouth) Date Initiated: 10/12/2024 Created on: 10/12/2024. I am at risk for experiencing discomfort or pain r/t (related to): Peg tube (g-tube) placement Date Initiated: 10/12/2024 Created on: 10/12/2024. Interventions: Monitor for s/s of substance abuse, such as changes in resident behavior, increased unexplained drowsiness, lack of coordination, slurred speech, mood changes, and/or loss of consciousness, etc. If s/s are noted, notify Physician and/or DON Date Initiated: 10/12/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #140's physician orders revealed: Oxygen and nebulizer orders were discontinued on 10/18/24 after Resident #140 self-removed her tracheostomy on 10/15/24. Enteral Feed two times a day at 65ml/hour for 22 hours to provide 2145 kcal, 97g protein, with automatic water flushes of 150ml/4hrs via pump. Downtime from 9am-11am. Active 10/28/2024. Discontinued 10/28/2024. Pleasure feeding was changed to Regular diet, Puree texture, Mildly Thick/Nectar-Like consistency related to dysphagia (difficulty swallowing) Active 10/23/2024. Enteral Feed Order every shift Check Gastric Tube placement by auscultation prior to water flushes Q (every) shift Active 10/23/24. Enteral Feed Order every shift Flush with 30ml H2O Q shift. Clean G-Tube stoma site with normal saline or wound cleanser, pat dry and leave open to air as needed and every evening shift Active 10/27/2024. Record review of Resident #140's progress notes dated 10/15/24 at 10:00 AM revealed the resident pulled oxygen tubing from trach and threw it behind her. Resident refused to allow nurse or NP (Nurse Practitioner) to check vitals or place oxygen on or around trach. EMS (Emergency Medical services) arrived and sent to ER. called RP to inform of trach removal. Record review of Resident #140's hospital records dated 10/15/24 revealed Resident #140 was sent to the ER in stable condition, and the tracheostomy was sutured closed at that time. Observation of Resident #140 and interview with DP on 10/28/24 at 9:20 AM revealed DP removed Resident #140's tracheostomy sutures at the bedside without difficulty. There was no bleeding or distress. DP explained the procedure and told Resident #140 that she would be able to eat food now, and she no longer required tube feedings. DP stated Resident #140 was doing very well. Resident #140 responded by smiling and nodding her head up and down indicating yes. In an interview with the DON on 10/29/24 at 2:35 PM she said, orders for EBP regarding g-tubes, tracheostomies and any tube were required. She said orders for Hospice were required. She said care plans should be updated at the time of changes in resident conditions. She said nursing was responsible for updating the care plans. She said she did not know how much time was acceptable to lapse between resident changes (good or bad) and updating care plans. She said care plans were supposed to be updated to coincide with resident care and to meet the individualized needs of the resident. She said the nurses and CNAs looked at the care plans to know how to take care of the residents they served. She said the resident came in with a trach and a g-tube and there were no EBP orders or PPE in the hallways for Resident #140. She said Resident #140's care plans were not updated, and there was no hospice in the physician orders. She said she was not sure how all these things got left out. She said she and the MDS nurse were responsible for overseeing care plans and the MDS, but there was no real monitoring in place. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the AD on 10/30/24 at 2:48 PM, she said Resident # 140 did not go to activities, but she had seen her in the dining room yesterday. She said she saw Resident #140 on admission when she could not talk because of the tracheostomy. She said she would go into Resident #140's room, turn the TV on and talk to her but did not realize Resident #140 could speak since she self-removed her trach. She said she did not have the exact date when she last saw her. She said she would make a point to get to know Resident #140. Record review of the facility policy revised January 2023 titled, Care Plans, under guidelines: The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate interventions in relation to the identified problem or risk, outcome objective, and the resident's ability, needs, medical condition, and preventable measures. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan should be updated and reviewed at least quarterly thereafter, then annually and with significant changes in conditions . The care plan should serve as a guide, which should direct care needs, choices, and preferences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46038 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments of one out of three medication cart (200-hall Medication Cart) reviewed for storage, in that: The facility failed to ensure the 200-hall Medication Cart was locked when left unattended. This deficient practice could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed mediations. The findings were: During an observation on 10/27/24 at 11:00 AM, the 200-hall medication cart was found unlocked and unattended. This surveyor was able to open all drawers revealing multiple blister packs and bottles of medication. In an interview on 10/27/24 at 11:52 AM LVN D stated she was helping a resident get ready to go out on pass. LVN D stated she did not realize she left the medication cart unlocked and did not usually leave the medication cart unlocked. LVN D stated it was important the medication cart was locked at all times due to resident, visitor, and staff safety. LVN D stated by the medication cart being unlocked, anyone could get into the cart and take medications from the cart. LVN D stated the last in-service on keeping medication carts locked was about a few weeks ago. In an interview on 10/29/24 at 01:07 PM the DON stated the medication cart should not have been unlocked as it would not be safe for residents and visitors. The DON stated if the medication cart was not locked someone other than the nurse, like a resident with dementia, could open the medication cart, take out the medications and take them. The DON stated in-services are done quarterly and the last in-service on keeping medication carts locked was sometime in July of 2024. The DON stated LVN D received a one-on-one training and all staff received in-service on keeping medication carts locked on 10/27/24. Record review of the facility's Medication Cart Use and Storage dated 3/15/23 stated: Compliance Guidelines The Nursing Team Members (Nurses & CMA's) use the medication cart to systematically distribute physician ordered medications to residents. Guidelines 1. Security (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medication cart and its storage bins should be kept closed, secured and/or in the line of sight when not in use.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Nursing & Rehabilitation	3922 W River Dr Corpus Christi, TX 78410

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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44748 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 safely for 1 of 1 kitchen reviewed for sanitation. The facility failed to label and date prepared refrigerated drinks and puree. The facility failed to ensure ingredients were not left open to air in the dry storage room freezer, and on prep tables. The facility failed to ensure the kitchen was free of gnats. The facility failed to ensure personal items were not on a prep table. The facility failed to ensure dirty dishes were not on the clean rack. The facility failed to ensure the ice machine, non-stick pans, and a large spatula was maintained and sanitary. The facility failed to ensure items in the kitchen were clean. The facility failed to store cases of food off the floor in the freezer. The facility failed to discard used grease properly. These failures could place residents at risk of foodborne illnesses. Findings were: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations and initial tour of the kitchen on 10/27/24 at 11:15 AM revealed 10 of 18 glasses of juice, 2 sippy cups with a clear liquid in one and a yellow liquid in the other, three small glasses of milk, and a partially full 5-liter container of prepared pureed bread that was open to air in the service refrigerator. All items were unlabeled and undated in the service refrigerator. The prepared bread puree had a scoop inside. 3 of 15, 16 oz. containers of spice were open to air. A large plastic bag of cereal was open to air on a prep table. There were boxes of garlic bread sticks, sliced carrots, and hamburger patties open to air in the freezer. There was an unlabeled, undated bag of vegetable blend in the freezer that had a brownish color on the vegetables inside, and the vegetables were wilted. There was also a build-up of ice crystals in the bag of vegetables. There was a partially full 8 lb. container of mixed peanut butter and jelly with the lid ajar. There was a personal phone on a prep table. There was a brownish red removable substance on the ice chute inside the ice machine. The mouthpiece of a sippy cup lid on a clean rack was clogged with an unknown substance. There were 2 non-stick pans that were stacked together on a prep table next to the stove. They were dirty, eroded and flaking on the bottoms and sides. There was one non-stick pan that was eroded and flaking on the bottoms and sides on the clean rack to be used. There was a large spatula that had chips broken off around the edges on the clean rack for use. There were 6 cases of frozen food stored on the floor of the walk-in freezer. There was a large vat on the floor under the 3-compartment sink that was full of a brown substance resembling used grease. In an interview with the cook, on 10/27/24 at 11:25 AM, she said the spice containers should always be closed because something could get in them and if the contaminated spices were used on the food, it could make residents sick. She said she should have labeled and dated the glasses of juice and milk because she made them around 7:00 AM this morning for the lunch service. She said the pureed bread in the refrigerator should not have been open to air nor have a scoop inside, and it should have been labeled and dated. She said it was left over from breakfast service around 7:00 AM. She said the sippy cups with juice and the glasses of milk should have been labeled and dated because she made them this morning around 7:00 AM for lunch service. She said the gnats had been a problem but could not say for how long but said for a while. She said the items in the freezer should not have been unsealed because they could get freezer burn which would alter the taste or because something else could get into the open food, get cross contaminated, and make the residents sick. She said she had just stocked the cases of frozen food on the shelf beside them and did not know how or who might have moved them onto the floor. She said the dirty non-stick pans should not have been on the prep table. She said the non-stick pan on the clean rack was there for use. She said all of the non-stick pans should have been discarded before they became eroded as much as they were. She said she did not know why she did not discard them. She said the spatula was used all the time because it was the only one they had. She said the spatula should have been discarded because the bits of plastic that were breaking off of the spatula could get into the resident's food and hurt them or make them sick. She said she did not know when the vat of grease was emptied. She said she thought it was weird the way the facility collected the grease and discarded it and she had never done that at the facility. In an interview with the DA on 10/27/24 at 11:30 AM, she said the removable reddish-brown substance on the ice chute inside the ice machine was mold or bacteria of some kind. She said the unknown substance in the mouthpiece of the sippy cup lid was gross and some kind of food. She said the container with the mix of peanut butter and jelly should not have been there with the lid halfway on and it had been sitting on the prep table since around 7:00 PM yesterday on 10/26/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DM on 10/30/24 at 3:57 PM, she said the kitchen staff should have known about labeling drinks, food and keeping foods sealed. She said the prepared pureed bread mix with the scoop inside should have been discarded or the scoop removed, the container covered properly, labeled, dated, and placed in the refrigerator. She said she did not know why the cereal was not put away properly because items that were open to the air could spoil and become cross contaminated. She said the peanut butter and jelly mixture should have been covered, labeled, dated and put away in the refrigerator. She said the personal phone, or any personal item was never allowed in the kitchen because of cross contamination. She said staff could touch a personal item with their hands and not wash their hands afterwards every single time. She said cross contamination could make the residents ill. She said the non-stick pans were contaminated and should have been discarded. She said the finish on the non-stick pans could come off in the food and make residents ill. She said the ice machine was cleaned weekly. She said the dirty dishes on the clean rack should not have been there and whatever was in the mouthpiece of the sippy cup should not have been there and especially not on the clean rack because residents were served from dishes on the clean rack. She said the cases of frozen on the floor was inexcusable and her staff knew better. She said the broken spatula and dirty non-stick pans should have been in the 3-compartment sink and more importantly, all of them should have been discarded before they got so bad. She said kitchen staff were responsible for letting her know when equipment needed to be replaced so she could order replacements in a timely manner. She said she did not know why kitchen staff were using such a large vat to discard used grease. She said the used grease should have been discarded properly as it was emptied from the deep fryer every time because the vat was so large, it could risk injury to the staff and create an environmental hazard if it spilled while pouring it in the grease trap outside. Record review of kitchen specific in-services: 08/26/24 Pot and pan cleaning, 09/30/24 Choking hazards, 10/08/24 Utilizing standardized menus, recipes, and extensions. Record review of the facility policy revised 06/01/19 titled Food Storage revealed under Dry Storage Room: 1. d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. H. Store all items at least 6 inches above the floor with adequate clearance between goods and ceiling to protect from overhead pipes and other contamination. Under Refrigerators: d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Under freezers: c. Store all foods on racks or shelves off the floor. E. Store frozen foods in moisture proof wrap or containers that are labeled and dated.

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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** 46038 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for one (Resident #61) of 4 residents reviewed for infection control practices, in that: The facility failed to ensure LVN E wore proper PPE during wound care for Resident #61 who required enhanced barrier precautions. This failure could place residents that require wound care at risk for healthcare associated cross-contamination and infections. The Findings included: Record review of Resident #61's face sheet dated 10/30/24 reflected a [AGE] year-old-male with an original admitted [DATE]. Diagnoses included arterial ulcer to right heel (deep sores or wounds in the skin of the lower leg or foot), acute osteomyelitis (acute inflammatory condition of bone secondary to infection), and type 2 diabetes mellitus (insufficient insulin production in the body). Record review of Resident #61's physician orders dated 5/28/24 stated: Enhanced barrier precautions when in contact with wound. Record review of Resident # 61's care plan created 9/20/24 stated Resident #61 was risk for infection or recurrent/chronic infection r/t compromised medical condition of active wounds. Interventions included: -Report changes in condition to doctor as clinically indicated. -Enhanced barrier precautions when in contact with wound. During an observation on 10/28/24 at 02:49 PM LVN E did not put on proper PPE such as a gown during wound care on Resident #61. In an interview on 10/30/24 at 11:18 AM the DON stated if there was an order for enhanced barrier precautions, then direct care staff providing care to a resident should be wearing the required PPE. The DON stated there should be an enhanced barrier precautions sign in the resident's room (observed above Resident #61's bed) and PPE was placed out in the hallways on a cart. In an interview on 10/30/24 at 01:31 PM LVN E stated she did not gown up due to forgetting. LVN E stated she did not see the PPE cart and that usually reminds her to put on PPE. LVN E stated it was important to wear PPE because it could compromise Resident #61's wound and could get infected. LVN stated there was an in-service on following infection control about a week ago. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/30/24 at 01:56 PM the DON stated it was important to follow doctor's orders and wear appropriate PPE to provide proper patient care. The DON stated LVN E should have worn PPE as ordered. The DON stated Resident #61 could be affected by wound getting infected. The DON stated if there was no PPE cart seen, then the charge nurse should have been notified and the charge nurse would tell the Infection Control Preventionist to get the proper supplies. The DON stated in-services are done at least quarterly. Record review of facility's Infection Prevention and Control policy dated 4/2024 stated: Compliance Guidelines: The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. In addition to isolation practices, Enhanced Barrier Precautions (EBP) maybe implemented as an infection control intervention designed to reduce transmission of resistant organisms. The use of PPE, such as gown and glove use during high contact resident care activities. Residents/Patients with the following clinical indication should be under EBP: Significant Wounds such as chronic wounds, ulcers, open PUI or complicated/non-healing surgical incisions or wounds, and/or open wounds requiring a dressing; excluding simple skin breaks or tears that are covered with an adhesive bandage (e.g., Band-Aid) or similar dressing.